

Adult Antibiotic Dosing Recommendations

Amoxicillin (Amoxil):*

1 gram PO every 8 hours for pneumonia. May use 500 mg to 1 gram PO every 8 hours for most indications.

Amoxicillin/clavulanate (Augmentin)*:

875 mg PO BID for most indications; may increase to every 8 hours for intra-abdominal infections

Azithromycin:

500 mg x 1 on day 1 followed by 250 mg PO daily x 4 days
May also consider 500 mg po daily x 3 days

Cefdinir*:

300 mg PO BID

Cephalexin*:

500 mg PO every 6 hours

Ciprofloxacin*:

500 mg to 750 mg PO BID

Doxycycline:

100 mg PO BID

Levofloxacin*:

500 mg to 750 mg PO daily

Metronidazole:

500 mg PO every 8 hours

Nitrofurantoin monohydrate/macrocrystals**:

100 mg PO BID

* Renal dose adjustments may be required
**Avoid use in geriatric patients and CrCl < 30 mL/min

Antimicrobial Stewardship Principles

REDUCING GENERAL ANTIBIOTIC USE: Some illnesses may not need antibiotics at all (self-limiting illness, non-bacterial illnesses)

SHORTENING THE COURSE: Most illnesses that are managed outpatient only need 3 to 5 days of antibiotics

AVOIDING RESISTANCE: Agents that have more than 10% resistance rates to the target microbe according to the local antibiogram should not be used when alternatives agents are available

NARROWING ANTIBIOTIC SPECTRUM: Many infection can be managed with antibiotics that are less broad than fluoroquinolones

Ensuring patients receive the right antibiotic, at the right dose, at the right time, and for the right duration reduces mortality, risk of Clostridium difficile-associated diarrhea, hospital stays, overall antimicrobial resistance within the facility, and costs.

Shorter Duration of Antibiotic Therapy

INFECTION	DAYS OF THERAPY
Community Acquired Pneumonia	5 Days
Ventilator Associated Pneumonia	≤ 8 Days
Uncomplicated Cystitis	3 to 5 Days
Pyelonephritis	5 to 7 Days
Intra-abdominal Infection	4 Days
Cellulitis	5 Days
Acute Bacterial Sinusitis	5 Days
Neutropenic Fever	Afebrile x 72 Hours

Verigene Resistance Markers

ORGANISMS	RESISTANCE GENE	INTERPRETATION
Staphylococcus aureus*	None	None
	MecA	Methicillin Resistance
S. epidermidis	None	None
	MecA	Methicillin Resistance
Enterococcus faecalis OR E. faecium	None	None
	Van A or Van B	Vancomycin Resistance
Escherichia coli, Klebsiella pneumoniae, Klebsiella oxytoca	None	None
	CTX-M	ESBL Producing Organism*
	KPC, NDM, OXA or VIM	CRE/MDR Organism*
Proteus sp. OR Enterobacter sp.	None	None
	CTX-M	ESBL Producing Organism*
Pseudomonas aeruginosa	None	None
	IMP, KPC, NDM, OXA or VIM	CRPA/MDR Organism*
Acinetobacter sp.	None	None
	IMP or OXA	CRAB/MDR Organism*
Enterobacter sp.	None	None
	CTX-M	ESBL producing organism*
	KPC, NDM, IMP or VIM	CRE/MDR Organism*

*ID Consult Strongly Recommended

Adult Outpatient/ED Antibiotic Recommendations for SJMC

Approved by the Antimicrobial Stewardship Committee & Infection Control Committee

INFECTION	1ST LINE	ALTERNATIVE / ALLERGY
Asymptomatic Bacteriuria	Do not treat with antibiotics*	
Uncomplicated Cystitis (Symptomatic)	Nitrofurantoin**	Cephalexin
Uncomplicated Pyelonephritis***	Cefdinir	Ciprofloxacin
Diverticulitis/colitis	Ciprofloxacin PLUS Metronidazole	Cefdinir PLUS Metronidazole
Community acquired pneumonia (CAP) – No comorbidities or risk factors for MRSA or Pseudomonas	Amoxicillin	Azithromycin OR Doxycycline
CAP with comorbidities (chronic heart, lung, liver, or renal disease, diabetes mellitus, alcoholism, malignancy or asplenia)	Amoxicillin-Clavulanate PLUS Azithromycin	Cefdinir OR Cefuroxime PLUS Azithromycin OR Doxycycline
Skin & Soft Tissue/ Cellulitis	Cephalexin OR TMP/SMX (if Staph suspected)	Doxycycline OR Clindamycin
Sinusitis	Amoxicillin-Clavulanate	Doxycycline

* Unless the patient is pregnant or undergoing genitourinary system intervention

**Avoid use in geriatric patients and CrCl < 30 mL/min

***Ensure patient received a parenteral antibiotic prior to discharge (i.e. ceftriaxone 1 gram IV/IM x 1)

INDICATION	NOTES	EXCEPTIONS
Nephrolithiasis	Not usually infectious	Unless UTI also present
Gastroenteritis	Usually viral and/or self-limiting	Unless traveler's diarrhea
Bronchitis	Only 6% of cases are bacterial	Unless pertussis suspected
COPD exacerbation per GOLD guidelines	Antibiotics only indicated when increased purulence of sputum AND either increased sputum volume or dyspnea	Admission to ICU, recommended duration 5 days
Diarrhea	Usually self-limiting	Unless C diff or traveler's diarrhea

St. Joseph's Medical Center - Stockton - Emergency Department

Antibiogram 01/01/2024 - 12/31/2024

		Penicillins				Cephalosporins					Carbapenems			Aminoglycosides			Fluoroquinolones		Other								
Percent (%) susceptible	# Tested (n)	Ampicillin	Oxacillin	Piperacillin/Tazo	Amp/Sulbactam	Cefazolin	Cefepime	Cefotaxime	Ceftazidime	Ceftriaxone	Ertapenem	Imipenem	Meropenem	Amikacin	Gentamicin	Tobramycin	Ciprofloxacin	Levofloxacin	Clindamycin	Erythromycin	Linezolid	Rifampin	Trimeth/Sulfa	Daptomycin	Tetracycline	Vancomycin	Nitrofurantoin*
Gram negative rods:																											
Enterobacter cloacae complex	48	0		73	0	0	88		73	63	83			100	100	100	95	95					85				55
Escherichia coli	1533	47		98	56	73	85		84	84	100	100		100	89	88	65	77					72				99
Klebsiella pneumoniae	274	0		94	79	82	87		86	86	100			100	93	92	84	88					85				56
Morganella morganii	34	0		100	28	0	100		84	82	97			100	85	97	56	56					65				0
Proteus mirabilis	172	71		100	76	12	92		90	90	100			99	85	82	70	72					74				0
Pseudomonas aeruginosa	114			86			91		87				91	99	0	0	86	85									
Gram positive cocci:																											
Enterococcus faecalis	259	99																*80			99			100		92	100
Staphylococcus aureus	112		40												89			55	78	36	100	100	95	100	65	100	100
Staphylococcus epidermidis	47		48												93			73			100	98			67	100	100

* Urinary Tract isolates only

Non urine

>= 5% more resistant 2024 than 2023

>= 5% more sensitive 2024 than 2023