Indication	No Antibiotic Allergies	Penicillin allergy – rash	Penicillin allergy – anaphylaxis	Comments
Acute Sinusitis[1] (Symptoms lasting 4-12 weeks)	Amoxicillin-clavulanic acid 875mg PO BID x5-7 days (High dose recommended if high rate of PCN-resistant S. pneumoniae (>10%), severe infection, age >65 y.o., recent hospitalization, antibiotic use within 30 days or immunocompromised. Amoxicillin-clavulanic acid 2g PO BID x5-7 days	Doxycycline monohydrate 100 mg PO BID x5-7 days	Doxycycline monohydrate 100mg PO BID x5-7 days	Use antibiotics when: • Onset with persistent symptoms (purulent mucus) lasting >10 days and not improving • Onset with severe symptoms for at least 3-4 days (high fever >39^{0}C/102^{o}F, purulent nasal discharge) • Viral symptoms that appear to improve but then suddenly worsen around days 5-6 ("double sickening") Non-pharmacologic recommendations: 1. Saline nasal irrigations 2. Intranasal corticosteroids (if hx allergic rhinitis No topical or oral decongestants or antihistamines are recommended
Pharyngitis[2] Group A Streptococcus	Penicillin VK 500 mg PO BID x10 days or Amoxicillin 500mg PO BID x10 days	Cephalexin 500 mg PO BID x10 days	Clindamycin 300mg PO TID x10 days Azithromycin 500 mg PO daily x1, 250 mg PO daily x4 days	Non pharmacologic recommendations: 1. APAP 2. NSAID
Bronchitis Acute	Routine antibiotic treatment for uncomplicated bronchitis is NOT recommended, regardless of duration of cough			
Pneumonia[3]	Cefuroxime axetil 500 mg PO BID + Doxycycline 100 mg PO BID x5-7 days or Amoxicillin-clavulanic acid 875mg PO BID AND + Doxycycline 100 mg PO BID x5-7 days	Cefuroxime axetil 500 mg PO BID + Doxycycline 100 mg PO BID x5-7 days	Levofloxacin 750 mg PO daily x5 days	Non-pharmacologic recommendations: 1. Oral hydration.
Uncomplicated[4] cystitis (well-controlled DM/elderly)	Creatinine clearance >30 ml/min Nitrofurantoin 100 mg PO BID x5 days TMP-SMX 1 DS PO BID x3 days (lower sensitivity rate) Creatinine clearance <30 ml/min Cephalexin 500 mg PO q8h x7 days	Creatinine clearance >30 ml/min Nitrofurantoin 100 mg PO BID x5 days TMP-SMX 1 DS PO BID x3 days (lower sensitivity rate) Creatinine clearance <30 ml/min Cephalexin 500mg PO q8h x7 days	Creatinine clearance >30 ml/min Nitrofurantoin 100mg PO BID x5 days TMP-SMX 1 DS PO BID x3 days (lower sensitivity rate) Creatinine clearance <30 ml/min, >10 ml/min Fosfomycin 3g PO x1	Non pharmacologic recommendations: Oral hydration If Pyridium is used, should only be used for 48 hours.
Uncomplicated[4] pyelonephritis	Ciprofloxacin 500 mg PO BID x7 days Levofloxacin 750 mg PO daily x5 days TMP-SMX DS PO BID x14 days Amoxicillin-clavulanic acid 500 mg/125 mg PO BID x10-14 days Based on resistance rates, may need a dose of ceftriaxone in office	Ciprofloxacin 500 mg PO BID x10 days Levofloxacin 750 mg PO daily x5 days TMP-SMX DS PO BID x14 days Cefpodoxime proxetil 200 mg PO BID x10-14 days Based on resistance rates, may need a dose of ceftriaxone in office	Ciprofloxacin 500 mg PO BID x7 days Levofloxacin 750 mg PO daily x5 days TMP-SMX DS PO BID x14 days Based on resistance rates, may need a dose of a aminoglycoside in office (based on renal function)	
Purulent Cellulitis[5]	TMP-SMX DS 1-2 PO BID x5 days (consider higher dose in obesity)	Sulfa allergy: Doxycycline monohydrate 100 mg PO BID x5 days	Sulfa/doxy allergy: Clindamycin 300 mg PO 4 times/daily x5 days	Antibiotics may not be needed with adequate I/D and no signs of systemic symptoms (SIRS).
Nonpurulent Cellulitis[5]	Cephalexin[6] < 60kg – 500mg PO 4 times daily 60-80kg – 1g PO 3 times daily >80kg – 1g PO 4 times daily Or Dicloxacillin 500mg PO 4 times/day X 5 days	Cephalexin < 60kg – 500mg PO 4 times daily 60-80kg – 1g PO 3 times daily >80kg – 1g PO 4 times daily X 5 days	Clindamycin 300mg PO 4 times/daily x 5 days	Non pharmacologic recommendations: Elevation of affected area Examine interdigital toe spaces and treat with topical antifungals if indicated.

References

1. Chow AW et al. Clin Infect Dis 2012;54(8):e72-112.
2. Shulman ST et al. Clin Infect Dis 2012;55(10):e86-102.
3. Niederman MS et al. Annals Intern Med 2015 (Oct 6)
4. Gupta K et al. Clin Infect Dis 2011;52(5)e103-120.
5. Stevens DL et al. Clin Infect Dis 2014;59(2):e-10-52.
6. Pallin DJ et al. Clin Infect Dis 2013;56(12):1754-62.