An Evaluation Of Antibiotics Prescribing Patterns In The Emergency Department Of A Tertiary Care Hospital In Saudi Arabia

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Background: Antibiotic prescriptions at emergency departments (ED) could be a primary contributing factor to the overuse of antimicrobial agents and subsequently antimicrobial resistance. The aim of this study was to describe the pattern of antibiotic prescriptions at an emergency department of a tertiary care hospital in Saudi Arabia.

Methods: A cross-sectional study, based on a review of antibiotic prescriptions was conducted. All cases who visited the emergency department over a three-month period with a complaint of infection were analyzed in terms of patient characteristics (age, sex, infection type, and number of visits) and prescription characteristics (antibiotic category, spectrum, course and costs). The World Health Organization and International Network of Rational Use of Drugs prescribing indicators were presented. Descriptive and analytic statistics were applied.

Results: A total of 36,069 ED visits were recorded during the study period, of which 45,770 drug prescriptions were prescribed, including 6,354 antibiotics. The average number of drugs per encounter was 1.26, while the percentage of encounters with a prescribed antibiotic was 17.6%. Among antibiotic prescriptions, the percentage of encounters with injection antibiotics was 15.2%. Almost 77% of antibiotics were prescribed by their generic names, and the percentage of antibiotics prescribed from the essential list was 100%.

Conclusion: The average number of drugs per encounter in general and antibiotics per encounter in specific at this setting was lower than the standard value. However, the percentage of antibiotics prescribed by its generic name was less than optimal.

Keywords: antibiotic, prescription, errors, prevalence, predictors, emergency
addition, numerous ED visits result in adverse reactions associated with systemic usage of antibiotics.\textsuperscript{14}

Unfortunately, there is a limited insight into the antibiotic prescription patterns at EDs in Saudi Arabia. Reports stated that 4.4% of the Saudi Arabian population have visited its healthcare facilities as outpatients, and 11.5% were admitted in 2014.\textsuperscript{15} A review of the literature revealed that only three studies have addressed antibiotic-prescribing patterns and its appropriateness at EDs in Saudi Arabia.\textsuperscript{16–18} One of these studies that was conducted in Central Saudi Arabia investigated the antibiotic prescriptions at a pediatric emergency setting and showed that 18.5% of prescriptions were antibiotics.\textsuperscript{16} A second study concluded that the duration of treatment was the most common inappropriate pattern in antibiotic prescriptions.\textsuperscript{17} In Western Saudi Arabia, almost half (47%) of ED prescriptions contained at least one systemic antibiotic.\textsuperscript{18} The aim of this study was to describe the pattern of antibiotic prescriptions at an emergency department of a tertiary care hospital in Saudi Arabia.

**Methods**

**Study Design And Setting**

This was a cross-sectional study, during which antibiotic prescriptions were revised over a period of 3 months at the ED of a major tertiary care facility in Riyadh, Saudi Arabia. King Abdulaziz Medical City (KAMC) is a distinguished Joint Commission International (JCI) accredited health care provider established since 1983 and under the umbrella of the Ministry of National Guard Health Affairs (MNG-HA). It has a total bed capacity exceeding 1,200 beds among which 90 beds are allocated within two adult and pediatric emergency wards. A team of more than 80 emergency consultants (specialists, associates, and assistants), staff physicians, fellows, and residents provide services at this facility.

**Study Population And Sampling Technique**

Consecutive sampling was done by screening all visits to the targeted ED during a 3-month period. Eligible participants were of all age groups (6 months to 65 years), registered at KAMC with a medical record number and received at least one antibiotic during each visit or encounter. ATB prescriptions that were either incomplete (e.g., missing ATB dosage or frequency) or had illegible handwriting were dropped out. Infants with weight less than 5 kg were excluded. At KAMC, prescriptions are generally cashed from an in-hospital pharmacy free of charge. This study was approved by the Institution Review Board of the Ministry of National Guard Health Affairs, Riyadh, Saudi Arabia (RR08/005).

**Methods Of Measurement**

Three certified and well-trained research coordinators collected the data. Training was performed by the study investigators on how to access, screen, and select eligible study cases from the medical records and document the findings on a controlled research form. The antibiotic prescriptions were written by medical residents, fellows, and consultants at the ED. All prescriptions were revised by the pharmacy staff through a computerized pharmacy data system (Legacy). The pattern of antibiotic prescription for each case was evaluated by two certified pharmacists with extensive research and clinical experience. Cases that lacked consensus during the evaluation were dropped out.

The data collection form was composed of patient characteristics (age, sex, number of visits, type of infection, cultures obtained) and prescription characteristics (antibiotic category, spectrum, number of courses and associated costs). The World Health Organization (WHO) and International Network of Rational Use of Drugs (INRUD) antibiotic-prescribing indicators at EDs were used in this study.\textsuperscript{19} The average number of drugs per encounter was calculated by dividing the total number of drugs prescribed at the ED over the total number of visits during the study period. The percentage of encounters with a prescribed antibiotic was calculated by dividing the number of prescribed antibiotics over the total number of ED visits multiplied by 100. The percentage of encounters with injection antibiotics was calculated by dividing the number of injection antibiotics over the total number of prescribed antibiotics multiplied by 100. The number of antibiotic prescriptions by generic name was divided over the total number of antibiotics to determine the percentage of antibiotics prescribed by generic name. As per the WHO Essential Medicine List for optimal use,\textsuperscript{20} the percentage of antibiotics prescribed from the essential list (classified as Access or Watch) was divided over the total number of prescriptions multiplied by 100.

**Statistical Analysis**

Data were analyzed using SPSS (version 25.0, IBM SPSS Inc., NY, USA). Descriptive statistics such as mean ± standard deviation (mean ± SD) were used to describe the quantitative variables. Frequencies (n) and percentages (%) were used to describe categorical variables. Bar charts were
generated to display the most common types and classes of antibiotics prescribed according to age groups and common diseases treated with antibiotics. Pearson’s chi-squared tests were used to assess for age group differences across various exposures. Independent two-sample Mann–Whitney U-test was used to assess the difference in the cost of the antibiotic prescription according to age groups. A P-value ≤0.05 was considered to indicate statistical significance.

Results
During the study period, there were 36,069 ED visits, resulting in 45,770 drug prescriptions, of which 6,354 were antibiotic prescriptions. The prevalence of prescribed oral antibiotics was 13.9%, whereas others (86.1%) were injections. Of the antibiotic prescriptions, 2,335 (36.7%) were prescribed for children (<18 years), while 4,019 (63.3%) were prescribed for adults. Significantly, more oral antibiotics (26.5%) were prescribed for adults than children (P = 0.001). Similar sex distribution was observed. Patients were treated mainly for upper respiratory tract infections (URTIs) and urinary tract infections (UTIs) (31.8% and 22.5%, respectively). Other types of infections were observed at lower rates, including otitis media (OM) (10.2%), and skin infections (6.3%). Cultures were obtained from 18.6% of patients only. The most frequent cultures were for samples of urine (51.2%), blood (21.1%), and throat swabs (11.3%). Only 27.9% of patients had positive cultures. The average cost of antibiotics prescribed was equivalent to US$17.8, with maximum costs up to $139.2 (Table 1).

Male children were more likely to be prescribed an antibiotic than male adults (56.9% vs 44.0%), while female adults were more likely to be prescribed an antibiotic than female children (56% vs 43.1%). The frequency of RTIs was significantly higher in children (42.9%) than adults (25.4%) (P = 0.001) and UTIs were observed in 29% of the adults and 11.5% of the pediatric patients. A significantly higher proportion of adult patients had positive culture results compared with the pediatric patients (30.2% vs 24.9%). The number of antibiotic courses was significantly associated with age groups (P = 0.001). A significantly higher proportion of children received a single course of antibiotics compared with the adult patients (90.7% vs 87.3%). In contrast, a significantly higher proportion of adult patients received two courses of antibiotics compared with children (10.4% vs 8.3%). The price of prescribed antibiotics was significantly higher among children compared to adults ($19.9 ± 12.5 vs $14.1±8.7, P = 0.001) (Table 2).

As shown in Figure 1, Augmentin was the most frequently prescribed antibiotic (22.1% vs 20.2% in adults), followed by cefuroxime (16.9% vs 3.5% in children vs 24.8% in adults), and amoxicillin (13.1% vs 20.7% in children vs 8.7% in adults). Penicillin was the most frequently prescribed class of antibiotics (35.5%; 46.3% in children vs 29.3% in adults), followed by cephalosporin (30.3%; 33.4% in children vs 28.5% in adults), and macrolides (20.9%; 18.5% in children vs 22.3% in adults). Figure 2 shows that the most common classes of antibiotics prescribed to URTI cases were penicillin (45%), including amoxicillin (24.1%) and Augmentin (21%), followed by macrolides (35.1%), including azithromycin.
(17.1%) and clarithromycin (18%), and cephalosporin (20%),
including cefuroxime (10%), cefprozil (8.1%), and cephalaxin
(1.6%). The most common classes of antibiotics prescribed for
UTI cases were cephalosporin (39.2%; mainly cefuroxime
33%), followed by penicillin (26.5%), including amoxicillin
9% and Augmentin (17.4%), and quinolones (23%; mainly
norfloxacin 21%). In OM, the most common classes of anti-
biotics prescribed were penicillin (62%), including amoxicillin
(16%) and Augmentin (46%), followed by cephalosporin
(30%; mainly cefprozil 25%).

The average number of drugs per encounter was 1.26, while
the percentage of encounters with a prescribed antibiotic was
17.6%. Among antibiotic prescriptions, the percentage of
encounters with injection antibiotics was 15.2%. Almost 77% of
antibiotics were prescribed by their generic names, and the
percentage of antibiotics prescribed from the essential list was
100%. The indicators were tabulated and compared to the
standard values of WHO/INRUD prescribing indicators at
EDs in Table 3.

Discussion
The prescribing indicators at this setting were compared to the
standard benchmark as well as figures published in the litera-
ture. The average number of drugs per encounter in general and
antibiotics in specific at this setting was lower than the standard
values. This can be attributed to the general Saudi Arabian

Table 2 Association Between Age Groups And Other Sample Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Adults</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2335 (36.7%)</td>
<td>4019 (63.3%)</td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1328</td>
<td>1769</td>
<td>0.001 a</td>
</tr>
<tr>
<td>Female</td>
<td>1007</td>
<td>2250</td>
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</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Upper RTI</td>
<td>1001</td>
<td>1019</td>
<td>0.001 a</td>
</tr>
<tr>
<td>UTI</td>
<td>268</td>
<td>1164</td>
<td></td>
</tr>
<tr>
<td>OM</td>
<td>432</td>
<td>219</td>
<td></td>
</tr>
<tr>
<td>Lower RTI</td>
<td>423</td>
<td>738</td>
<td></td>
</tr>
<tr>
<td>Skin infection</td>
<td>101</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>110</td>
<td>584</td>
<td></td>
</tr>
<tr>
<td>Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>1222</td>
<td>2310</td>
<td>0.001 a</td>
</tr>
<tr>
<td>Two</td>
<td>575</td>
<td>887</td>
<td></td>
</tr>
<tr>
<td>Three or more</td>
<td>538</td>
<td>822</td>
<td></td>
</tr>
<tr>
<td>Type of culture</td>
<td></td>
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<tr>
<td>Blood</td>
<td>138</td>
<td>113</td>
<td>0.001 a</td>
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<tr>
<td>Urine</td>
<td>162</td>
<td>446</td>
<td></td>
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<tr>
<td>Throat</td>
<td>117</td>
<td>17</td>
<td></td>
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<tr>
<td>Others</td>
<td>85</td>
<td>110</td>
<td></td>
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<tr>
<td>Culture results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>377</td>
<td>479</td>
<td>0.045 a</td>
</tr>
<tr>
<td>Positive</td>
<td>125</td>
<td>207</td>
<td></td>
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<tr>
<td>Spectrum of antibiotic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Broad</td>
<td>1727</td>
<td>3167</td>
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</tr>
<tr>
<td>Narrow</td>
<td>608</td>
<td>852</td>
<td></td>
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<tr>
<td>Antibiotic category</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cephalosporin</td>
<td>779</td>
<td>1145</td>
<td>0.001 a</td>
</tr>
<tr>
<td>Macrolide</td>
<td>432</td>
<td>895</td>
<td></td>
</tr>
<tr>
<td>Penicillin</td>
<td>1081</td>
<td>1178</td>
<td></td>
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<tr>
<td>Quinolone</td>
<td>15</td>
<td>631</td>
<td></td>
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<tr>
<td>Others</td>
<td>28</td>
<td>170</td>
<td></td>
</tr>
<tr>
<td>Antibiotic courses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>1918</td>
<td>3029</td>
<td>0.001 a</td>
</tr>
<tr>
<td>Two</td>
<td>176</td>
<td>362</td>
<td></td>
</tr>
<tr>
<td>Three or more</td>
<td>21</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Cost (US$), mean ± SD</td>
<td>19.9±12.5</td>
<td>14.1±8.7</td>
<td>0.001 a</td>
</tr>
</tbody>
</table>

Notes: *Pearson Chi-squared test significant at α = 0.05. †Mann–Whitney U-test significant at α = 0.05.
Abbreviations: RTI, respiratory tract infection; UTI, urinary tract infection; SD, standard division; OM, otitis media.
population’s prevalence of infections compared to other Asian countries. For instance, The Saudi Commission for Health Specialties in Saudi Arabia has stated that lower respiratory infections ranked 5th on the top 10 list for mortality. In countries like Yemen, Mongolia, Uzbekistan, Philippines, Pakistan and India, lower respiratory infections, as well as diarrheal diseases and tuberculosis, have been reported as the worst-ranked countries in Asia in terms of these infections. This justifies why the percentage of antibiotic encounters was less in Saudi Arabia compared to others.

The percentage of encounters with a prescribed antibiotic could be influenced by some factors. For instance, these figures might be inflated due to the lack of compliance of ED physicians with the standards of practice, or deficient hospital resources to confirm infections by ordering cultures. In Saudi Arabia, the health care industry is highly supported and funded by the government, courtesy to the high economic revenues generated by the oil industry. Therefore, ED physicians at this setting were probably more conservative in antibiotic selection. They were capable of ordering laboratory cultures and confirming any suspected microbe prior to antibiotic prescriptions. However, the percentage of antibiotics prescribed by their generic name was less than optimal, compared to other studies. In this setting, the most common antibiotic used by its brand name was Augmentin. WHO recommend prescribing drugs by their generic name (rational prescribing) since it has been shown to be cost-effective and provides flexibility in its purchase from drug stores. It is noteworthy that this policy is applicable to both the public and private healthcare settings, yet at this setting, this lack of compliance had trivial effects as antibiotics are cashed from the in-hospital pharmacy and monitored by licensed pharmacists, free of charge to the patients.

Antibiotics accounted for 17.6% of all prescribed medications in this study. This figure was found to be rational, as it falls below the WHO index that stated antibiotic

Table 3 WHO/INRUD Prescribing Indicators At EDs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value (SD)</th>
<th>Standard Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of drugs per encounter (n=45,770)</td>
<td>1.26</td>
<td>1.6–1.8</td>
</tr>
<tr>
<td>Percentage of encounters with a prescribed antibiotic (n=6354)</td>
<td>17.6 (0.4)</td>
<td>20.0–26.8%</td>
</tr>
<tr>
<td>Percentage of encounters with an injection antibiotics (n=5470)</td>
<td>15.2 (0.4)</td>
<td>13.4–24.1%</td>
</tr>
<tr>
<td>Percentage of antibiotic prescribed by generic name (n=4881)</td>
<td>77 (1.1)</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of antibiotic prescribed from the essential list (n=6354)</td>
<td>100</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: *Access and Watch classified antibiotics.

Figure 1 The most frequently prescribed antibiotics by age group.

Figure 2 The most frequently prescribed classes of antibiotics by disease.
prescriptions range between 20.0% and 26.8% of the total prescriptions in EDs.\textsuperscript{24} The ED at this facility is continuously implementing updated policies and guidelines to monitor the usage of antibiotics. A variety of training programs are performed annually to educate clinicians on the proper usage of antibiotics. It has been reported that staff education is the most useful option in improving such outcomes.\textsuperscript{25} These initiatives are more likely to contribute to the rational use of oral antibiotics recorded at this setting, although further studies are required to explore the impact of these guidelines and training programs.

Augmentin was the most common antibiotic prescribed at this ED which was not consistent with a Saudi Arabian study reported by Oqal et al.\textsuperscript{18} In this setting, the most frequently prescribed antibiotics were penicillin, cephalosporin, and macrolides, which was comparable to findings reported by previous local studies.\textsuperscript{16,18} Similar to previous studies,\textsuperscript{18,26–30} this study showed that URTIs and UTIs were the leading types of infection for which antibiotics are prescribed in EDs. For patients who complained of URTIs, broad-spectrum antibiotics, predominantly Augmentin and macrolides were prescribed more often than narrow-spectrum antibiotics. This pattern of prescription was similar to previous reports that cautioned about the phenomenon of Augmentin\textsuperscript{18,31} or macrolides\textsuperscript{27,32} over-prescription in the treatment of URTIs. Apparently, such an increase in the selection of broad-spectrum antibiotics by ED clinicians is expected because of uncertainty regarding the patients’ diagnoses.\textsuperscript{33}

The present study has some limitations. First, the study was conducted in EDs only; thus, our findings may not be generalized to other types of healthcare settings or populations. Second, the study period was short (3 months) and retrospective in nature; therefore, some prescriptions might have been missed. Authors were unable to collect other important information as our study was based mainly on chart review. Regardless of these limitations, this study provides important information on the prescribing pattern in a major healthcare facility in Saudi Arabia.

Conclusions
This study described the pattern of antibiotic prescriptions at an ED. Evaluation of antibiotic prescription patterns is crucial to improve the rational usage of antimicrobial agents. The pattern of antibiotic prescription at this setting appears to be rational, as it fell within the standard WHO prescribing indexes. It is noteworthy that the variations in prescription indicators across countries might be attributed to the differences in the spread of infections and availability of resources to conduct confirmatory laboratory tests. Continuous surveillance on the implementation of guidelines is important to improve prescribing practices and reduce the misuse of antibiotics.

Ethics Approval And Consent To Participate
Data collectors were full-time employees; thus, preserving the confidentiality of the patients’ information is an essential norm of their job requirements. MRNs of enrolled patient charts were recorded to further investigate the validity of data collected. No written consents were obtained, as the study was a retrospective chart review. Patient’s privacy and confidentiality of data were secured by the authors of this study. The research committee at King Abdullah International Medical Research Center approved this study (RR08/005). This study followed the recommendations of the International Conference on Harmonization for Good Clinical Practice (ICH-GCP) and in compliance with the Declaration of Helsinki.

Availability Of Data And Materials
Data supporting the findings are available with the corresponding author.

Acknowledgments
The authors would like to acknowledge King Abdullah International Medical Research Center and King Saud bin Abdulaziz University for Health Sciences. Special thanks go to Drs Ahmed Alaskar, Farha Nazir, Abdul Rahman Jazieh, Amin Kashmeery, Abdulhaleem Sawas, Abdullah Adlan, and Salah Al-dkhail.

Author Contributions
All authors contributed to the study concept, analysis and interpretation of data, drafting and critically revising the paper, gave final approval of the version to be published, and agreed to be accountable for all aspects of the work.

Disclosure
The authors report no conflicts of interest in this work.

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