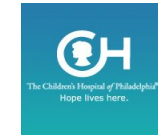




Exclusion criteria:
 Chronic lung disease (except asthma)
 Immunodeficiency, HIV
 Tracheostomy
 Risk factors for aspiration pneumonia
 IV antibiotic therapy during previous 30 d
 HA pneumonia (<14 d from previous hosp)

Community-Acquired Pneumonia Pocket Guide

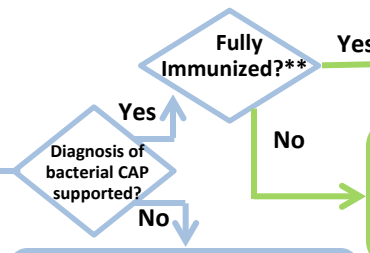
Children > 90 days



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Mild Pneumonia
 -Age > 3 months
 -Absence of respiratory distress
 -SatO2 > 92% in room air
 -Non-toxic appearance
 -Ability to tolerate oral medications and fluids
 -Adequate observation/follow-up care

Consider Chest X-ray only if diagnosis uncertain. Routine CXRs are not necessary to confirm the CAP diagnosis



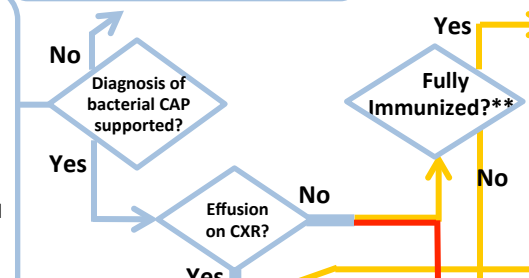
First line initial therapy:
 Amoxicillin 90 mg/kg/day, div Q8hrs; (max: 1g/dose) X 7 d
 Alternatives if PCN allergy***

No clinical improvement > 48-h
 Reassess the patient

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Moderate Pneumonia
 -Age < 3 months
 -Moderate-severe dyspnea
 -SatO2 < 92% in room air
 -Alteration in mental status
 -Concern for inadequate outpatient care/FU
 -Dehydration, vomiting, inability to take oral meds
 -Clinical concern for inpatient-level observation

Recommended: Chest X-ray
 CBC w/diff, CRP
Sometimes recommended: Blood cx, Respiratory viral panel, Mycoplasma rapid serology*, Sputum cx (in children that can produce a sputum sample)



First line initial therapy:
 Ampicillin 200-300 mg/kg/day div Q6hrs max: 2g/dose x 7 d
 Alternatives if PCN allergy***

Switch from IV to PO and discharge when improving within 48-72 h based upon: Resp rate, resp effort, fever, O2 requirement
Duration: 7 d or at least 48 h from resolution of fever and tachypnea (whichever is longer), including PO/outpatient therapy

No clinical improvement > 48 h
 Reassess the patient

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Severe Pneumonia
 -Need for mechanical ventilator support with artificial airway
 -New or increased CPAP or BiPap support
 -Severe resp distress or concern for respi failure
 -Hypoxemia (SatO2 < 90%) despite significant O2 (40% high flow nasal cannula, 100% non-rebreather mask)
 -Systemic signs of inadequate perfusion
 -Parapneumonic effusion requiring emergent drainage

Complicated Pneumonia (moderate parapneumonic effusion)
Clindamycin 40 mg/kg/day div Q8hrs; max 2.7 g/day
AND
Ceftriaxone 100 mg/kg/day Q24hrs; max: 2 g/dose
Alternatives if PCN allergy:
 Instead of ceftriaxone
Levofloxacin (IV/PO) ≥ 6mo and < 5 yrs: 20 mg/kg/day div Q12hrs ≥ 5yr: 10 mg/kg/day Q24hrs; max: 500 mg
OBTAIN US OF CHEST AND CONSULT GENERAL SURGERY FOR EFFUSIONS REQUIRING DRAINAGE****
Duration: 7 d from drainage.
 If not amenable to drainage, 7 d from afebrile

First line initial therapy:
 Ceftriaxone 50-100 mg/kg/day Q24hrs or div Q12hrs or cefotaxime 150 mg/kg/day div Q8hrs
Switch from IV to PO and discharge when improving within 48-72 h based upon: Resp rate, resp effort, fever, O2 requirement
Duration: 7 d, or at least 48 h from resolution of fever and tachypnea (whichever is longer), including PO/outpatient therapy

Severe Pneumonia (including complicated severe pneumonia)
Vancomycin 60 mg/kg/day (max 500 mg/dose), div Q6hrs
AND
Ceftriaxone 100 mg/kg/day Q24hrs max: 2 g/dose
Alternatives if PCN allergy:
AND
Vancomycin 60 mg/kg/day (max 500 mg/dose) div Q6hrs
AND
Levofloxacin (IV/PO) ≥ 6mo and < 5 yrs: 20 mg/kg/day div Q12hrs ≥ 5yr: 10 mg/kg/day Q24hrs; max: 500 mg
IV-PO Switch and Discharge: Chest tube out, Feeding well, No O2 requirement, Fever curve trending down, able to take PO abx

No clinical improvement > 48 h
 Reassess the patient

*Confirmed/Presumed *M. pneumoniae* infection: **Azithromycin:** 10 mg/kg on day 1, single dose (max: 500 mg/day), followed by 5 mg/kg/day, once daily, days 2-5 (max: 250 mg/day) **OR Clarithromycin** 15 mg/kg/day div Q12hrs for 10 days
 **Not fully immunized for *H. influenzae* type b and *S. pneumoniae* (less than 2 doses)
 *** Alternatives if PCN allergy: If not IgE mediated: 2 or 3 generation oral cephalosporin, only for mild pneumonia!! (cefuroxime (30 mg/kg/day div Q12hrs), cefpodoxime, (10 mg/kg/day div Q12hrs) for 7 d, If IgE mediated: Clindamycin (IV) 40 mg/kg/day div Q8hrs; max 2.7 g/day or (PO) 30 mg/kg/day div Q8hrs; max 1.8 g/day, Levofloxacin: (IV/PO) ≥ 6mo and < 5 yrs: 20 mg/kg/day, div Q12hrs ≥ 5yr: 10 mg/kg/day, Q24hrs max: 500 mg
 **** Large and/or growing in size, Impairing pulmonary function, Organized and loculated

References:
 The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America
 Harris M et al, British Thoracic Society guidelines for the management of community acquired pneumonia in children: update 2011. Thorax