Acute Sinusitis

Diagnosis

Halitosis, fatigue, headache, decreased appetite and most physical findings are non-specific and do not differentiate bacterial from viral causes.

Bacterial diagnosis maybe established based on the presence of one of the following:

- Persistent symptoms without improvement: nasal discharge or daytime cough >10 days
- Worsening symptoms: worsening or new onset fever, daytime cough, or nasal discharge after initial improvement of a viral URI
- Severe symptoms: fever ≥ 39°C, purulent nasal discharge for at least 3 consecutive days

Imaging tests are no longer recommended for uncomplicated cases

Management

If bacterial infection is established:

- Watchful waiting for up to 3 days may be offered for children with persistent symptoms. Antibiotics should be prescribed for severe or worsening disease.
- First line: Amoxicillin (90mg/kg/day BID) or amoxicillin/clavulanate (90mg/kg/day of amoxicillin BID)
- Children who cannot tolerate oral; single dose of ceftriaxone can be used then switch to oral if improving
- Further recommendation: AAP or IDSA guidelines

WVU Medicine Children's

Pediatric Treatment Recommendations Pocket Card

Expanded content and references available at:
cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/pediatric-treatment-rec.html

Acute Otitis Media (AOM)

Diagnosis

Definitive diagnosis requires either:

- Moderate or severe bulging of the tympanic membrane (TM) or new onset otorrhea not due to otitis externa
- Mild bulging of the TM and recent (<48h) onset of otalgia (holding, tugging, rubbing of the ear) or intense erythema of the TM

AOM should not be diagnosed in children without middle ear effusion (based on pneumatic otoscopy and/or tympanometry)

Management

- Watchful waiting for mild cases with unilateral symptoms in children 6-23 months or unilateral or bilateral symptoms in children >2y
- **First line:** Amoxicillin (80-90 mg/kg/day BID) for children who have not received it within the past 30 days
- Amoxicillin/clavulanate (90 mg/kg/day of amoxicillin BID) if amoxicillin was prescribed within the past 30 days, concurrent purulent conjunctivitis, or history of recurrent AOM unresponsive to amoxicillin
- **For non-type I hypersensitivity to PCN:** Cefdinir (14 mg/kg/day QD/BID), cefuroxime (30 mg/kg/day BID), cefpodoxime (10 mg/kg/day BID), or ceftriaxone (50 mg/kg) IM for 1-3 days)
- **Duration:** Children< 2 yrs and children with severe symptoms, a 10-day course. For children 2 to 5 years of age with mild or moderate AOM 7 d course. For children>6 years with mild to moderate symptoms, a 5- to 7-day course is adequate treatment.
- Prophylactic antibiotics are not recommended to reduce recurrence of AOM

Pharyngitis

Diagnosis

Clinical features alone do not distinguish between group A streptococci (GAS) and viral pharyngitis. During the winter, up to 20% of asymptomatic children can be colonized with GAS leading to more false-positives from Rapid Antigen Detection Test (RADT)

Do not test in children <3 years (GAS rarely causes pharyngitis and rheumatic fever is rare)

- Negative RADT should have reflex throat culture
- Positive RADTs do not require a backup culture

Children with a sore throat plus 2 or more should undergo RADT:

- Absence of cough
- Presence of tonsillar exudates or swelling
- History of fever
- Presence of swollen and tender anterior cervical lymph nodes
- Age <15 years

Management

- **First line:** Amoxicillin (50 mg/kg day BID) or penicillin V (50mg/kg/day BID) round to nearest tablet size
- **For non-type I hypersensitivity to PCN:** Cephalexin (50 mg/kg/day BID), cefadroxil (30 mg/kg QD)
- **For immediate type I hypersensitivity to PCN:** Clindamycin (20mg/kg/day TID), clarithromycin (15mg/kg/day BID) or azithromycin (12 mg/kg QD)
- **Duration:** 10 days for all oral beta lactams

WVU Medicine Children's

Pediatric Treatment Recommendations Pocket Card

Expanded content and references available at:
cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/pediatric-treatment-rec.html

Urinary Tract Infections (UTIs)

Diagnosis

Common signs and symptoms:

- In infants: fever and or strong-smelling urine
- In school-aged children: dysuria, frequency, or urgency

A definitive diagnosis requires both of the following:

- A urinalysis suggestive of infection: presence of pyuria (leukocyte esterase or ≥5 WBCs per HPF), bacteriuria, or nitrites
  - Nitrites are not a sensitive measure for UTI in children and cannot be used to rule out UTIs
- At least 50,000 CFUs/mL of a single uropathogen from urine obtained through catheterization or suprapubic aspiration (NOT urine collected in a bag) for children 2–24 months

Urine testing for all children 2-–24 months with unexplained fever is not recommended and should be based on the child's likelihood of UTI

Management

- Antibiotic treatment of asymptomatic bacteriuria is not recommended
- **First Line:** Amoxicillin/clavulanate (50 mg/kg/day of amoxicillin TID) or sulfamethoxazole/trimethoprim (15-20mg/kg/day TID)
- **For non-type I hypersensitivity to PCN:** Cefdinir (14 mg/kg/day QD/BID) cefpodoxime (10 mg/kg/day BID)
- **Duration:** 7-14 days.
- During or following the first UTI, febrile infants with UTIs should undergo renal and bladder ultrasonography. Further testing is required for abnormal imaging results.
- Further recommendations: AAP guidelines