

Adult Appropriate Antibiotic Use Summary

Diagnosis	CDC Principles of Appropriate Antibiotic Use
Upper respiratory infections, not otherwise specified	<ol style="list-style-type: none"> 1. The diagnosis of nonspecific upper respiratory tract infections or acute rhinopharyngitis should be used to denote acute infection that is typically viral in origin, and in which sinus, pharyngeal, and lower airway symptoms, although frequently present, are not prominent. 2. Antibiotic treatment of nonspecific upper respiratory infections in adults does not enhance illness resolution or prevent complications, and is therefore not recommended. 3. Purulent secretions in the nares and throat (commonly reported and seen in patients with an uncomplicated, upper respiratory tract infection) neither predict bacterial infection nor benefit from antibiotic treatment.
Acute pharyngitis	<ol style="list-style-type: none"> 1. Group A beta hemolytic streptococcus (GABHS) is the etiologic agent in approximately 10% of adult cases of pharyngitis. The large majority of adults with acute pharyngitis have a self-limiting illness, which would do well with supportive care only. 2. The benefits of antibiotic treatment of adult pharyngitis are limited to those patients with GABHS infection. All patients with pharyngitis should be offered appropriate doses of analgesics, antipyretics and other supportive care. 3. Limit antibiotic prescriptions to those patients with the highest likelihood of GABHS. <ol style="list-style-type: none"> A. Clinically screen all adult patients with pharyngitis for the presence of the 4 Centor criteria: (1) history of fever, (2) tonsillar exudates, (3) no cough, and (4) tender anterior cervical lymphadenopathy (lymphadenitis). B. Do not test and do not treat patients with none or only one of these criteria. These patients are unlikely to have GABHS infection. C. For patients with 2 or more criteria the following strategies are appropriate: <ol style="list-style-type: none"> i. Test patients with 2, 3, or 4 criteria using a rapid antigen test. Limit antibiotic therapy to patients with a positive test. ii. Test patients with 2 or 3 criteria using a rapid antigen test. Limit antibiotic therapy to patients with a positive test or patients with 4 criteria. iii. Do not use any diagnostic tests. Limit antibiotic therapy to patients with 3 or 4 criteria. 4. Throat cultures are not recommended for the routine primary evaluation of adults with pharyngitis, nor for the confirmation of negative rapid antigen tests. Throat cultures may be indicated as part of investigations of outbreaks of GABHS disease, for monitoring the development and spread of antibiotic resistance, or when pathogens such as gonococcus are being considered. 5. The preferred antibiotic for treatment of acute GABHS pharyngitis is penicillin, or erythromycin for a penicillin-allergic patient.
Rhino-sinusitis	<ol style="list-style-type: none"> 1. Most cases of acute rhinosinusitis diagnosed in ambulatory care are due to uncomplicated viral, upper respiratory tract infections. 2. Bacterial and viral rhinosinusitis are difficult to differentiate on clinical grounds. The clinical diagnosis of acute bacterial rhinosinusitis should be reserved for patients with rhinosinusitis symptoms lasting 7 days or more and who have maxillary facial/tooth pain or tenderness (especially when unilateral) and purulent nasal secretions. Patients who have rhinosinusitis symptoms for less than 7 days are unlikely to have a bacterial infection. 3. Sinus radiographs are not recommended for diagnosis in routine cases. 4. Acute bacterial rhinosinusitis resolves without antibiotic treatment in the majority of cases. Symptomatic treatment and reassurance is the preferred, initial management strategy for patients with mild symptoms. Antibiotic therapy should be reserved for patients meeting the criteria for the clinical diagnosis of acute bacterial rhinosinusitis who have moderately severe symptoms, and for those with severe rhinosinusitis symptoms—especially those with unilateral face pain—regardless of duration of illness. Initial treatment should be with the most narrow-spectrum agent that is active against likely pathogens <i>Streptococcus pneumoniae</i> and <i>Haemophilus influenzae</i>.
Bronchitis	<ol style="list-style-type: none"> 1. The evaluation of adults with an acute cough illness, or with presumptive diagnosis of uncomplicated acute bronchitis, should focus on ruling out pneumonia. In the healthy, non-elderly adult, pneumonia is uncommon in the absence of vital sign abnormalities or asymmetrical lung sounds, and chest radiography is usually not indicated. In patients with cough lasting 3 weeks or longer, chest radiography is warranted in the absence of other known causes. 2. Routine antibiotic treatment of uncomplicated bronchitis is not recommended, regardless of duration of cough. In the unusual circumstance when pertussis infection is suspected, a diagnostic test should be performed and antimicrobial therapy initiated. 3. Patient satisfaction with care for acute bronchitis is most dependent on the doctor-patient communication rather than on whether or not an antibiotic is prescribed.

