

## Responsible Use of Fluoroquinolone Antibiotics: The responsible, moral, and ethical approach (vs. the profit approach).

Author: JMR, <http://fluoroquinolonethyroid.com>

Fluoroquinolone Antibiotics, originally designed to be used judiciously as a last resort antibiotic, are currently being used widely and indiscriminately as a “first choice” antibiotic for simple bacterial infections, presumed or suspected (non-confirmed) bacterial infections, and even viral infections.

I am not against the usage of these drugs. Instead, I am calling for a return to a much more judicious and responsible use of this class of antibiotics, as they were originally intended. This includes the following recommendations:

1. Fluoroquinolones should only be considered an option for severe, life threatening proven bacterial infections, based on culture and sensitivity. For example, they should NOT be considered for routine uncomplicated urinary tract infections, sinus infections or prostate infections for which no culture has been done. They also should NOT be prescribed for infections which may be viral in nature. They should NOT be prescribed “prophylactically”, which means to prevent potential infections that don’t yet exist.
2. If a severe, life threatening, proven bacterial infection exists, the fluoroquinolones should only be prescribed as the antibiotic of “last choice”, based on the culture and sensitivity done for the infection. This means ruling out ALL other available antibiotics that may work for that infection (ie, the bacteria for this infection are resistant to all other antibiotic choices). This includes ruling out ALL other available antibiotics due to patient allergies to those antibiotics. This means there is NO OTHER CHOICE of an antibiotic available for this infection. Patients have a right to receive the copy of their culture reports as proof of this from their physician.
3. If the first two criteria are met, the patient or person with power of attorney should be appropriately warned as to the potential side effects of these antibiotics, including rare, but possible long-term disability due to these adverse effects. The patient should be warned of currently known risk factors that may predispose or increase the likelihood of adverse reactions, and be appropriately screened for these, treated if necessary, and monitored over time. The patient should understand that they are being prescribed a drug that not only functions as an antibiotic, but as a chemotherapeutic (anti-cancer) agent as well.
4. Patients receiving fluoroquinolone antibiotics should not be prescribed the antibiotic Metronidazole (common name Flagyl) concurrently or even serially close in time, if possible, as both of these antibiotics list neuro-toxicity as potential side effects. Additionally, it should be noted that, unlike other antibiotics on the market, both of these classes of drugs (fluoroquinolones and **nitroimidazoles**) target and break DNA, which may contribute to their adverse effect profile if crossover to human DNA is occurring. Although prescribing a Fluoroquinolone antibiotic concurrently with Metronidazole is considered the “standard of care” for some conditions (ie, diverticulitis), this standard of care should be reviewed and reconsidered given the potential adverse effects. Patients also should not be given Prednisone, other steroids, or NSAIDS (non-steroidal anti-inflammatories) concurrently or serially close in time, as these also may potentiate adverse reactions.

Author: JMR, <http://fluoroquinolonethyroid.com>

5. The patient taking fluoroquinolones should be offered protective measures, to the best of our current knowledge, against these adverse effects. For example, this may include supplementation with a full complement of minerals, but in particular Magnesium, Calcium, Iron, and Zinc, anti-oxidants either in oral or IV form, and potential rescue agents such as Vitamins A, C, D, and E.
6. Lastly, but also extremely important, I do recommend an **enforced** ban to prevent this entire class of antibiotics from being used in chronic sub-therapeutic doses in food animals. These antibiotics are often used in this fashion to make food animals grow faster, as well as prevent infection due to crowded and unsanitary conditions in our factory-farmed food supply. There is no faster way to increase bacterial resistance and create “super-bugs” than to use antibiotics in this fashion in any population. This practice more than any other ultimately destroys the very health a population is working to maintain in the long run.

Restricting the fluoroquinolone antibiotics in this fashion would result in several outcomes:

1. Fluoroquinolone Antibiotics would be used rarely, thereby preventing bacterial resistance from developing. *This issue alone would ensure that there would always be an antibiotic of last choice to use for patients who need them in the future.*
2. The number of patients adversely affected by this class of antibiotics would decrease as well. The horrific stories of severe and permanent disability as a result of this class of drugs would hopefully become a thing of the past.
3. The fluoroquinolone residue load in our environment, including water, soils, and even bee pollen, would be substantially decreased or essentially eliminated to non-detectable levels.

## What is truthful “informed consent”?

All antibiotics have side effects. What differentiates this class of antibiotics from others is its ability to cause severe adverse reactions that can permanently disable patients for a lifetime and even cause death.

Patients have a right to truthful, informed consent about the possibility of long term or permanent disability from this class of drugs. As such, here is what I believe the Black Box Warning should say, and what doctors and pharmacists should present to their patients every single time before prescribing these drugs. No size 5 font buried among other information, no sugar coating the possibilities or spin, no happy people with happy music in the background like in the direct to consumer commercials. Just the plain truth.

If, despite these warnings, a patient still wants to take these antibiotics even if other alternative antibiotics exist, they should be willing to sign an “informed consent” to the above warning. Brand name, not generic, should be prescribed. Patients should be aware that if an adverse reaction occurs with generic drugs, there is **no** legal action or recourse available to the patient.

Alternative antibiotics can be found here:

<http://www.emedexpert.com/lists/antibiotics.shtml> Lists of antibiotics

[http://en.wikipedia.org/wiki/List\\_of\\_antibiotics](http://en.wikipedia.org/wiki/List_of_antibiotics) Lists of antibiotics

Research the internet and go to Amazon to read reviews for “D-Mannose” as an option or adjunct for simple (uncomplicated) UTI treatments. Be aware that D-Mannose in general only works for *E. Coli* infections, of which approximately 85-90% of UTI’s are. So you have an 85-90% chance this will work or help. Always culture UTI’s and be aware that D-Mannose will not work for other types (about 10-15%) of bacterial UTI’s.

For serious or chronic infections, Phage therapy may become available more and more: [Minireview: Bacteriophage Therapy](#). A few real life experiences, both pros and cons, here: [Mail Order Viruses Are The New Antibiotics](#).

[Doctors Have Begun to Adopt a Surprising Ancient Treatment to Help Heal Painful Infected Injuries](#). A somewhat unpalatable, but another potential option for some types of chronically infected wounds.

[Edward-Elmhurst “Gerbusters” Take Aim at Drug Resistant Bacteria](#) From 9/18/16 Chicago Tribune, an example of how decreasing the use of Levaquin is beneficial: *“These efforts have led to changes in several protocols at Edward-Elmhurst Health, says Van Hise. “Levaquin has been one of the top ten prescribed drugs in the country, leading to increased resistance and ineffectiveness. At Edward-Elmhurst, we’ve decreased its used tenfold and now only use it for targeted infections. We’ve replaced Levaquin with **less expensive and more effective antibiotics** . . . Through education and revised hospital protocols, the team has **decreased mortality and lengths of stay**, while **saving more than \$3 million in health care costs** . . . Says Van Hise, “If new protocols like this can be adopted by other hospitals in the US for one of the most common infections in the world, this will be a game-changer.”*

## Here’s what the Black Box Warning for *patients* SHOULD say about fluoroquinolone antibiotics:

***WARNING: THERE IS A SMALL, BUT SIGNIFICANT RISK THAT THIS ANTIBIOTIC MAY CAUSE WHOLE BODY TENDON, LIGAMENT, AND CARTILAGE DAMAGE, PERIPHERAL NERVE DAMAGE, CENTRAL NERVOUS SYSTEM DAMAGE, AUTONOMIC SYSTEM DAMAGE, ENDOCRINE SYSTEM DAMAGE, CARDIAC DAMAGE, GENOME (DNA) DAMAGE, AND MITOCHONDRIAL DAMAGE. These adverse effects may range from mild to severe, and may cause temporary or permanent crippling and partial or total disability. These reactions may occur immediately, or may be delayed for up to an unknown period of time after stopping the drug. It is unknown at this point in time who may be affected, and for what severity and duration. Prior exposure to these antibiotics may increase this risk in subsequent exposures. Taking this drug safely in the past does not guarantee that you will not have a reaction in the future. If this risk is acceptable to you for your current condition, then take this drug. However, if this is an unacceptable risk to you, be aware there are many alternative antibiotics available for most people with equal efficacy and less risks for your condition.***