# MY TOP 5

## TAKES ON A PAPER TITLED

## When not to start antibiotics: avoiding antibiotic overuse in the intensive care unit

1

### Avoid 'Just-in-Case' Antibiotics

Antibiotic in non-infected patients can increase their risk for adverse reactions, secondary infections as well as antimicrobial resistance. Authors proposed avoidance of antibiotic in ICU patients, unless strong evidence of infection is present.

### Appropriate history, thorough examination and targeted culture

2&3

**1) Diagnosing infection in ICU is NOT straightforward.**
Many clinical signs/cues are non-specific (e.g. tachycardia and fever).

**2) Some cultures are just difficult (to grow/interpret).**
This gold standard takes time (≥ 24 hours) and the yield may be poor due to antibiotic exposure and poor collection technique. Besides, not everything that grows demand our attention (clue: sputum/urine/swab culture).

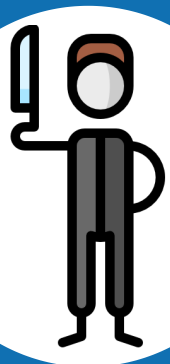
4

### Strike (accurately) as early as possible

**Initial appropriate antibiotic can make all the difference** (viz. between life and death). Accurate-spectrum antibiotic should always be our target, not just broad or powerful ones. However, in non-shocked patients, author suggested a delay in antibiotic commencement to allow adequate investigation and culture.

### Knife always, then only pills/injection

5



Adequate source control in patients with abscesses and removal of hardware like lines/ports would benefit patients more than our carbapenem/AA antibiotics combined in many instances.

Authors even went on and stated that in some cases, importance of antibiotic administration may be overemphasized, and source control should always be our main goal and in these cases antibiotic can be delayed to allow source recognition.