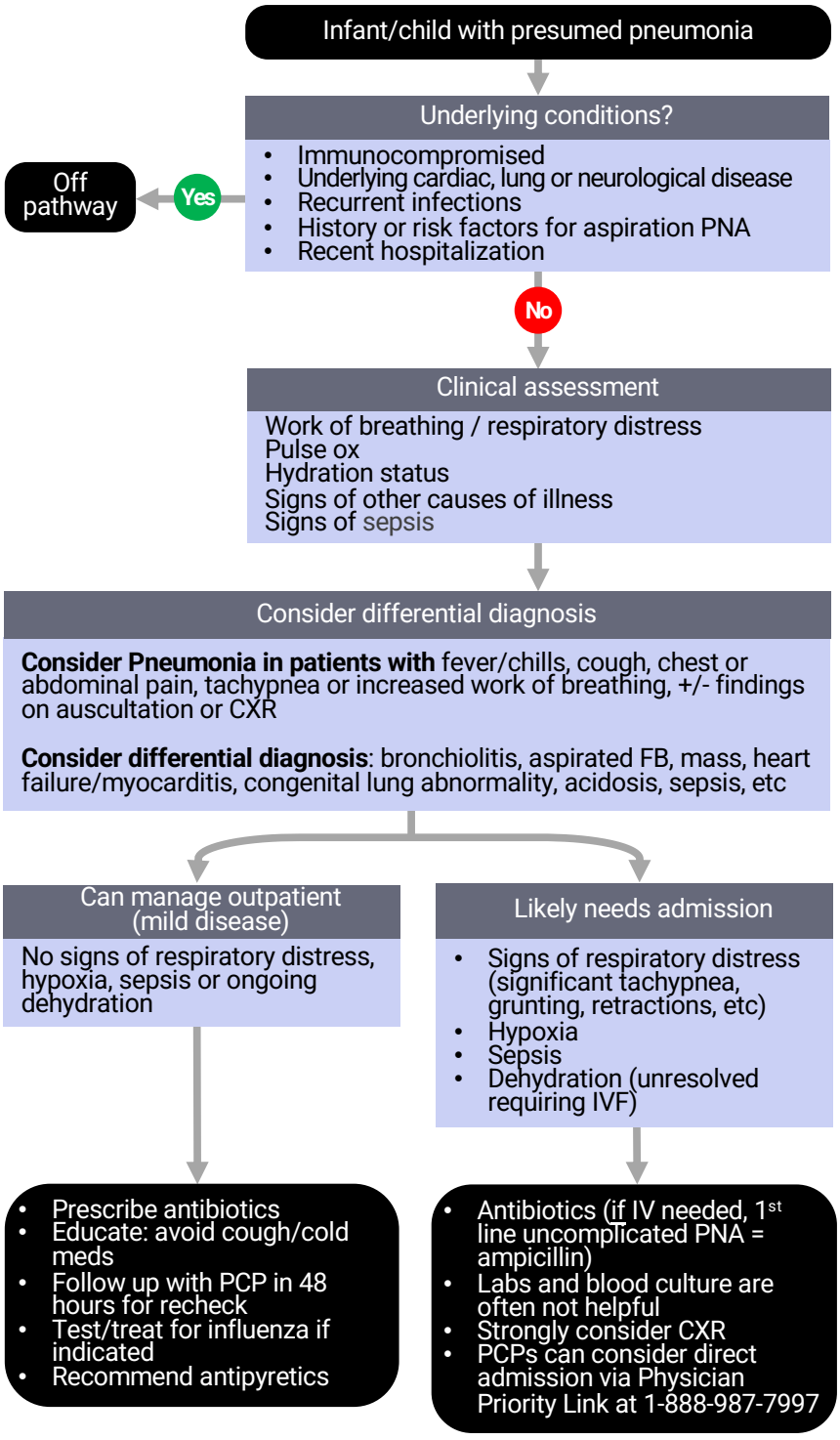
Community-Acquired Pneumonia

Emergency Department / Urgent Care / Primary Cares
Age ≥ 2 months



Testing Considerations

Chest X-rays are not always necessary for PNA that can be managed as an outpatient.

CBC, blood culture, ESR and other routine bloodwork are often not helpful

Influenza testing (especially if influenza treatment indicated)

Chest X-ray findings (if done)

Complete lobar opacification – very unusual in PNA unless effusion present, consider discussion with pulmonary or further imaging

Persistent similar consolidations over time (persist or recur in the same location) – consider FB evaluation (CT), or other diagnosis; consider discussing with pulmonology before dispo

Preferred treatment - Amoxicillin

90 mg/kg/day divided BID w/ max 4000 mg/day for 5 days

Other treatment considerations

PCN allergy (non-anaphylaxis) – Cefdinir 14 mg/kg/day divided BID, max 300 mg/day for 5 days Refer to Pediatric Antibiotic Allergy Testing Service (PATS) or send e-consult (PCPs)

PCN AND cephalosporin allergy – consider clindamycin or levofloxacin

Amox in the last 30 days – Amox/clavulanate (high dose, ES or XR) X 5 days

Treatment failure

No clinical improvement in 48-72 hours:

- Assess for appropriate antibiotic dose and compliance
- Consider additional diagnostic testing for a wider array of causative organisms, chest X-ray
- Consider inpatient admission for IV antibiotics if clinically warranted (ampicillin for oral abx intolerance; or ceftriaxone +/- targeted to suspected cause)

Failed amoxicillin: High-dose Augmentin. Consider adding atypical coverage. Consider 7-10 days

Failed azithromycin: consider changing to a quinolone or adding typical (amoxicillin) coverage.

Atypical PNA

Consider testing or treatment for atypical PNA in children >= 5 with consistent symptoms or failed tx with amoxicillin

Azithromycin 10mg/kg (max 500mg) on day 1, then 5mg/kg (max 250mg) on days 2-5.