Adult Recommendations for Managing Acute Respiratory Tract Infections

Condition	Epidemiology	Diagnosis	Management

Acute uncomplicated bronchitis	• Cough is the most common symptom for adult ambulatory visit, and acute bronchitis is the most common diagnosis provided	• Colored sputum does not indicate bacterial infection
		• Evaluation should focus on ruling out pneumonia
		• Pneumonia is exceedingly rare among healthy adults in the absence of
		  ○ Abnormal vital signs (pulse ≥100 beats/min, respiratory rate ≥24 breaths/min, or temperature ≥38°C), AND
		  ○ Abnormal lung examination findings (focal consolidation, egophony, fremitus)
		• Chest radiography is **not** indicated in most cases
			Antibiotic treatment of uncomplicated acute bronchitis **does not provide benefit and is not recommended**, regardless of cough duration.
			
			Use symptomatic therapy such as:
			• Cough suppressants (benzonatate, dextromethorphan)
			• First-generation antihistamines (diphenhydramine, promethazine)
			• Decongestants (phenylephrine, pseudoephedrine)
			• Although evidence supporting these symptomatic therapies is limited

Acute rhinosinusitis	• 90-98% of rhinosinusitis cases are viral
	• Even when caused by bacteria, antibiotics are not guaranteed to help
	• 1 out of 8 adults (12%) reported being diagnosed with rhinosinusitis in 2012, resulting in >30 million diagnoses
		• Diagnose acute bacterial rhinosinusitis based on symptoms that are:
		  ○ **Severe (>3-4 days)** = fever ≥39°C (102°F) + purulent nasal discharge or facial pain *OR*
		  ○ **Persistent (>10 days) without improvement** = nasal discharge, facial pain, congestion *OR*
		  ○ **Worsening (3-4 days)** = worsening or new onset fever, facial pain, congestion after initial improvement of symptoms
		• Sinus radiographs are **not** recommended
			If a bacterial infection is established:
			• Watchful waiting is reasonable for uncomplicated cases with reliable follow-up
			• **First-line therapy** = amoxicillin/clavulanate 875mg BID x 5-7 days
			• **Penicillin allergy** = doxycycline 100mg BID or levofloxacin 500mg daily x 5-7 days
			• **Not recommended** = macrolides (azithromycin, etc.) due to high resistance rate in *Streptococcus pneumoniae* (~40%)

Source: https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/adult-treatment-rec.html

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Condition	Epidemiology	Diagnosis	Management
Common cold or non-specific upper respiratory tract infection (URI)	• The common cold is the third most frequent diagnosis in office visits, and most adults experience 2-4 colds annually • At least 200 viruses can cause the common cold	• Prominent cold symptoms include fever, cough, rhinorrhea, nasal congestion, postnasal drip, sore throat, headache, and myalgias • Symptoms such as cough and congestion commonly last 7-10 days	**Do not use antibiotics to treat viral upper respiratory tract infections (URI)** • Decongestants (phenylephrine or pseudoephedrine) combined with a first-generation antihistamine may provide short-term symptomatic relief • Acetaminophen or non-steroidal anti-inflammatory drugs can also be used • Evidence is lacking to support antihistamines alone, opioids, intranasal corticosteroids as effective treatments for cold symptom relief • Weigh the benefits and harms of symptomatic therapy
Pharyngitis	• Group A beta-hemolytic streptococcal (GAS) infection is the **only** common indication for antibiotic therapy for sore throat cases • Only 5-10% of adult sore throat cases are caused by GAS	• Patient with pharyngitis should be evaluated using the **Centor criteria** (fever, tonsillar exudates, tender cervical lymphadenopathy, absence of cough) • Patients meeting <2 criteria should **not** be tested or treated for GAS • For those with ≥2 criteria, perform a Rapid Strep Test (RST) as clinical features alone are not adequate to distinguish between GAS and viral pharyngitis • Throat cultures are not routinely recommended for adults	Antibiotic treatment is **not** recommended for patients with a negative RST or meeting <2 Centor criteria • **First-line therapy** = amoxicillin 500mg BID or penicillin VK 500mg BID • **Non-severe penicillin allergy** = cephalexin 500mg BID or cefuroxime 250mg BID • **Severe penicillin allergy** = clindamycin 300mg TID or macrolides • Avoid macrolides and clindamycin if possible as resistance in GAS is increasingly common • Recommended duration is 10 days, except 5 days for azithromycin

Source: https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/adult-treatment-rec.html