

PEDIATRIC TREATMENT CARDS

Acute Sinusitis	Diagnosis	Treatment	Typical Duration
	<p>Non-specific viral/bacterial findings: halitosis, fatigue, headache, decreased appetite</p> <p>Bacterial diagnosis: (one of the following)</p> <ul style="list-style-type: none"> • Persistent symptoms: nasal discharge or daytime cough >10 days • Worsening symptoms: worsening or new onset fever, daytime cough, or nasal discharge after initial improvement of a viral URI • Severe symptoms: fever $\geq 39^{\circ}\text{C}$, purulent nasal discharge for at least 3 consecutive days <p>Imaging tests are no longer recommended for uncomplicated cases</p>	<p>If bacterial infection is established:</p> <ul style="list-style-type: none"> • First line: amoxicillin or amoxicillin/clavulanate • If non-severe penicillin allergy: cefdinir, cefuroxime, cefpodoxime, or ceftriaxone • Children who cannot tolerate oral: single dose of ceftriaxone can be used then switch to oral if improving 	<ul style="list-style-type: none"> • 5-7 days

Acute Otitis Media (AOM)	Diagnosis	Treatment	Typical Duration
	<p>Definitive diagnosis requires either:</p> <ul style="list-style-type: none"> • Moderate or severe bulging of the tympanic membrane (TM) or new onset otorrhea not due to otitis externa • Mild bulging of the TM AND recent (<48 hours) onset of otalgia (holding, tugging, rubbing of the ear) or intense erythema of the TM <p>AOM should not be diagnosed in children without middle ear effusion (based on pneumatic otoscopy and/or tympanometry)</p>	<ul style="list-style-type: none"> • First line: amoxicillin for children who have not received in within the past 30 days • Amoxicillin/clavulanate if amoxicillin has been taken within 30 days, concurrent purulent conjunctivitis, or history of recurrent AOM unresponsive to amoxicillin • If non-severe penicillin allergy: cefdinir, cefuroxime, cefpodoxime, or ceftriaxone 	<ul style="list-style-type: none"> • <2 years or severe symptoms: 10 days • 2-5 years: 7 days • >6 years: 5 days

Acute Pharyngitis

Diagnosis	Treatment	Typical Duration
<p>Clinical features alone do not distinguish between GAS and viral pharyngitis</p> <p>Children with a sore throat plus 2 or more should undergo a Rapid Antigen Detection Test (RADT):</p> <ul style="list-style-type: none"> • Absence of cough • Presence of tonsillar exudates or swelling • History of fever • Presence of swollen & tender cervical lymphadenopathy • Age <15 years <p>Do not commonly test in children <3 years (GAS rarely causes pharyngitis and rheumatic fever is uncommon) without significant exposure history</p> <ul style="list-style-type: none"> • Negative RADT should be backed up by a throat culture • Positive RADTs do not require back-up culture 	<ul style="list-style-type: none"> • First line: amoxicillin and penicillin V • Allergy: cephalexin, cefadroxil, clindamycin, clarithromycin, or azithromycin 	<ul style="list-style-type: none"> • 10 days

Community Acquired Pneumonia (CAP)

Diagnosis	Treatment	Typical Duration
<ul style="list-style-type: none"> • Blood cultures are usually not needed in fully immunized children with CAP • Chest radiography is not needed to confirm CAP in children who are well enough to be treated in outpatient setting • Pulse oximetry should be performed in all children with pneumonia 	<ul style="list-style-type: none"> • Empiric therapy: <ul style="list-style-type: none"> ○ Amoxicillin or penicillin for fully immunized patients in regions without high prevalence of penicillin-resistant pneumococcus ○ If atypical pathogen suspected, add a macrolide ○ If MRSA suspected, add clindamycin • If penicillin allergy: clindamycin or levofloxacin 	<ul style="list-style-type: none"> • 5 days from uncomplicated CAP improving during that time

Urinary Tract Infection (bacterial cystitis & pyelonephritis)

Diagnosis	Treatment	Typical Duration
<ul style="list-style-type: none"> • Infants: fever and/or strong-smelling urine • School aged children: dysuria, frequency, or urgency, abdominal/suprapubic pain, flank pain more indicative of pyelonephritis • Definitive diagnosis: (all required) <ul style="list-style-type: none"> ○ Urinalysis suggestive of infection <ul style="list-style-type: none"> ▪ Pyuria (leukocyte esterase or 5 WBCs), bacteriuria, or nitrites* ○ At minimum $\geq 50,000$ CFEs/mL of a single uropathogen ○ Obtained through catheterization or suprapubic aspiration (not bag) for children 2-24 months • The decision to assess for UTI in urine testing for all children 2-24 months with unexplained fever is no longer recommended but should be based on the child's likelihood & risk factors for UTI <p>*Nitrites are not a sensitive measure in children and cannot be used to rule out UTIs</p>	<ul style="list-style-type: none"> • Antibiotics are not recommended for asymptomatic bacteriuria • Initial treatment should be based on suspicion for localized vs. systemic disease with any potential need for hospitalization and blood culture acquisition, age of the patient, and local susceptibility & antibiogram data • Bacterial cystitis <ul style="list-style-type: none"> ○ <12 years: cephalexin, cefdinir, trimethoprim-sulfamethoxazole ○ ≥ 12 years: nitrofurantoin, cephalexin, cefdinir, trimethoprim-sulfamethoxazole • Uncomplicated pyelonephritis <ul style="list-style-type: none"> ○ <12 years: cephalexin, trimethoprim-sulfamethoxazole ○ ≥ 12 years: nitrofurantoin, cephalexin, cefdinir, trimethoprim-sulfamethoxazole • Febrile infants with UTIs should undergo renal and bladder US during or following their first UTI. Abnormal imaging results require further testing 	<ul style="list-style-type: none"> • Bacterial cystitis <ul style="list-style-type: none"> ○ <12 years: 3 days ○ ≥ 12 years: 3 days • Uncomplicated pyelonephritis <ul style="list-style-type: none"> ○ <12 years: 7 days ○ ≥ 12 years: 7 days

SSTI non-purulent (Cellulitis, Erysipelas)			
	Diagnosis	Treatment	Typical Duration
SSTI non-purulent (Cellulitis, Erysipelas)	<ul style="list-style-type: none"> Cultures not routinely recommended. Exceptions <ul style="list-style-type: none"> Animal bite wounds Cancer patients receiving chemo or with malignancies. Immersion injuries Neutropenia Severe cell-mediated immunodeficiency Mild/moderate <ul style="list-style-type: none"> no signs/symptoms of systemic infection Severe <ul style="list-style-type: none"> Signs/symptoms of systemic infection Immunocompromised state 	<ul style="list-style-type: none"> Mild/moderate (oral) <ul style="list-style-type: none"> Cephalexin History of MRSA or PCN severe allergy: Clindamycin Severe (IV) <ul style="list-style-type: none"> Cefazolin Clindamycin Vancomycin <p>Outpatient therapy is recommended for patients who do not have SIRS, altered mental status, hemodynamic instability</p>	5-7 days is common.

SSTI purulent (Furuncle, Carbuncle, Abscess)			
	Diagnosis	Treatment	Typical Duration
SSTI purulent (Furuncle, Carbuncle, Abscess)	<ul style="list-style-type: none"> Larger furuncles, carbuncles and abscesses may utilize Gram stain and culture of pus is recommended. Larger abscesses should have Gram stain and culture from incision and drainage performed Mild/moderate <ul style="list-style-type: none"> no signs/symptoms of systemic infection abscess < 2 cm Severe <ul style="list-style-type: none"> Abscess > 2 cm Signs/symptoms of systemic infection Immunocompromised state I&D and oral antimicrobial failure (no improvement 24-48 hours of antibiotics post I&D) 	<ul style="list-style-type: none"> Mild/moderate <ul style="list-style-type: none"> Often incision and drainage only; abx. only if indicated Severe <ul style="list-style-type: none"> Incision & drainage Culture and sensitivity Non-systemic illness (oral): <ul style="list-style-type: none"> clindamycin, trimethoprim-sulfamethoxazole, or doxycycline Systemic illness (IV): <ul style="list-style-type: none"> Vancomycin or daptomycin if MRSA a consideration Nafcillin or cefazolin, if MSSA and/or <i>S. pyogenes</i> considered predominant target <p>*With susceptibilities, consider narrowing</p>	At minimum, 5 days from SSTI source control pending any systemic involvement including BSI