

Pediatric Treatment Recommendations Card

Expanded content and references available at: <https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/pediatric-treatment-rec.html>



| Acute Sinusitis | Diagnosis | Management |
|------------------------|--|--|
| | <p>Non-specific viral/bacterial findings: Halitosis, fatigue, headache, decreased appetite</p> <p>Bacterial diagnosis: (One of the following)</p> <ul style="list-style-type: none"> • Persistent symptoms: nasal discharge or daytime cough > 10 days • Worsening symptoms: worsening or new onset fever, daytime cough, or nasal discharge after initial improvement of a viral URI. • Severe symptoms: fever $\geq 39^{\circ}$ C, purulent nasal discharge for at least 3 consecutive days. <p>Imaging tests are no longer recommended for uncomplicated cases</p> | <p>If bacterial infection is established:</p> <ul style="list-style-type: none"> • Watchful waiting for up to 3 days may be offered for children with persistent symptoms. Antibiotics should be prescribed for severe or worsening disease. • First line: amoxicillin or amoxicillin/clavulanate • Children who cannot tolerate oral: single dose of ceftriaxone can be used then switch to oral if improving • Further recommendations: AAP or IDSA guidelines^{1,2} |

| Acute Otitis Media (AOM) | Diagnosis | Management |
|---------------------------------|--|---|
| | <p>Definitive diagnosis requires either:</p> <ul style="list-style-type: none"> • Moderate or severe bulging of the tympanic membrane (TM) or new onset otorrhea not due to otitis externa • Mild bulging of the TM AND recent (<48h) onset of otalgia (holding, tugging, rubbing of the ear) or intense erythema of the TM <p>AOM should not be diagnosed in children without middle ear effusion (based on pneumatic otoscopy and/or tympanometry)</p> | <ul style="list-style-type: none"> • Watchful waiting for mild cases with unilateral symptoms in children 6-23 months or unilateral or bilateral symptoms in children >2y • First line: amoxicillin for children who have not received it within the past 30 days • Amoxicillin/clavulanate if amoxicillin has been taken within 30d, concurrent purulent conjunctivitis, or history of recurrent AOM unresponsive to amoxicillin • Allergy: cefdinir, cefuroxime, cefpodoxime or ceftriaxone • Prophylactic antibiotics are not recommended • Further recommendations: AAP guidelines³ |

| Pharyngitis | Diagnosis | Management |
|--------------------|---|--|
| | <p>Clinical features alone do not distinguish between GAS and viral pharyngitis</p> <p>Children with a sore throat plus 2 or more should undergo a Rapid Antigen Detection Test (RADT):</p> <ul style="list-style-type: none"> • Absence of cough • Presence of tonsillar exudates or swelling • History of fever • Presence of swollen and tender anterior cervical lymph nodes • Age < 15 years <p>Do not test in children < 3 years (GAS rarely causes pharyngitis and rheumatic fever is uncommon)</p> <ul style="list-style-type: none"> o Negative RADT should be backed up by a throat culture o Positive RADTs do not require back-up culture | <ul style="list-style-type: none"> • First line: amoxicillin and penicillin V • Allergy: cephalixin, cefadroxil, clindamycin, clarithromycin or azithromycin • Duration: 10 days |

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Common Cold or non-specific upper respiratory infection (URI)

| Diagnosis | Management |
|--|--|
| <ul style="list-style-type: none"> Viral URIs are often characterized by nasal discharge and congestion or cough. Usually nasal discharge begins as clear and changes throughout the course of the illness. Fever, if present, occurs early in the illness | <ul style="list-style-type: none"> Symptomatic relief. Antibiotics should not be prescribed for these conditions Potential for harm and no proven benefit from OTC cough and cold medications in children < 6 years. Inhaled corticosteroids and oral prednisolone do not improve outcomes in children without asthma |

Bronchiolitis

| Diagnosis | Management |
|---|--|
| <ul style="list-style-type: none"> Occurs in children < 24 months Characterized by: rhinorrhea, cough, wheezing, tachypnea and/or increased respiratory effort Routine lab tests and radiologic studies are not recommended, but a chest x-ray may be warranted in atypical disease (absence of viral symptoms, severe distress, frequent recurrences, lack of improvement) | <ul style="list-style-type: none"> Usually patients worsen between 3-5 days, then improve Antibiotics should not be used Nasal suctioning is mainstay of therapy Albuterol and nebulized racemic epinephrine should not be administered outside of the hospitalized setting No evidence to support routine suctioning of the lower pharynx or larynx (deep suctioning) No role for corticosteroids, ribavirin, or chest physiotherapy |

Urinary Tract Infections (UTI)

| Diagnosis | Management |
|---|---|
| <ul style="list-style-type: none"> Infants: fever and/or strong-smelling urine School aged children: dysuria, frequency, or urgency Definitive diagnosis: (all required) <ul style="list-style-type: none"> Urinalysis suggestive of infection <ul style="list-style-type: none"> Pyuria (leukocyte esterase or 5 WBCs), bacteriuria, or nitrites* ≥50,000 CFUs/mL of a single uropathogen Obtained through catheterization or suprapubic aspiration (NOT bag) for children 2-24 months The decision to assess for UTI in urine testing for all children 2-24 months with unexplained fever is no longer recommended but should be based on the child's likelihood of UTI. <p>*Nitrites are not a sensitive measure in children and cannot be used to rule out UTIs</p> | <ul style="list-style-type: none"> Initial treatment should be based on local susceptibility Ages 2-24 months: <ul style="list-style-type: none"> Suggested agents: TMP/SMX, amoxicillin/clavulanate, cefixime, cefpodoxime, cefprozil or cephalexin Duration: 7-14 days Antibiotics not recommended for asymptomatic bacteriuria Febrile infants with UTIs should undergo renal and bladder US during or following their first UTI. Abnormal imaging results require further testing Further recommendations: AAP guidelines⁴ |

1. Clinical practice guideline for the diagnosis and management of acute bacterial sinusitis in children aged 1 to 18 years. *Pediatrics*. 2013;132(1):e262-80. <http://pediatrics.aappublications.org/content/early/2013/06/19/peds.2013-1071>
2. IDSA clinical practice guideline for acute bacterial rhinosinusitis in children and adults. *Clin Infect Dis*. 2012;54(8):e72-e112. <https://academic.oup.com/cid/article/54/8/1041/364141/Executive-Summary-IDSA-Clinical-Practice-Guideline>
3. The diagnosis and management of acute otitis media. *Pediatrics*. 2013;131(3):e964-99. <http://pediatrics.aappublications.org/content/early/2013/02/20/peds.2012-3488>
4. Urinary tract infection: Clinical practice guideline for the diagnosis and management of the initial UTI in febrile infants and children 2 to 24 months. *Pediatrics*. 2011;128(3):595-610. <http://pediatrics.aappublications.org/content/early/2011/08/24/peds.2011-1330>