

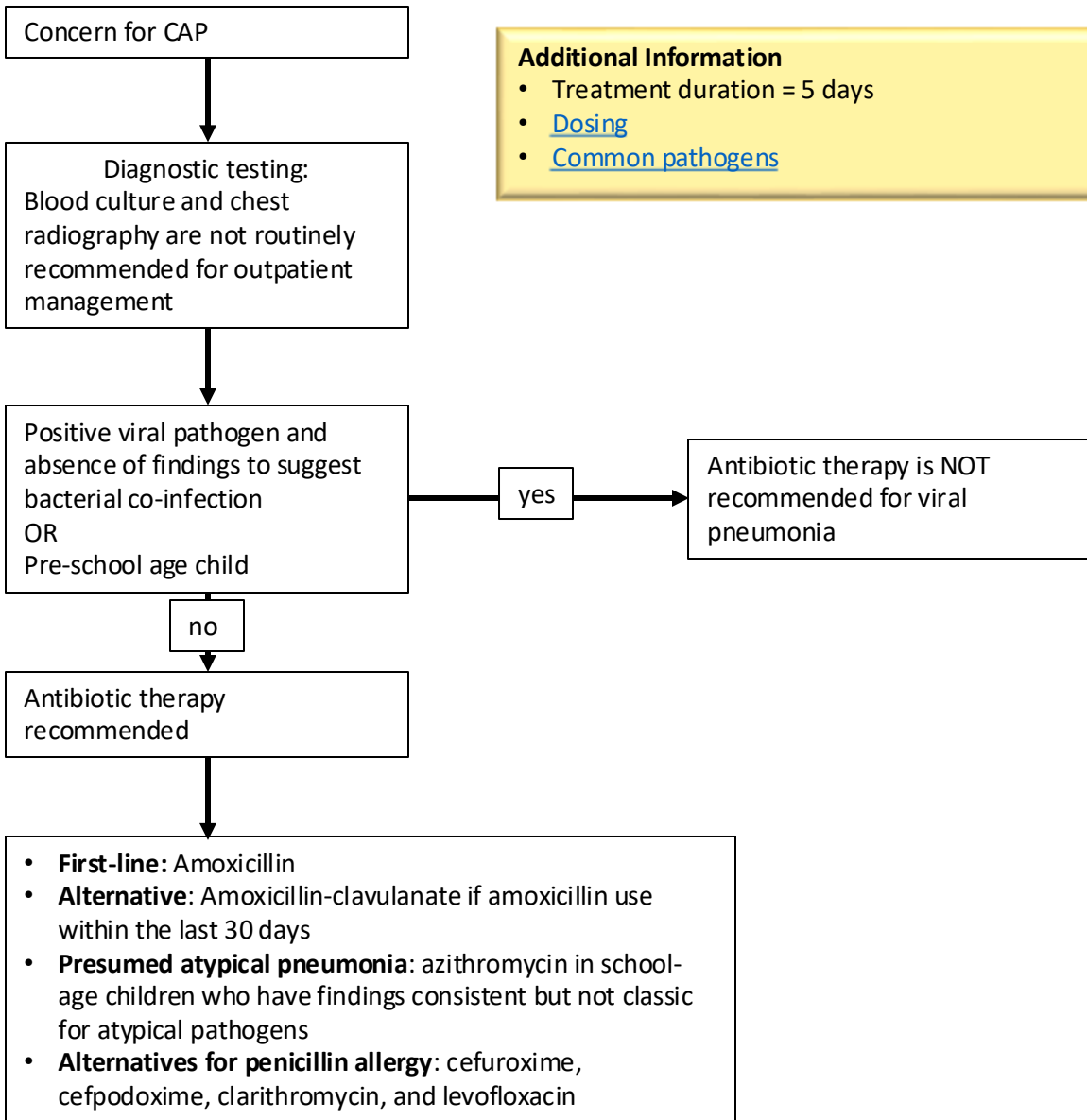


Pediatric Uncomplicated Community Acquired Pneumonia (CAP) Empiric Treatment Algorithm for Outpatient Management Ages >3 months

[Clinical Pearls](#)

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Additional Information

- Treatment duration = 5 days
- [Dosing](#)
- [Common pathogens](#)

Clinical Pearls

- Cefdinir is **not** preferred for treatment of pediatric bacterial infections due to (1) poor pharmacokinetic (PK) characteristics; (2) high rates of resistance; and (3) broad but mismatched spectrum of coverage^{3,4,5}
- Amoxicillin-clavulanate products are not interchangeable. Incorrect ratios could lead to sub therapeutic concentrations or severe diarrhea. High-dose, BID regimens should use 14:1 or 16:1 formulations: 600mg/42.9mg per 5 mL (ES) or 1000mg/62.5mg (Extended Release) tablet
- Up to 90% of penicillin allergies are misdiagnosed. Always clarify history of allergy and de-label if appropriate (e.g. family history without patient history). For more information on patient screening, contact the ASP pharmacist (502-629-5568) or consider referral to outpatient allergy.

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Common CAP Bacterial Pathogens

- ▶ *Streptococcus pneumoniae*
- ▶ *Haemophilus influenzae*
- ▶ *Streptococcus pyogenes*
- ▶ *Staphylococcus aureus*
- ▶ *Moraxella catarrhalis*

Atypical Pathogens

- ▶ *Mycoplasma pneumoniae*
- ▶ *Chlamydia trachomatis*
- ▶ *C. pneumoniae*

Antibiotic dosing

- Amoxicillin 80-90 mg/kg oral BID (max 4,000 mg/day)
- Amoxicillin-clavulanate 90 mg/kg per day oral in 2 divided doses (max 4,000 mg amoxicillin/day)
 - Using ES-600 suspension or 1000 mg/62.5 mg ER tablet
- Cefuroxime 30 mg/kg oral BID (max 500 mg/dose)
- Cefpodoxime 10 mg/kg oral BID (max 200 mg/dose)
- Azithromycin 10 mg/kg once on day 1 (max 500 mg/dose), followed by 5 mg/kg/dose (max 250 mg/dose) once daily on days 2 to 5
- Clarithromycin 7.5 mg/kg BID (max 500 mg/dose)
- Levofloxacin < 5 years: 10 mg/kg BID; 5-16 years: 10 mg/kg once daily (max 750 mg/dose)

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References

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The policies set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible solutions that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If a policy contains references to clinical literature or other resources, such as Lippincott, Ovid, and/or Elsevier, these resources are only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Norton Healthcare specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set or circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

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