the PRUDENT prescriber

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In this edition:

Peanut Allergy Prevention Guidelines

Peanut allergy is a growing public health problem. In 2010 peanut allergy prevalence was approximately 2% among children in a national survey. Peanut allergy is the leading cause of death related to food induced anaphylaxis the United States. Although overall mortality is low, the fear of a life-threatening anaphylactic reaction contributes significantly to the medical and psychosocial burden of disease.

In February 2015, the New England Journal published the results of the Learning Early About Peanut Allergy (LEAP) trial. The trial randomized 640 children between four and 11 months of age with severe eczema, egg allergy, or both to consume or avoid peanut containing foods until 60 months of age, at which time a peanut oral food challenge was conducted to determine the prevalence of peanut allergy. Among the participants with a negative baseline skin response to peanuts, the prevalence of peanut allergy at 60 months of age was 13.7% in the peanut avoidance group and 1.9% in the peanut consumption group. (NNT=8) Among 98 participants with a measurable peanut skin test response, the prevalence of peanut allergy was 35.3% in the avoidance group and 10.6% in the consumption group. NNT = 4)

The 2017 Guidelines in a peaNUT SHELL:

Addendum Guideline	Infant Criteria	Recommendations	Earliest Age of Peanut Introduction
1	Severe eczema, egg allergy or both	Strongly advise evaluation by peanut-specific IgE or a peanut skin prick test	4-6 months
2	Mild to moderate eczema	Introduce peanut containing foods	Around 6 months
3	No eczema or any food allergy	Introduce peanut containing foods	Age-appropriate, and in accordance with family preferences

MY TAKE

My Take: The implementation of the Addendum #1 guideline for babies at higher risk is work for our allergy colleagues. Advising parents of babies with mild to moderate eczema to introduce peanut containing foods at six months is a piece of cake.

Quick Takes

- **Paxlovid Rebound:** In a prospective cohort study (Ann Intern Med 2023 Nov 14) utilizing serial nasopharyngeal swabs from patients with COVID-19 (57% of whom received Paxlovid) virologic rebound occurred in approximately 20% of patients who received Paxlovid and in less than 2% of those who did not. The duration of viral shedding was 14 days in those with viral rebound versus 3 days in those without rebound.

My Take: These data plus increasing evidence that a large number needed to treat (NNT) to prevent hospitalization/death in even the elderly with lots of co-morbid conditions plus Pfizer's avarice ($1400/course) spells, *"I have taken Paxlovid off my personal prescribing formulary."*

- **Best antibiotic treatment for group A streptococcal pharyngitis:** A Cochrane Database Systemic Review 2023, November 15; 11 (11) looked at randomized, double-blind trials, comparing different antibiotics for group A streptococcal pharyngitis that reported at least one of the following: clinical care, clinical relapse, or complications and/or adverse events. In their summary of 19 trials, including 5839 randomized participants, the authors concluded "Antibiotics have a limited effect in the treatment of group A beta hemolytic strep pharyngitis. The results do not demonstrate that other antibiotics are more effective than penicillin. In the context of antimicrobial stewardship, penicillin can be used if treatment with an antibiotic is indicated. All studies were conducted in high income countries with a low risk of streptococcal complications.

My Take: There is a growing group of infectious disease experts who make the rather convincing case that we should cease and desist from looking for and treating strep throat. They argue that the risk of significant allergic reactions to penicillin far out way the benefits.

- **DEA Renewal:** Over the last three months I've received multiple email reminders that my DEA registration will expire soon. A part of that reminder is the information that as of December 29, 2022, there is a one time, eight-hour training requirement for all DEA registered practitioners on the treatment and management of patients with opioid or other substance use disorders. After stumbling around the Internet for an hour, I discovered the New England Journal of Medicine (NEJM) Knowledge+ site. This is a compendium of continuing medical education tutorials, including preparations for internal medicine, family medicine, and pediatric boards. ($650 each) Also available is an eight-hour course entitled "Pain Management and Opioids." This 63 case presentation CME is an "in the trenches", practical, palatable answer to the DEA educational requirement and it's FREE.

- **Making Emergency Contraception More Effective**
  My Way, generic Plan B, (a single 1.5 mg dose of levonorgestrel, $12-$20/dose) disrupts ovulation when taken within three days after unprotected sexual intercourse. It is also known that Cox inhibitors, mostly used as anti-inflammatory drugs, also disrupt ovulation. A study from Hong Kong (Lancet, 2023, September 9) randomized 860 healthy women requesting emergency contraception to 1.5 mg of levonorgestrel plus 40 mg of piroxicam (generic Feldene $8 for 30 tabs) or 1.5 mg levonorgestrel plus placebo. The average time between unprotected sex and emergency contraception was 18 hours.
  Results:

- Seven pregnancies occurred in the levonorgestrel alone group (1.7%) and one pregnancy occurred in the combined levonorgestrel/piroxicam group (0.2%). The number needed to treat (NNT) with the addition of piroxicam to Plan B to prevent one pregnancy was 70.
- The side effect profiles of the two groups were similar: nausea and fatigue.

My Take:

- Since My Way is available over the counter, spreading the word about this simple, safe, inexpensive intervention may be difficult.
- How do you get $.50 worth of piroxicam into the hands of the worried patient?
- And recall that prescription Ella ($41-$50) is much more effective than Plan B alone.

- **Insulin Less Heat Sensitive than Previously Thought**
  My thanks to Dr Carol Greenlee, endocrinologist extraordinaire, for pointing out a new Cochrane Review (November 2, 2023). The review included 17 studies in 22 published articles. The data suggest that it is possible to store unopened, short and intermediate acting human insulin vials, pens and cartridges and pre-filled plastic syringes at temperatures up to 25˚C (77˚ F) for a maximum of six months and up to 37˚C (98.6˚F) for a maximum of two months without a clinically relevant loss of insulin potency. The review also found that isolating temperatures between 25˚C (77˚F), and 37˚C (98.6˚F), typical of daytime and nighttime fluctuations in tropical countries, for up to three months did not result in clinically relevant loss of insulin activity for short – acting, intermediate – acting, or mixed human insulin.

My Take: This review offers practice changing information for individuals living in challenging environments where access to refrigeration is limited. It also offers reassurance for individuals in developed countries who forget to refrigerate their insulin.

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