ANTI-INFECTIVE GUIDELINES FOR COMMUNITY-ACQUIRED INFECTIONS 2012 - *UPDATE*

CHANGES BETWEEN 2010 & 2012 EDITIONS

A few general observations:

- Cefixime removed as a treatment option for pharyngitis, otitis media, and sinusitis due to increasing *Strep pneumo* resistance.
- More conservative cephalosporin pediatric dosing (e.g. epigloittitis, Lyme disease, bacterial meningitis) and additional guidance for pediatric dosing for certain infections (e.g. CA-MRSA, Traveller's Diarrhea).
- Recommendations more detailed for drug, dose and duration regarding certain recurrent infections (e.g. VVC, CDI, BV).
- Excellent, practical & Canadian guideline for managing community acquired infections common in primary care.
- References, dosing and costs have been checked and up-dated for all therapeutic categories.

	Infection	2010 Guidelines	2012 Guidelines
URTI	Epiglottitis	Cefuroxime 150mg-200mg/kg/day divided q8h	↓ dose: Cefuroxime 75mg-100mg/kg/day divided q8h
URTI	Seasonal Influenza	Provided weight based oseltamivir prophylaxis & treatment dosing for patients 1-12 yo	Oseltamivir pediatric dosing: "Consult product monograph"
URTI	Croup	Removed statement that nebulized budesonide has no advantage over oral dexamethasone	
URTI	Acute Rhinitis & Flu Prevention	"There is **limited evidence to support** the use of vitamin C, Echinacea or zinc."	"Evidence suggests that North American ginseng extract, vitamin C, Echinacea or zinc **may be of benefit** in reducing the frequency, duration & severity of colds."
URTI	Sinusitis – Adult: Acute	Duration of therapy: 10-14 days	↓ Duration of therapy: 5-10 days. Switch antibiotics if no response within 3 days. Plus clearer definition of acute bacterial sinusitis.
URTI		Intranasal steroids: modest benefit, weak efficacy data.	Intranasal steroids: +ve benefit (↓severity of sx, ↑ recovery) +/- antibiotics
	Pneumonia, Community Acquired	Now includes CRB-65 (a pneumonia risk scoring tool)	
	Pneumonia – Children: Hospitalized	NEW - Cefotaxime IV 200mg/kg/day divided q4-6h can be used as an alternative to IV cefuroxime	
	CELLULITIS –Uncomplicated: Mild (PG. 46) Uncomplicated: Severe (PG. 47)		Added: Empiric coverage for community acquired methicillin resistant *S. aureus* (CA-MRSA) should be considered in areas where MRSA is commonly isolated (> 10-15% of *S.aureus*) or in patients with prior hospital admissions (over last 6-12 months) or where there is purulent drainage or exudate in the absence of a drainable abscess (Liu, 2011)
Skin	CA-MRSA Normal Host	Vancomycin – adult dosing only	Vancomycin –pediatric dosing added
Skin	Lyme Disease	Cefotaxime 150-200mg/kg/day divided q6-8h	↓ dose: Cefotaxime 100-180mg/kg/day divided q6-8h
Skin	Herpes Simplex Virus – Keratitis/Keratoconjunctivitis	Duration of trifluridine: 7-21 days	Duration of trifluridine: 7 days (warns of tx >21d)

	Infection	2010 Guidelines	2012 Guidelines
GU	Acute UTI	Distinction between re-infection & relapse.	Distinction between recurrent, re-infection & relapse (see pg. 64)
	Pyelonephritis	levofloxacin 250mg IV q24h	levofloxacin 250-500mg IV q24h
	Prostatitis – Chronic	New: "Alpha-blockers and antibiotics, as well as combinations of these therapies, appear to achieve the greatest improvement in clinical symptom scores compared to placebo."	
	Epididymitis & Pelvic Inflammatory Disease	ceftriaxone 250mg IM x 1	ceftriaxone 250-500mg IM x 1
	Pelvic Inflammatory Disease	New: "For patients with CI to tx with cephalosporins or quinolones evidence suggests a short course of azithromycin (250mg daily x 7 days OR 1 g weekly x 14 days) plus metronidazole is effective in producing clinical cure."	
	Vaginitis:Trichomoniasis	New: Asymptomatic & Pregnant – defer or don't treat.	
	Vaginitis: Bacterial Vaginosis (BV)	• 2nd line agents now listed as 1st line (i.e. metronidazole 0.75% gel & clindamycin 2% cream). • Added metrondiazole 2g x 1 as a 2nd line agent. • New: "A single dose of metronidazole has a cure rate of 85% but a higher relapse rate at 1 month (30-50% vs 20-33%). • Now provides guidance on recurrent BV.	
	Vulvovaginal Candidiasis (VVC)	Now recommends Induction Treatment prior to Maintenance Therapy for recurrent VVC.	
CN	Urethritis – Gonococcal ≥9 years old	Ceftriaxone 250mg IM x 1	Ceftriaxone 250-500mg IM x 1
	Bacterial Meningitis – 3 months-18 years old	Cefotaxime 200-300mg/kg/day IV divided q6-8h	Cefotaxime 200mg/kg/day IV divided q6-8h
GI	Traveller's Diarrhea	Inserted information for pediatrics: • Azithromycin: dosing, drug of choice for treatment, prophylaxis in high risk patients. • FQ: guidance for patients <16yo as 2nd line	
	C. difficile Infection (CDI)	Vancomycin **125-500mg** po QID for **7-10** days	Vancomycin **125mg** po QID for **10-14** days
		New • "Use of proton pump inhibitors (PPIs) is independently associated with an increased risk of C. difficile and administration of PPIs within 14 days of diagnosis of C. difficile is an independent risk factor for recurrence." • For recurrent CDI, added that metronidazole should only be used for the first recurrence.	
Proph	Malaria Prophylaxis	Additions: mefloquine loading dose, buy DEET prior to departure (re: counterfeit products); Atovaquone-proguanil - take with food; Hydroxychloroquine dosing (in text vs table).	
		Mefloquine & Pregnancy: Caution, especially in 1st trimester.	Mefloquine & Pregnancy: 1st trimester – avoid, 2nd & 3rd trimester – caution. Avoid pregnancy within 3 months of stopping prophylaxis.

Reference: Anti-infective Review Panel. Anti-infective guidelines for community-acquired infections. Toronto: MUMS Guideline Clearinghouse; 2012. http://www.mumshealth.com/