Appendix A: Example of Antimicrobial Guideline Pocket Card

DIAGNOSIS	SUSPECTED PATHOGENS	1ST-LINE TREATMENT	2ND LINE/ALLG	STEP-DOWN	DURATION (DAYS)	COMMENTS
CAP	*S. pneumoniae, H.influenzae, M.catarrhalis, M.pneumonia, C.pnemoniae*	**Ceftriaxone 1g IV q24h** PLUS **Azithromycin 500mg PO QDAY x1, 250mg QDAY x4d** *Aspiration AND cavity, alcoholic, empyema, poor dentition*: **Ampicillin/Sulbactam 3g IV q6h** OR **Clindamycin 600mg IV q8h**	**Levaquin 750mg IV/PO q24h**	**Levaquin 750mg PO q24h** *OR* **Cefpodoxime 200mg PO BID** PLUS one of the following: **Azithromycin 500mg PO QDAY x1, 250mg QDAY x4d** or **Doxycycline 100mg PO BID**	No structural lung disease, no immunocompromise(IC): 5 Moderate IC and/or structural lung disease: 7 Significant IC, poor initial clinical response, and/or initially inappropriate therapy: **10-14**	*QTc prolongation in FQs/macrolides *Patients at risk for Pseudomonas should be treated as HCAP *Moderate IC=remote solid organ transplant, chronic immunosuppression (ie, pred 10mg/day), immunomodulators, HIV/CD4>200 *Significant IC=new solid organ transplant, active chemotherapy, HIV/CD4<200, neutropenia,
HCAP: - Hospitalization in previous 90 days - Long-term care facility resident - Broad-spectrum antibiotics in previous 90 days - Prior history of resistant pathogens - Severe structural lung disease - Frequent COPD exacerbations requiring steroids or antibiotics	*Pseudomonas, MRSA,* MDR GNRs	**Piperacillin/Tazobactam 4.5g IV q8h** PLUS **Vancomycin IV (nomogram)^**	Non-life threatening allg: **Cefepime 1g IV q8h** PLUS **Vancomycin IV (nomogram)^** Life-threatening allg: **Aztreonam 1g IV q8h** PLUS **Vancomycin IV (nomogram)^**	Based on culture results. If no culture results available: **Levaquin 750mg PO q24h**	Uncomplicated/ clinical improvement within 72h: **8** Pseudomonas, Stenotrophomonas, Acinetobacter, or Burkholderia: **14**	*Obtain sputum culture when possible *PCN allg AND suspect aspiration: Add Metronidazole 500mg IV q8h (if Vancomycin has already been d/c'ed, add Clindamycin 600mg IV q8h) *Linezolid 600mg IV/PO q12h can be substituted if Vancomycin intolerance (SSRI interaction, CBC monitoring for cytopenias) ^Consider adding Azithromycin 500mg qday x1, then 250mg qday x4d IF suspect atypicals *QTc prolongation in FQs/macrolides *goal Vancomycin trough 10-15
HCAP: (lower risk) - Chronic dialysis, home infusion or wound care without other risk factors	*S. pneumoniae, H.influenzae, M.catarrhalis, M.pneumonia, C.pnemoniae*	**Ceftriaxone 1g IV q24h** PLUS **Azithromycin** *Aspiration AND cavity, alcoholic, empyema, poor dentition:* **Piperacillin/Tazobactam 4.5g IV q8h**	**Levaquin 750mg IV/PO q24h**	**Levaquin 750mg PO q24h** *OR* **Cefpodoxime 200mg PO BID** PLUS one of the following: **Azithromycin 500mg PO QDAY x1, 250mg QDAY x4d** or **Doxycycline 100mg PO BID**		
C. diff: for all patients: - Discontinue/change antibiotics if possible. - Avoid PPI/H2 blockers without an appropriate indication. - Implement infection control measures	Mild/Moderate: WBC<15K and creatinine <1.5x baseline	Mild/Moderate: **Metronidazole 500mg PO TID**	Rifaximin, nitazoxanide, fidaxomicin, IVIG, stool transplant may be appropriate in certain patient populations; ID approval required	N/A	Mild/Moderate: **10-14**	*Flagyl interacts with coumadin *See UMHS guidelines for treatment of recurrences, relapses and vancomycin taper
	Severe: WBC>15K or creatinine >1.5x baseline	Severe: **Vancomycin 125mg PO QID**			Severe: **10-14**	
	Severe with complications: Hypotension, shock, ileus, or megacolon	Severe with complications: **Metronidazole 500mg IV q8h** PLUS **Vancomycin 500mg PO QID** (consider Vancomycin enemas if ileus; surgical consulation)			Severe with complications: at least **10-14**, consult ID	
Non-purulent cellulitis:	Beta-hemolytic streptococcus; *MSSA*	**Cefazolin 1g q8h**	**Clindamycin 600mg IV q8h**	**Cephalexin 500mg PO QID** *OR* **Clindamycin 300-450 PO TID**	**7–10**	*Linezolid 600mg IV/PO q12h can be substituted if Vancomycin intolerance (SSRI interaction, CBC monitoring for cytopenias) *Baseline and weekly CK for Daptomycin *goal Vancomycin trough 10-15
	CA-*MRSA* (therapy for Beta-hemolytic strep likely not necessary) Suspect if: - not improving on IV-B-lactam therapy >48 hours - rapidly progressive infection - prior h/o MRSA skin/soft tissue infection - signs of systemic toxicity	**Vancomycin IV (nomogram)**	**Linezolid 600mg PO q12h** *OR* **Ceftaroline 600mg IV q12h** *OR* **Daptomycin 4mg/kg IV q24h**	**Cephalexin 500mg PO QID** PLUS **TMP-SMX 1 DS PO BID-TID** *OR* **Clindamycin 300-450 PO TID** *OR* **Cephalexin 500mg PO QID** PLUS **Doxycycline 100mg PO BID**		
Purulent cellulitis: - purulent drainage/exudate without drainable abscess	CA-*MRSA* (therapy for Beta-hemolytic strep likely not necessary)	**Vancomycin IV (nomogram)**	**Linezolid 600mg PO q12h** *OR* **Ceftaroline 600mg IV q12h** *OR* **Daptomycin 4mg/kg IV q24h**	**TMP-SMX 1 DS PO BID-TID** *OR* **Clindamycin 300-450 PO TID** *OR* **Doxycycline 100mg PO BID**	**7-10** May need longer duration based on clinical response; consider ID consult	*blood cultures and culture from exudate recommended in patients with fever, rapidly progressive cellulitis, signs of systemic illness *goal Vancomycin trough 10-15
UTI: see pocket card/poster						