How to prescribe antibiotics for patients discharging from the ED

	Antibiotic	Dose	Length of treatment	Notes
AOM	Amoxicillin	45 mg/kg po q12h - Max: 800-1,000 mg per dose	5 days (>6 yo) 7 days (2-6 yo) 10 days if <2yo, perforated, or recurrent	If bilateral in less than 2 y/o or if severe; otherwise watch and wait Severe – Moderate/severe pain, pain for 48+ hours, fever 39+ Watch and wait – Prescribe antibiotic if no improvement in 48-72 hours Can dose amoxicillin q12h in AOM due to prolonged half-life in the middle ear
	Amoxicillin-clavulanate (Augmentin) - If previously treated with amoxicillin within last 30 days - If recurrent and resistant to amoxicillin - If concurrent purulent conjunctivitis	45 mg/kg po q12h - Suspension ES 600mg/5mL; max 800-1,000 mg per dose - Tablet max 875 mg-125 mg		
Pneumonia	Amoxicillin - Typical, completed 3 of 4 primary series for PCV and Hib	30 mg/kg po q8h - Max: 800-1,000 mg per dose	5 days	Recommend to avoid oral cephalosporins; per IDSA guidelines, only cover 60%–70% of currently isolated strains of pneumococcus; if absolutely necessary, cefpodoxime has the best serum levels and coverage **Clindamycin does not cover *H. influenzae*, if patient is not fully vaccinated clindamycin is not a good alternative agent If you prescribe levofloxacin you do not need to add azithromycin for atypical coverage (levofloxacin provides this)
	Amoxicillin-clavulanate (Augmentin) - Typical, did not complete at least 3 of 4 primary series for PCV and Hib	30 mg/kg po q8h - Suspension ES 600mg/5mL; max 800-1,000 mg per dose - Tablet max 875 mg-125 mg		
	Clindamycin** or levofloxacin - Penicillin allergy	Clindamycin: 13 mg/kg po q8h - Max 600 mg per dose Levofloxacin: max 750 mg per day - ≤ 5 yo: 10 mg/kg po q12h - 6-10 yo: 7 mg/kg po q12h - > 10 yo: 10 mg/kg po q24h		
	Azithromycin - Atypical	10 mg/kg po q24h x 1 day (max 500 mg per dose) Followed by 5 mg/kg po q24h x 4 days (max 250 mg per dose)		

Cystitis	Nitrofurantoin* First line for cystitis in patients Uncomplicated UTI and only if ≥ 1 month of age	Furadantin or Macrodantin (suspension) - 1.5 mg/kg po q6h, max of 100 mg per dose Macrobid (capsule): adolescents 100 mg po q12h	5 days 7 days if complicated anatomy	* Only indicated for simple cystitis (patients without pyelonephritis or pre-existing genitourinary/kidney abnormalities or altered anatomy) - Contraindicated for patients with G6PD deficiency and pregnant patients at term (38-42 weeks) ** Avoid cefdinir for UTI as it has very poor concentrations in the serum and <12% of active drug concentrates in the urine - Other reasonable cephalosporins include cefixime 4 mg/kg po q12h (max 200 mg per dose) or cefpodoxime 4 mg/kg po q12h (max 200 mg per dose) *** Avoid in patients with lupus or G6PD deficiency; for pregnant patients, avoid in first trimester, may be considered in 2nd or 3rd trimester if no other options
	Cephalexin** First line for complicated UTI/pyelonephritis or unable to have nitrofurantoin	25mg/kg po q6h - Max 500 mg/dose for cystitis, 1,000 mg per dose for pyelonephritis 16 yo and older: can consider 1 g po q8h vs 500 mg po q6h		
	Alternative – TMP-SMX*** Only if ≥ 2 months of age *Dosing based on trimethoprim (TMP) component*	2-24 months: 6 mg/kg po q12h > 24 months: 5 mg/kg po q12h Pyelonephritis: 6 mg/kg po q12h Max: 160 mg TMP/dose		
Cellulitis	Cephalexin (MSSA, group A strep)	25mg/kg po q6h - Max 500mg/dose 16 yo and older: can consider 1g po q8h vs 500 mg po q6h	Cellulitis: 5 days Abscess: if drained 5 days. If undrained 7 days	*Caution with clindamycin for empiric coverage of *S. aureus* isolates, current antibiogram demonstrates only 73% of MSSA is sensitive to clindamycin and only 68% of MRSA is sensitive to clindamycin **Caution with TMP-SMX with undrained abscess; literature has shown increased amounts of exogenous thymidine in pus which can bypass the two-step mechanism of folate inhibition, and allow for bacterial DNA synthesis through the supplemental thymidine, regardless of the presence of TMP-SMX. *** Use with caution in children <8 years of age; data has shown is safe for short durations (< 14 days)
	Penicillin Allergy – Clindamycin* (low MSSA and MRSA coverage, group A strep)	Clindamycin: 13mg/kg po q8h - Max 600 mg per dose		
	Abscess, drained – TMP-SMX** (MSSA and MRSA) *Dosing based on trimethoprim (TMP) component*	6 mg/kg q12h Max: 160 mg TMP/dose		
	Abscess – Doxycycline*** (MSSA and MRSA, low levels of strep coverage)	≤ 45 kg: 2 mg/kg po q12h >45 kg: 100 mg po q12h		

Group A Strep Throat	Amoxicillin	25 mg/kg po q12h - Max of 500 mg per dose	10 days	Azithromycin is not recommended for patients with penicillin allergies due to increasing resistance Due to current, on-going Penicillin benzathine shortage it is being reserved for pregnant patients with syphilis
	Penicillin allergy- clindamycin	7 mg/kg po q8h - Max of 300 mg per dose		