Practice Guidance for Judicious Use of Antibiotics

In the well-appearing patient, antibiotics are not the answer.

Acute Sinusitis / Rhinosinusitis — Children

Sinus congestion/pressure, nasal discharge

Upper respiratory infection with mild to moderate discharge lasting < 10 days

OR

Severe symptoms lasting < 3 days

Purulent nasal secretions or sputum do not predict bacterial infection.

The majority of case of acute rhinosinusitis seen as outpatients are caused by uncomplicated viral upper respiratory infection.

Treatment of viral infections with antibiotics does nothing to prevent complications or improve symptoms.

Management

Nasal corticosteroid spray (particularly in patients with allergic rhinitis)

Sinus irrigation

Acetaminophen or ibuprofen as needed

Supportive care

Persistent symptoms for >10 days without improvement

OR

Severe symptoms AND purulent nasal discharge or facial pain for >3 days at beginning of illness

OR

Worsening of symptoms (new fever, headache, nasal discharge) after having initially improved after 5 days of a typical upper respiratory infection

Management

Amoxicillin (45 mg/kg/day bid x 7–10 days)

Use high dose amoxicillin (90 mg/kg/day bid) if risk factor for penicillin-resistant pneumococcus present (local rates of PCN resistance > 10%, age < 2 years, day care exposure, immunocompromise, recent hospitalization or antibiotic use in past 3 months)

Treatment failure: High dose amoxicillin-clavulanate

Mild penicillin allergy (no hives or anaphylaxis): cefixime, cefpodoxime or cefdinir

If history of hives or anaphylaxis with penicillin: levofloxacin or doxycycline (if age > 8 years)

If still no improvement after 72 hours, consider imaging or ENT consultation

These guidelines were produced in collaboration with the Infectious Diseases Society of Oregon.

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