

Adult Treatment Recommendations

Antibiotic prescribing guidelines establish standards of care and focus quality improvement efforts. The table below summarizes the most recent recommendations for appropriate antibiotic prescribing for adults seeking care in an outpatient setting.

Condition	Epidemiology	Diagnosis	Management
Acute rhinosinusitis ^{1, 2}	<ul style="list-style-type: none"> About 1 out of 8 adults (12%) in 2012 reported receiving a diagnosis of rhinosinusitis in the previous 12 months, resulting in more than 30 million diagnoses. Ninety–98% of rhinosinusitis cases are viral, and antibiotics are not guaranteed to help even if the causative agent is bacterial. 	<ul style="list-style-type: none"> Diagnose acute <u>bacterial</u> rhinosinusitis based on symptoms that are: <ul style="list-style-type: none"> Severe (>3-4 days), such as a fever $\geq 39^{\circ}\text{C}$ (102°F) and purulent nasal discharge or facial pain; Persistent (>10 days) without improvement, such as nasal discharge or daytime cough; or Worsening (3-4 days) such as worsening or new onset fever, daytime cough, or nasal discharge after initial improvement of a viral upper respiratory infections (URI) lasting 5-6 days. Sinus radiographs are not routinely recommended. 	<p>If a bacterial infection is established:</p> <ul style="list-style-type: none"> Watchful waiting is encouraged for uncomplicated cases for which reliable follow-up is available. Amoxicillin or amoxicillin/clavulanate is the recommended first-line therapy. Macrolides such as azithromycin are not recommended due to high levels of <i>Streptococcus pneumoniae</i> antibiotic resistance (~40%). For penicillin-allergic patients, doxycycline or a respiratory fluoroquinolone (levofloxacin or moxifloxacin) are recommended as alternative agents.
Acute uncomplicated bronchitis ³⁻⁵	<ul style="list-style-type: none"> Cough is the most common symptom for which adult patients visit their primary care provider, and acute bronchitis is the most common diagnosis in these patients. 	<ul style="list-style-type: none"> Evaluation should focus on ruling out pneumonia, which is rare among otherwise healthy adults in the absence of abnormal vital signs (heart rate ≥ 100 beats/min, respiratory rate ≥ 24 breaths/min, or oral temperature $\geq 38^{\circ}\text{C}$) and abnormal lung examination findings (focal consolidation, egophony, fremitus). Colored sputum does not indicate bacterial infection. For most cases, chest radiography is not indicated. 	<p>Routine treatment of uncomplicated acute bronchitis with antibiotics is not recommended, regardless of cough duration.</p> <p>Options for symptomatic therapy include:</p> <ul style="list-style-type: none"> Cough suppressants (codeine, dextromethorphan); First-generation antihistamines (diphenhydramine); Decongestants (phenylephrine); and Beta agonists (albuterol).
Common cold or non-specific upper respiratory tract infection (URI) ^{6,7}	<ul style="list-style-type: none"> The common cold is the third most frequent diagnosis in office visits, and most adults experience two to four colds annually. At least 200 viruses can cause the common cold. 	<ul style="list-style-type: none"> Prominent cold symptoms include fever, cough, rhinorrhea, nasal congestion, postnasal drip, sore throat, headache, and myalgias. 	<ul style="list-style-type: none"> Decongestants (pseudoephedrine and phenylephrine) combined with a first-generation antihistamine may provide short-term symptom relief of nasal symptoms and cough. Non-steroidal anti-inflammatory drugs can be given to relieve symptoms. Evidence is lacking to support antihistamines (as monotherapy), opioids, intranasal corticosteroids, and nasal saline irrigation as effective treatments for cold symptom relief. <p>Providers and patients must weigh the benefits and harms of symptomatic therapy.</p>

Pharyngitis ^{8,9}	<ul style="list-style-type: none"> Group A beta-hemolytic streptococcal (GAS) infection is the only common indication for antibiotic therapy for sore throat cases. Only 5–10% of adult sore throat cases are caused by GAS. 	<ul style="list-style-type: none"> Clinical features alone do not distinguish between GAS and viral pharyngitis; a rapid antigen detection test (RADT) is necessary to establish a GAS pharyngitis diagnosis Those who meet two or more Centor criteria (e.g., fever, tonsillar exudates, tender cervical lymphadenopathy, absence of cough) should receive a RADT. Throat cultures are not routinely recommended for adults. 	<ul style="list-style-type: none"> Antibiotic treatment is NOT recommended for patients with negative RADT results. Amoxicillin and penicillin V remain first-line therapy due to their reliable antibiotic activity against GAS. For penicillin-allergic patients, cephalexin, cefadroxil, clindamycin, or macrolides are recommended. GAS antibiotic resistance to azithromycin and clindamycin are increasingly common. Recommended treatment course for all oral beta lactams is 10 days.
Acute uncomplicated cystitis ^{10, 11}	<ul style="list-style-type: none"> Cystitis is among the most common infections in women and is usually caused by <i>E. coli</i>. 	<ul style="list-style-type: none"> Classic symptoms include dysuria, frequent voiding of small volumes, and urinary urgency. Hematuria and suprapubic discomfort are less common. Nitrites and leukocyte esterase are the most accurate indicators of acute uncomplicated cystitis 	<p>For acute uncomplicated cystitis in healthy adult non-pregnant, premenopausal women:</p> <ul style="list-style-type: none"> Nitrofurantoin, trimethoprim/sulfamethoxazole (TMP-SMX, where local resistance is <20%), and fosfomycin are appropriate first-line agents. Fluoroquinolones (e.g. ciprofloxacin) should be reserved for situations in which other agents are not appropriate.

References

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