RECOMMENDATIONS FOR THE EMPIRIC TREATMENT OF ADULT COMMUNITY ACQUIRED PNEUMONIA

<u>OUTPATIENT</u>

First Line:

Doxycycline 100mg PO BID x 5 days

Second Line:

For patients who have contraindications or intolerance to first line agent.

Levofloxacin 750 mg PO q day x 5 days

Patients with significant comorbidities (diabetes, immunosuppression, chronic lung disease, etc.):

Amoxicillin/clavulanic acid 2g PO BID + Doxycycline (dosed as above) x 5 days

Comorbidities and penicillin allergy, or failing to respond to above therapies:

Levofloxacin 750mg PO q day x 5 days

<u>INPATIENT</u>

Ceftriaxone 2 grams IV q day

+

Doxycycline 100 mg IV/PO BID

For severe beta-lactam allergy: Levofloxacin 750mg IV/PO g day

ICU patients at high risk of pneumonia with *P. aeruginosa* (e.g. prior isolated *P. aeruginosa* on respiratory cultures, recent hospitalization, recent prior parenteral antibiotics, etc.) - consider empiric therapy with an anti-Pseudomonal agent: Cefepime 2 g IV q8h*

ICU patients at risk for staphylococcal pneumonia (e.g. positive Gram stain, IVDU, post-influenza, etc.) - consider adding vancomycin*.

Consider procalcitonin, Streptococcus pneumoniae antigen (urine), and Legionella antigen (urine)

*Respiratory cultures should be obtained to guide de-escalation or confirm indication for continued therapy. **Stepdown therapy**

Once patient stabilized, improving, and has functioning GI tract, a switch to oral therapy is strongly encouraged (usually within 3-5 days)

- Routine use of an oral fluoroquinolone is discouraged.
- Routine addition anaerobic coverage (e.g. metronidazole) in the setting of aspiration is discouraged unless lung abscess or empyema is suspected.
- Patients who respond to antibiotic therapy should not be reimaged (i.e. repeat chest x-ray discouraged) to confirm cure.

IDSA / ATS guidelines provide additional information – Am J Respir Crit Care Med Vol 200, Iss 7, pp e45–e67, Oct 1, 2019

Approved by UCDH Pharmacy and Therapeutics Committee 8/19/2020