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*F I X I N G  T H E  A N T I B I O T I C*

# TREATMENT CHOICE DRIFT

*- A brand-led playbook to restore Brand UMI as a consciously chosen first-line option -*

*2026*

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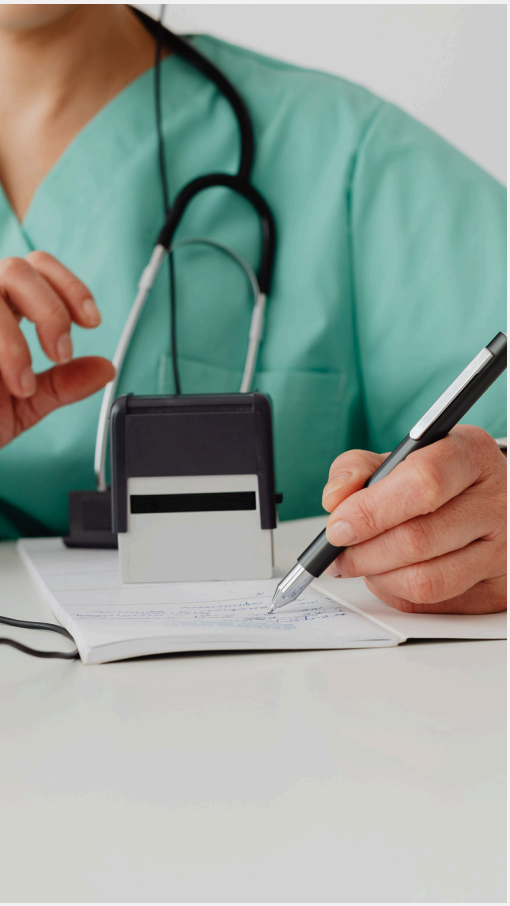
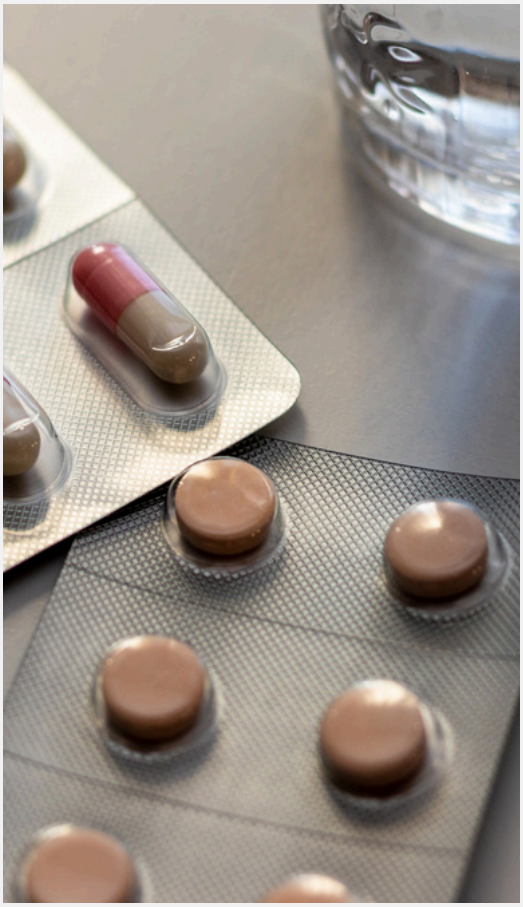
# EXECUTIVE SUMMARY

*THE DRIFT DEFINITION*






Brand UMI is built on a molecule that remains clinically valid, guideline-listed, and safety-established.

Co-trimoxazole continues to be recommended within frameworks endorsed by the Indian Academy of Pediatrics, the World Health Organization, and national treatment guidance for defined pediatric and general practice indications. The scientific position is stable. The evidence base has not eroded.

Yet, in real-world practice, the brand is progressively under-selected.

This does not stem from gaps in awareness, access, or clinical relevance. It reflects a systemic displacement at the level of treatment choice.

Over time, prescribing behaviour has shifted upward in spectrum intensity. Broader-spectrum antibiotics are now frequently initiated as the empiric default - even in scenarios where narrower, guideline-aligned options remain appropriate.

This shift has been gradual, behavioural, and largely unconscious, rather than evidence-driven.

*The result is a structurally imbalanced environment:*

- *The antibiotic category continues to expand*
- *Empiric intensity escalates*
- *Brand UMI is bypassed at the point of first prescription*

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The molecule is not rejected. It is simply no longer mentally prioritised. Conventional revival levers - legacy recall, safety reassurance, or molecule-level re-education : do not correct this dynamic. In fact, when escalation bias is left unaddressed, category education can unintentionally reinforce antibiotic confidence while first-line selection migrates further toward broader agents.

The strategic question for Brand UMI is therefore precise and time-bound : How can Co-trimoxazole be repositioned as a consciously selected, stewardship-aligned first-line option in defined indications - rather than a secondary consideration in an era of broad-spectrum reflex prescribing?

This is not a relevance issue, but a treatment hierarchy problem that must be corrected at the point where spectrum intensity is chosen.

# MARKET REALITY

## *THE GUIDELINE–REALITY GAP*

For Brand UMI, the scientific and guideline base remains intact. Co-trimoxazole continues to be endorsed within rational antibiotic use frameworks of the Indian Academy of Pediatrics, included in the World Health Organization essential medicines list, and referenced in national guidance for defined pediatric infections. Its therapeutic positioning is clearly established.

What has evolved is prescribing behaviour.

In routine practice, empiric therapy is increasingly escalated early. Broader-spectrum agents are selected pre-emptively, de-escalation is inconsistently applied, and stewardship principles – while accepted - are not reliably translated into first-line decisions.
Guidelines define therapeutic eligibility. They do not determine treatment selection.

As a result, Brand UMI is not displaced by evidence, but by escalation comfort and prescribing reflex. The molecule remains recommended, yet real-world choice has shifted upward in spectrum intensity.

The gap is not scientific. It is behavioural and hierarchical, centred on how treatment intensity is chosen at initiation.

# PROBLEM FRAMEWORK

*THE BRAND PAIN*

For Brand UMI, treatment-choice drift translates into three reinforcing commercial pressures that operate before clinical comparison even begins.

**1. ESCALATION BIAS PRE-EMPTS EVALUATION**

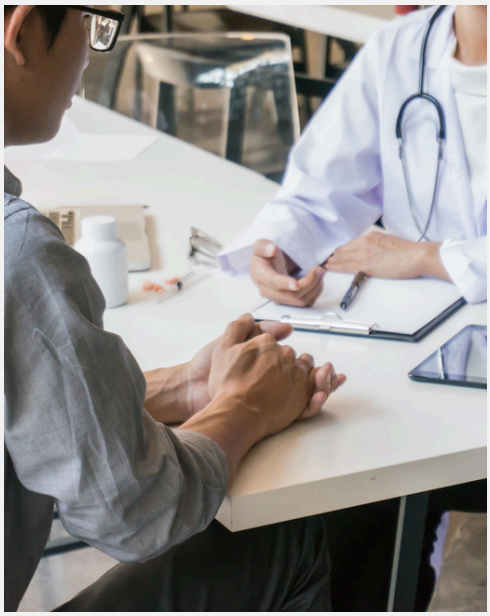
In environments where broader-spectrum agents are perceived as lower-risk defaults, narrow-spectrum options are frequently bypassed – not because they are inadequate, but because caution favours escalation.

Brand UMI is therefore excluded upstream, before its clinical appropriateness is actively assessed.

**2. CATEGORY EDUCATION AMPLIFIES ASYMMETRY**

Broad antimicrobial education strengthens confidence in antibiotic use as a category. However, in the absence of molecule-specific anchoring, this confidence disproportionately benefits brands already associated with escalation.

As a result, Brand UMI often contributes to category reassurance while prescription lift accrues elsewhere.



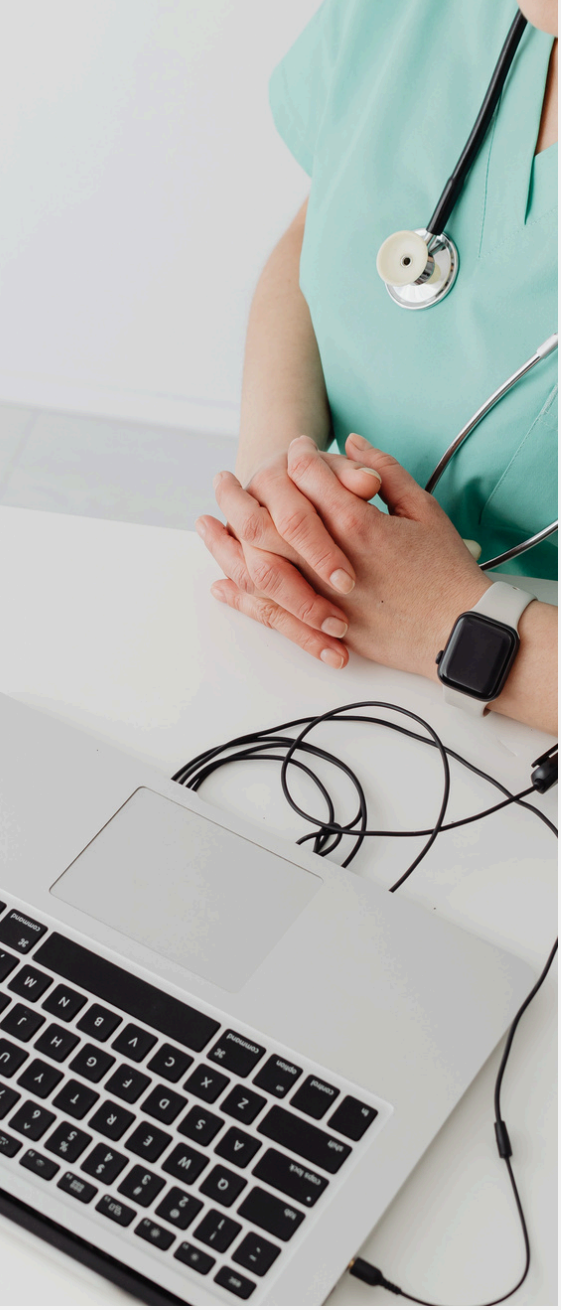
**3. HIERARCHICAL PERCEPTION CONSTRAINS MENTAL AVAILABILITY**

Despite guideline alignment, Co-trimoxazole is often subconsciously positioned as a lower-tier or earlier-generation option. This hierarchical framing limits momentum at the point of choice–independent of resistance data or indication fit.

Brand UMI is thus affected less by scientific objection and more by where it sits in the prescriber's internal ordering of options.

## THE STRATEGIC IMPLICATION

*In antibiotics, growth is not created by expanding usage. It is created by influencing the starting point of empiric therapy in appropriate patients. Until Brand UMI is re-established as an intentional first-choice option - anchored within contemporary stewardship logic and treatment hierarchy - it will remain clinically justified, yet commercially constrained. The challenge, therefore, is not validation. It is re-entry at the point of first decision.*



# THE BEHAVIOURAL MOMENT MAP

Antibiotic treatment choice is not a single decision. It is shaped across three sequential moments - only one of which is commercially decisive.

**MOMENT 1: DIAGNOSTIC UNCERTAINTY**

The clinician assesses infection severity and likely pathogen.

Uncertainty is highest at this stage, and escalation bias begins to influence the decision frame.

**MOMENT 2: EMPIRIC THERAPY SELECTION (DECISIVE)**

Here, initial antibiotic intensity is set. This is the point at which:

- narrow versus broad spectrum is determined,
- stewardship principles are either activated or deferred.

This moment defines whether Brand UMI enters the treatment pathway at all.

**MOMENT 3: STEP-DOWN OR DE-ESCALATION**

Clinical response is evaluated and therapy may be adjusted.

By this stage, the first-line choice has already shaped the course of treatment.

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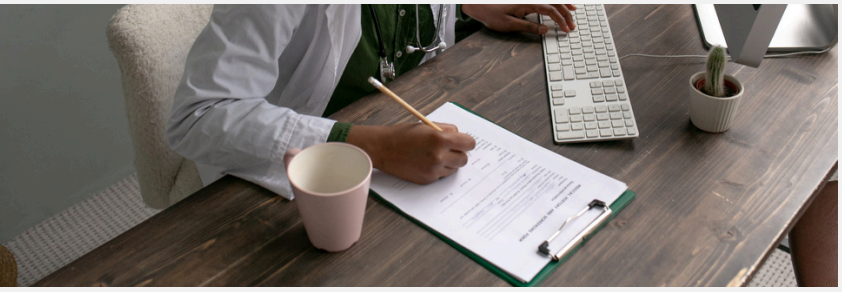
*Implication: If correction is not achieved at empiric selection, it cannot be recovered downstream. The commercial and clinical opportunity for Brand UMI therefore resides squarely at Moment 2.*

# THE CLINIC-CENTRED SOLUTION FRAMEWORK

*RE-ANCHOR → REFRAME → RE-INSTATE*



**REFRAME (From "old" to "intentionally narrow")**

Shift perception from:

- legacy antibiotic

to:

- stewardship-aligned, spectrum-conscious choice.

This reframing addresses escalation bias directly – without comparative claims or competitive confrontation.

**RE-INSTATE (Case-led treatment logic)**

Through structured, case-based communication:

- demonstrate appropriate use in URTI, UTI, SSTI, and mild LRTI,
- make visible where broader agents add no incremental value,
- embed Brand UMI within practical, stepwise treatment algorithms.

Brand UMI is reinstated as a deliberate clinical decision, not a default or a fallback.

The objective is not advocacy. It is to align first-line antibiotic selection with evidence, stewardship, and appropriate spectrum use.

**RE-ANCHOR (Guideline legitimacy)**

Leverage education aligned with the Indian Academy of Pediatrics to:

- delineate precise indications,
- clarify scenarios where narrow-spectrum therapy is sufficient,
- reinforce stewardship-based selection logic.

Brand UMI is positioned within current clinical reasoning, not historical recall.

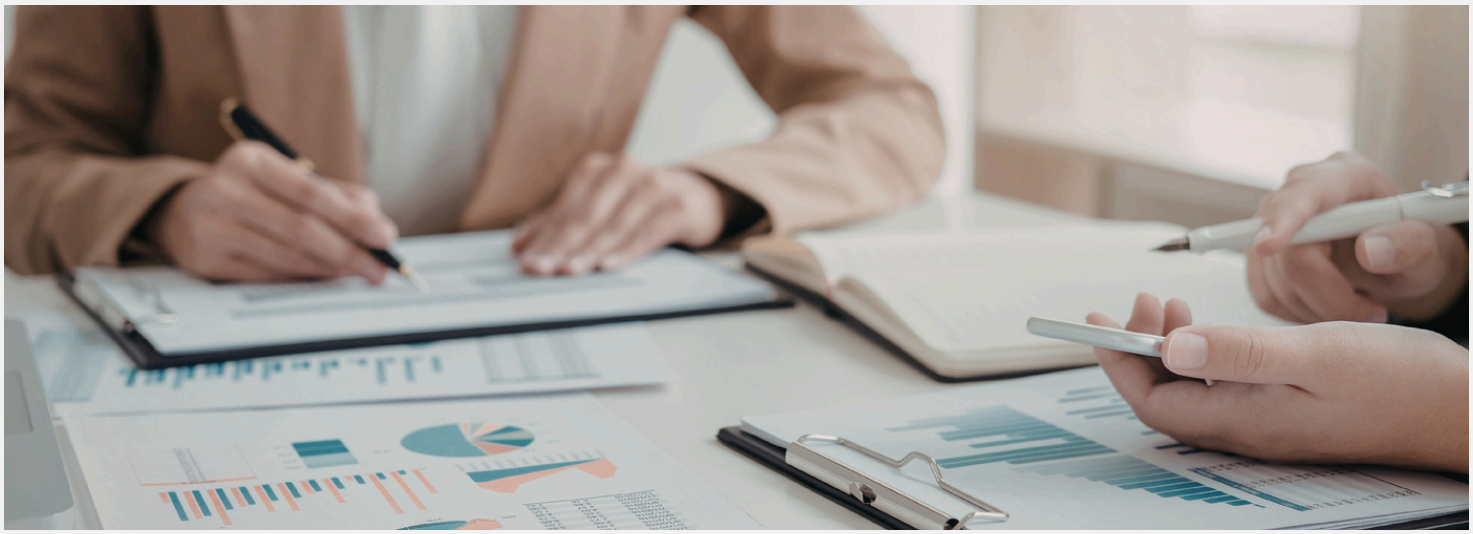
*Strategic Outcome*

*Brand UMI re-enters the empiric decision at the point where treatment intensity is set - aligned with stewardship, supported by guidelines, and operational within real clinic workflows.*

# REPLICATION BLUEPRINT

*IMPLEMENTATION MODULES*

| Module | What is implemented | How it functions in clinic | Brand UMI Impact (Treatment Choice) |
|---|---|---|---|
| In-Clinic Mini-CME Series | 6–10 guideline-aligned academic sessions | Focused on rational antibiotic selection and spectrum discipline | Re-anchors Co-trimoxazole within stewardship-led first-line reasoning |
| Case Publication Series | Structured pediatric and GP case sets | Illustrates appropriate use in routine clinical scenarios | Normalises first-line consideration in defined indications |
| Guideline Mapping Sheets | IAP/WHO indication summaries | Rapid reference at point of empiric decision | Improves mental availability during therapy initiation |
| Field Distribution (Print + PDF) | Consistent academic reinforcement | Sustains recall through case-based exposure | Maintains re-entry at empiric selection over time |



# *REPLICATION BLUEPRINT*

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## *TREATMENT CHOICE EXECUTION CHECKLIST →*

1.

ANCHORED WITHIN CURRENT GUIDELINE LOGIC, NOT HISTORICAL RECALL

2.

RESTRICTED TO CLEARLY DEFENSIBLE FIRST-LINE INDICATIONS

3.

EXPLICITLY DESIGNED TO INTERRUPT ESCALATION BIAS AT EMPIRIC SELECTION

4.

DOES NOT RELY ON CATEGORY-LEVEL ANTIBIOTIC PROMOTION FOR IMPACT

5.

REINFORCES BRAND UMI AS AN INTENTIONAL FIRST-CHOICE OPTION, NOT A FALLBACK

# BRAND OUTCOME

*MEASUREMENT LOGIC*

Treatment choice shift cannot be measured by antibiotic volume alone. It must be inferred through structured signals.

| Measurement Layer | What is Tracked | What it Indicates for Brand UMI |
|---|---|---|
| CME Participation | Number of doctors completing modules | Engagement with stewardship logic |
| Case Publication Uptake | Repeat access and distribution | Case-based recall reinforcement |
| Prescriber Base Growth | Increase in unique writers | Treatment choice reconsideration |
| Indication Mix Analysis | Brand usage in guideline-aligned cases | Restoration of first-line positioning |
| Brand-of-Use Proxy | Shift from broad-spectrum to Co-trimoxazole in defined cases | Treatment choice correction |

# STRATEGIC OPPORTUNITY & CTA

*Brand UMI does not need to be repositioned as new. It needs to be intentionally selected.*

In a stewardship environment shaped by resistance concern and escalation reflex, competitive advantage will not come from breadth of spectrum, but from appropriateness of choice.

By re-anchoring Co-trimoxazole within current guideline logic and operationalising it through case-based clinical reasoning, Brand UMI can transition from passive recall to conscious first-line consideration.

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*The path forward is not revival. It is the deliberate restoration of Brand UMI's role at the empiric therapy decision point.*