Antibiotic Selection

Indications: This protocol provides general guidance for antibiotic selection when the evaluation of a patient determines that an infection in which antibiotic treatment is appropriate under the Community Paramedicine Program. The CP will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To provide guidance for appropriate antibiotic treatment for the patient with an infection amendable to initial treatment at home.

CP Directives:

1. Follow General Protocol for CP Patient Assessments.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Obtain manual and automated vital sign readings and obtain patient medication prescription and usage and history of any recent antibiotic usage.
4. Determine whether the patient has additional symptoms which may be related to the infection such as: Fever, chills, sweats, weakness, dizziness or altered mental status. If inclusion criteria for sepsis are present, consider lactate determination, if available or ETCO2 level measurement. If either are abnormal, transport may be indicated.
5. If the patient does not meet criteria for transport, determine the type of infection needing treatment. Once the type of infection has been determined, use the following as a guideline for initial antibiotic treatment:
    a. Cellulitis, simple cellulitis may use Cephalexin, cellulitis with concern for MRSA should use Trimethoprim/Sulfamethoxazole or Clindamycin.
        1. Cephalexin 500 mg, QID, 5 – 10 days, duration depends on severity and follow up arrangements.
        2. Trimethoprim/Sulfamethoxazole 160 mg/800 mg, BID, 5 – 10 days.
        3. Clindamycin 300 mg, QID, 5 – 10 days.
    b. Urinary tract infection or pyelonephritis (in order of preference) determine duration based on condition, simple UTI shorter, pyelonephritis longer.
        1. Cephalexin 500 mg, QID, 3 – 10 days.
        2. Trimethoprim/Sulfamethoxazole 160 mg/800 mg, BID, 3 – 10 days.
        3. Ciprofloxacin 500 mg, 3 – 10 days. This antibiotic has concerns for tendon rupture and has a high incidence of c-difficile after treatment.

c. Exudative pharyngitis. Strep pharyngitis is the only pharyngitis with an antibiotic indication. Amoxicillin containing antibiotics may cause a drug ash in a patient with mononucleosis.
   1. Penicillin V potassium 500 mg, QID, 7 – 10 days.
   2. Cephalexin 500 mg, QID, 7 – 10 days.
   3. Azithromycin 250 mg, 2 on first day followed by 1 daily for 4 additional days.
   4. Amoxicillin/clavulanate 500 mg/125 mg, TID, 7 – 10 days.

d. Bronchitis. Cough with possible wheezing, no fever, often smoking history.
   1. Azithromycin 250 mg, 2 on first day followed by 1 daily for 4 additional days.
   2. Amoxicillin/clavulanate 500 mg/ 125 mg, TID, 7 – 10 days.

e. Bite injuries. This includes all animal and human bite injuries.
   1. Amoxicillin/clavulanate 500 mg/ 125 mg, TID, 7 – 10 days.

f. Tooth infection. Tooth Pain with gingival erythema.
   1. Penicillin V potassium 500 mg, QID, 7 – 10 days.
   2. Clindamycin 300 mg, QID, 5 – 10 days.

6. Contact the PCP or on-line medical direction per the General Protocol for CP Patient Assessments. Provide patient reports and discuss treatment and continuity plans.
7. Continue treatment and follow the General Protocol for CP Patient Assessments until a disposition is determined and continuity plan completed.