TORONTO EAST
GENERAL HOSPITAL

Antibiotic Stewardship Committee
"The right drug for the right bug at the right time"

Empiric Antibiotic Therapy for Adults in the Emergency Room

Urinary Tract Infections:

- Asymptomatic Bacteriuria – No treatment required
- Outpatients:
  - Uncomplicated cystitis
    - 1st line: Nitrofurantoin macrocrystals (MacroBID) 100 mg PO BID x 5 days
    - 2nd line: TMP-SMX DS 1 tab PO BID x 3 days
    - 3rd line: Cephalexin 500 mg PO QID x 7 days
  - Uncomplicated cystitis in pregnancy
    - Amoxicillin-Clavulanic acid 875/125 mg po bid x 7 days or Nitrofurantoin macrocrystals (MacroBID) 100 mg PO BID x 7 days
  - Pyelonephritis or Complicated UTI in well patient
    - 1st line: Amoxicillin-Clavulanic acid 875/125 mg po bid x 7 days
    - 2nd line: TMP-SMX DS 1 tab PO BID x 7 days
- Patients requiring admission:
  - Pyelonephritis or complicated UTI
    - 1st line: Ceftriaxone 1 g IV q24h
    - Penicillin Anaphylaxis: Septra DS 1 tab PO BID or Ciprofloxacin 500 mg PO BID/400 mg IV q12h
  - Pyelonephritis in pregnancy
    - 1st line: Ceftriaxone 1 g IV q24h
    - Penicillin anaphylaxis: Gentamicin 1.5 mg/kg IV q8h

*If culture information available tailor therapy to cultures

Skin and Soft Tissue Infections:

Cellulitis:

- Outpatients:
  - 1st line: Cephalexin 500 mg PO QID x 5-7 days (cephalexin has >90% oral bioavailability)
  - Penicillin Anaphylaxis: Moxifloxacin 400 mg PO daily x 5-7 days
- Patients requiring admission:
  - Cefazolin 1g IV q8h
  - Penicillin Anaphylaxis: Vancomycin (dose based on weight and Cr)

Cellulitis with known or suspected MRSA infection *with* abscess*:

* I&D usually sufficient treatment for abscess and no antibiotics needed unless significant surrounding cellulitis or recurrent infection

- Outpatients:
  - 1st line: Septra DS 1 tab PO BID 7 days
  - Alternative: Doxycycline 100 mg PO BID 7 days
- Patients requiring admission:
  - Vancomycin (dose based on weight and Cr)

Bites:

- Prophylaxis for certain bites:
  - Amoxicillin/Clavulanic Acid 875/125 mg PO BID x 3-5 days
- Outpatients or not severe:

    - Amoxicillin/Clavulanic Acid 875/125mg PO BID x 7 days
- Severe requiring admission:
    - Ceftriaxone 1g IV q24h + Metronidazole 500mg PO/IV q12h
- Penicillin anaphylaxis:
    - Moxifloxacin 400 mg PO daily OR doxycycline 100 mg PO BID

Diabetic foot infections:

**Most infections do NOT require anti-pseudomonal coverage unless documented on deep cultures, or severe, chronic ulcer or hemodynamic instability with septic shock*

- Mild Infections: Superficial, localized infections in systemically well patients
    - Outpatients:
        - 1st line: Cephalexin 500 mg PO QID x 7 days
        - Penicillin anaphylaxis: Moxifloxacin 400 mg PO daily x 7 days
    - Patients requiring admission:
        - 1st line – Cefazolin 1g IV q8h
        - Penicillin Anaphylaxis: Moxifloxacin 400 mg PO daily
- Moderate Infections: full thickness ulcer with deep tissue involvement, systemically well
    - Outpatients:
        - 1st line: Amoxicillin/Clavulanic Acid 875/125mg PO BID x 14 days
        - Penicillin anaphylaxis: Moxifloxacin 400 mg PO daily x 14 days
    - Patients requiring admission:
        - 1st line: Ceftriaxone 1g IV q24h + Metronidazole 500 mg PO BID
        - Penicillin anaphylaxis: Moxifloxacin 400mg PO daily
- Severe Infections: Systemic or bone involvement - Consult ID
    - Patients requiring admission:
        - 1st line: Ceftriaxone 1g IV q24h + Metronidazole 500 mg PO/IV q12h OR Piperacillin/Tazobactam 3.375g IV q6h;
        - Penicillin anaphylaxis – Moxifloxacin 400mg PO/IV daily + Metronidazole 500mg PO/IV q12h

*If MRSA colonization or known prior MRSA infection consider adding Vancomycin for inpatients or TMP-SMX for outpatients

Community Acquired Pneumonia:

- Outpatients:
    - 1st line: Amoxicillin/Clavulanic Acid 875/125mg PO BID x 7 days +/- Azithromycin 500 mg PO x 1, 250 mg PO x 4 days
    - Penicillin Anaphylaxis: Moxifloxacin 400 mg PO daily x 5 days
- Patients requiring admission:
    - 1st line: Ceftriaxone 1g IV + Azithromycin 500mg IV/PO x 1, 250mg IV/PO x 4 days
    - Penicillin Anaphylaxis: Moxifloxacin 400 mg IV/PO q24h
    - If critically ill and MRSA colonization known/suspected consider addition of Vancomycin

* If patient has received fluoroquinolone in last 3 months should use a different class of antibiotics since resistant strep pneumonia more likely

*If any suspicion of TB, **avoid** moxifloxacin as can partially treat and sterilize cultures

ENT - Dental Abscess/Sialoadenitis/Head and neck abscess:

- Outpatients:
  - 1st line: Amoxicillin/Clavulanic Acid 875/125mg PO BID
  - Penicillin Anaphylaxis: Moxifloxacin 400 mg PO daily
- Patients requiring admission:
  - 1st line: Ceftriaxone 1g IV q24h +/- Metronidazole 500 mg PO/IV q12h
  - Penicillin anaphylaxis: Moxifloxacin 400 mg PO daily

*Clindamycin is not recommended for routine treatment due to high resistance rates to Group A Streptococci and high risk of C. difficile.

Intra-abdominal Infections:

- Outpatients:
  - Amoxicillin/Clavulanic Acid 875/125mg PO BID
- Patients requiring admission:
  - Mild-moderate infections: Cefazolin 1g IV q8h + Metronidazole 500 mg PO/IV q12h
  - Severe infections: Ceftriaxone 1g IV q24h + Metronidazole 500 mg PO/IV q12h OR Piperacillin-tazobactam 3.375g IV q6h
  - Penicillin anaphylaxis: Gentamicin (dose based on weight and Cr) + Metronidazole 500mg PO/IV q12h

*Duration depends on achieving adequate source control.

For more information please see the **TEGH Antimicrobial Handbook** found on icare or contact Infectious Diseases on call.
On ***icare*** folllow quick link to ***Virtual Library*** then ***TEGH Antimicrobial Handbook***