Initial Antibiotic Management:

Dosage and Course Table

Condition	Antibiotic	Dose	Maximum Dose	Course
Acute Otitis Media ***First-line treatment***	**amoxicillin**	80–90 mg/kg/day po divided BID	2 g/dose 4 g/day divided BID	10 days*
If amoxicillin in the past 30 days, concurrent purulent conjunctivitis, or has a history of recurrent AOM unresponsive to amoxicillin	amoxicillin clavulanate**	90 mg/kg/day of the amoxicillin component with 6.4 mg/kg/day of clavulanate po divided BID	2 g amoxicillin component/dose 4 g/day divided BID	10 days
If nonsevere penicillin or amoxicillin allergy[1]	cefdinir	14 mg/kg/day po divided in 1 or 2 doses	300 mg/dose 600 mg/day divided BID	10 days
	cefpodoxime	10 mg/kg/day po divided BID	400 mg/dose 800 mg/day divided BID	10 days
	cefuroxime	30 mg/kg/day po divided BID	500 mg/dose	10 days
	ceftriaxone IV/IM	50 mg/kg once daily	2 g/dose	1–3 days
Group A Streptococcal Pharyngitis ***First-line treatment***	**amoxicillin**	50 mg/kg/day po single daily dose	1,000 mg/dose if using once daily	10 days
	penicillin V, oral	Children: 250 mg 2–3 times daily Adolescents and adults: 250 mg 4 times daily	500 mg/dose	10 days
	benzathine penicillin G	<27 kg, 600,000 units IM ≥27 kg 1,200,000 units IM	1,200,000 units	1 dose
If nonsevere penicillin allergy	cephalexin +avoid if type 1 hypersensitivity to penicillin	40 mg/kg/day po divided BID	500 mg/dose	10 days
	cefadroxil +avoid if type 1 hypersensitivity to penicillin	30 mg/kg po once daily	1,000 mg/dose	10 days
If severe penicillin allergy+	clindamycin	20–30 mg/kg/day po divided TID	600 mg/dose 1.8 g/day divided TID	10 days
	azithromycin well-documented resistance	12 mg/kg/dose po once daily	500 mg/dose	5 days
Acute Bacterial Sinusitis ***First-line treatment***	**amoxicillin**	80–90 mg/kg/day po divided BID***	2 g/dose 4 g/day divided BID ***	10 days
If moderate to severe illness, younger than	amoxicillin-clavulanate**	80–90 mg/kg/day po of amoxicillin with 6.4	2 g amoxicillin component/dose	10 days

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2 years old, attending childcare, recently treated with antibiotics, or concurrent purulent conjunctivitis concurrent		mg/kg/day of clavulanate divided BID	4 g/day divided BID	
If penicillin allergy	cefdinir	14 mg/kg/day po divided BID	300 mg/dose 600 mg/day divided BID	10 days
	cefpodoxime	10 mg/kg/day po divided BID	400 mg/dose 800 mg/day divided BID	10 days
	cefuroxime	30 mg/kg/day po divided BID (suspension) 250 mg every 12 hours (film-coated tablets)	500 mg/dose	10 days
	ceftriaxone	50 mg/kg IM/IV	2 g/dose	3 days
*If young children (<2 years) have a serious type 1 hypersensitivity to penicillin and moderate to severe sinusitis, a combination of clindamycin and cefixime may be prudent. Alternatively, levofloxacin can be used, although concerns regarding toxicity, cost, and resistance have limited its use in pediatrics.****				

* Shorter course for nonsevere symptoms and older children: 5–7 days (nonsevere and ≥6 years); 7 days (nonsevere and 2–5 years).

**Amoxicillin-clavulanate is dosed based on the amoxicillin component. There are a variety of dosage forms that include varying doses of the clavulanate component. However, BID dosing should only be used certain formulations, eg, amoxicillin 600 mg and clavulanate 57 mg/5 mL solution, due to clavulanate component. Children weighing more than 40 kg should not use the amoxicillin 600 mg and clavulanate 57 mg/5 mL solution. Children weighing less than 40 kg should not be prescribed the 250 mg film-coated tablets, which contain a higher clavulanate dose than the chewable tablets.

[1] If the patient has a true penicillin or amoxicillin allergy, cefdinir, cefuroxime, cefpodoxime, and ceftriaxone are highly unlikely to be associated with cross-reactivity with penicillin allergy.

*** If a multidrug-resistant pathogen (ie, pneumococcus) is highly suspected or confirmed, levofloxacin or linezolid may be chosen in consultation with an infectious disease specialist.

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