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

Community-Acquired Pneumonia — Children

Clinical Considerations

Unlike for adults, decisions about site of care should be based on clinical assessment of severity of illness.

Factors favoring hospitalization:

- Presence of respiratory distress (tachypnea, retractions, grunting, nasal flaring, apnea, altered mental status)
- Pulse oximetry measurement < 90%
- Age < 6 months

CXR and blood culture:

- Should be obtained from children treated as inpatients.
- Not necessary for nontoxic-appearing children who are fully vaccinated against SP and HI treated as outpatients.

Consider testing for viral agents (influenza, RSV) based on clinical symptoms and season.

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

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Acute and Communicable Disease Prevention
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Phone: 971-673-1111 Fax: 971-673-1100
www.healthoregon.org/antibiotics
oregon.aware@state.or.us

Management of Outpatients

Children < 5 years:

- Do not routinely require antibiotics, since the majority of cases of CAP in this age group are of viral etiology.
- Amoxicillin or amoxicillin-clavulanate (45 mg/kg/day bid) for presumed bacterial pneumonia.
- Use high dose amoxicillin or amoxicillin-clavulanate (90 mg/kg/day bid) if risk factor for penicillin-resistant pneumococcus present (local rates of pneumococcus PCN resistance ≥ 10%, age < 2 years, day care exposure, immunocompromise, recent hospitalization, or antibiotic use in past 3 months.)

Children > 5 years:

- For presumed atypical pneumonia add coverage with azithromycin (10 mg/kg on day 1, followed by 5 mg/kg once a day on days 2–5) or clarithromycin (15 mg/kg/day bid) or doxycycline for children > 8 years of age unless etiology known.

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