RECOMMENDED ANTIMICROBIAL TREATMENT FOR COMMON ILLNESSES: CHILDREN

CHILDREN	1st Line	2nd Line (Allergy/Resistance)
OTITIS MEDIA TREAT <2y OR >2y IF SEVERE SX[1]	**amoxicillin** 90 mg/kg/d po ÷ q12h, <2y: x10d. ≥2y: x 5-7d [1i]	**amox/clav ES** susp 90mg/kg/d (amox comp) ÷ q12h[1] **OR cefdinir** 7mg/kg po q12, <2y: x10d. ≥2y: x 5-7d[1]
SINUSITIS 98-99.5% VIRAL.[2] ONLY TREAT AFTER 10 DAYS[1]	**amox/clav ES** susp 90 mg/kg/d (amox comp) po ÷ q12h x10-14d[1]	**levofloxacin** >6mo &<50kg: 16 mg/kg/d ÷q12h, max of 250 mg/d. If >50 kg: 500 mg po q24h x 10-14d[1] **OR clindamycin** 30-40 mg/kd/d ÷ q8h **AND cefdinir** 14 mg/kg/d po ÷ q12-24h x10-14d[1]
UTI	**nitrofurantoin** 2 mg/kg po q24h x 3d[1,6]	**TMP/SMX** 8-12 mg/kg/d (TMP comp) ÷ q12x 3d[1,6]
URI* R/O PNA & PERTUSSIS OTHERWISE ALMOST ALWAYS VIRAL[2]	**ALMOST ALWAYS VIRAL**[1] Abx tx only indicated w: associated sinusitis or no improvement in one week.[1] CAP: **amoxicillin** 90 mg/kg/d ÷ q12h x 5d[1]	
CELLULITIS (I&D FOR SIMPLE SKIN ABCESS, ABX TX RARELY INDICATED[3])	**cephalexin** 25-50 mg/kg/day PO divided q12h x 7-10d	Suspected MRSA: **TMP/SMX DS** 8-10 mg/kg/day (TMP comp) PO ÷ q12h x 7-10d **AND cephalexin** or an agent active against GAS (**OR clindamycin** 10-20 mg/kg/day in 3 divided doses/day[3])

* BRONCHITIS: Antibiotics are NOT recommended, regardless of the duration of cough (expect to last ~ two weeks). If cough > 2 weeks, rule out pertussis.
SINUSITIS: True sinusitis in children < 9 yrs is RARE

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

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RECOMMENDED ANTIMICROBIAL TREATMENT FOR COMMON ILLNESS: ADULTS

ADULTS	1st Line	2nd Line (Allergy/Resistance)
OTITIS MEDIA	**amoxicillin** 1000 mg po tid x 10d[1]	**amox/clav ER** 2000/125 mg po bid x 10d[1] **OR levofloxacin** for PCN allergy
SINUSITIS 98-99.5% VIRAL.[2] ONLY TREAT AFTER 10 DAYS[1]	**amox/clav ER** 2000/125 mg po daily x 5-7d[1]	**levofloxacin** 750 mg po once daily x 5-7d[1] **OR doxycycline** 100 mg/bid[5]
UTI DON'T TREAT ASYMPTOMATIC COLONIZATION IN CERTAIN PTS	**nitrofurantoin** 100 mg po bid x 5d[1,3] **OR cephalexin** 500 mg qid x 5d *ME specific	**TMP/SMX DS** 1 tab bid x3d[1]
URI* R/O PNA & PERTUSSIS OTHERWISE ALMOST ALWAYS VIRAL[2]	**ALMOST ALWAYS VIRAL**[2] Can possibly treat acute exacerbation of COPD w: **amoxicillin** 500 mg po tid x 5-7d[1] **OR doxycycline** 100 mg pd bid x 5-7d[1] CAP: **azithromycin** 500 mg po x 1, then 250 mg/d x 4d[1], check local patterns of resistance	
CELLULITIS (I&D FOR SIMPLE SKIN ABCESS, ABX TX RARELY INDICATED[3])	**cephalexin** 500 mg po q6h x 7-10d[1,3]	Suspected MRSA: **doxycycline** 100 mg po bid x 7-10d[1,3] **OR TMP/SMX DS** one tab po bid x 7-10d[1,3] **AND cephalexin** or an agent active against GAS (**OR clindamycin** 300-400 mg/kg tid[3])

*BRONCHITIS: Antibiotics are NOT recommended, regardless of the duration of cough (expect to last ~ two weeks). If cough > 2weeks, rule out pertussis.

1 Sanford guide 2013 version 3.06
2 Up-to-date
3 Stevens, et al, Practice Guidelines for the Diagnsois and Management of Skin and Soft-Tissue Infections, IDSA guidelines, 2005.
4 Sanchez, G.V., Master, R.N., Karlowsky, J.A., & Bordon, J.M. (2012). In vitro antimicrobial resistance of urinary E. coli isolates amount U.S. outpatients from 2000 to 2010. Antimicrob Agents Chemother, 56(4), 2181-2183.
5 Simon,H. University of Maryland Medical Center Medical Reference Guide: Sinusities, 7/10/12 at http://umm.edu/health/medical/reports/articles/sinusitis
6 Michael M, Hodson EM, Craig JC, Martin S, Moyer VA. (2003) Short versus standard duration oral antibiotic therapy for acute urinary tract infection in children. Cochrane Database Syst Rev. 1:CD003966.