

widely considered to imply frailty, and European advocacy organisations have pressed for rejection of its use as a descriptor for older people.⁵ It would be helpful if *Clinical Medicine* would consider avoiding the term and instead use 'older person' or 'older people', which are less value-laden and of greater scientific utility.

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Outpatient parenteral antimicrobial therapy in a changing NHS: challenges and opportunities.

Editor – Dr Chapman made the case for more outpatient parenteral antimicrobial therapy (OPAT) (*Clin Med* February 2013 pp 35–6). The figures in an earlier paper of hers on the clinical efficacy and cost effectiveness of OPAT state that 59% of the treatment episodes were for soft tissue sepsis.¹ The majority of these patients had cellulitis and were receiving ceftriaxone intravenously (IV) with a mean duration of IV antibiotics exceeding 7 days. There are studies comparing inpatient IV therapy with outpatient IV therapy for cellulitis which demonstrate mutual efficacy,² but Dr Chapman does not supply the data to support the benefit of IV

therapy over oral antibiotic therapy. A large study comparing an oral treatment to IV therapy for cellulitis showed marginally improved outcome with oral therapy.³ Why, then, do we need to give patients with cellulitis long courses of broad spectrum IV antibiotics, when we have a range of effective oral antibiotics? It may be that many of these patients, because of very slowly resolving skin damage, are mistakenly regarded as having failed initial oral antibiotic therapy, when in fact the duration of recovery is independent of the route of the antibiotic.

Perhaps, before we encourage the Department of Health and our new commissioners to invest in OPAT services, we ought to produce some evidence that IV therapy is better than oral treatment for those conditions in which we are proposing OPAT?

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In response

Editor – Dr Brindle makes the important point that oral antibiotics should always be used in preference to intravenous (IV) antibiotics where possible. However, the evidence base demonstrating the relative effectiveness of oral and IV antibacterials for significant soft tissue sepsis is limited.¹ The paper he cites by Bernard *et al*² used oral pristinamycin in comparison with intravenous penicillin in only a small subset of patients with soft tissue sepsis; that is, patients with erysipelas of moderate severity. The study demonstrated that in these patients pristinamycin was non-inferior to IV penicillin. Although drop-out

rates were similar in the two groups, pristinamycin was associated with a significant increase in gastrointestinal upset.

Currently it is accepted that a proportion of patients with soft tissue sepsis will require IV antibiotics, but not admission. The CREST guidelines³ classify cellulitis by severity into four classes ranging from mild infection (class I) to severe life-threatening infection or sepsis syndrome (class IV). Class II patients have cellulitis with systemic symptoms of sepsis, or with comorbidities that may complicate or delay resolution of infection – for example, lymphoedema, peripheral vascular disease or chronic venous insufficiency. Intravenous antibiotics, through OPAT where available, are recommended for this group, which includes approximately 30% of patients presenting to hospital with cellulitis.⁴

However, there is a real danger of overuse of IV therapy in patients with mild infection⁴ and this may be more likely where an OPAT service exists. In our earlier paper this issue was discussed,⁵ but it was noted that virtually all patients were referred to OPAT by a physician (either GP or medical admissions unit doctor) and were then further assessed by a specialist OPAT doctor and nurse before being accepted in order to ensure as far as possible that IV therapy was appropriate. Our more recent (unpublished) data show that 8% of patients with cellulitis referred for OPAT are not accepted but are given optimised oral antibiotic therapy; virtually all have already received oral therapy from other healthcare providers, reinforcing the importance of ensuring oral therapy is adequate before considering parenteral antibiotics.

In managing soft tissue sepsis, as with many other infections, choice of IV vs oral antibiotic therapy is often determined to a large extent by clinical judgement, and it is important therefore that their use in OPAT and more generally is overseen through a robust antibiotic stewardship programme.⁶ There remain many uncertainties and therefore a need for further prospective comparative studies.

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