



Empiric Recommendations for Common Infections for Adult LTC Patients

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Disclaimer: This guidance is intended for educational purposes only. We do not provide direct medical care treatment planning, or medical treatment services to individuals. The information provided through the service is not a replacement for local expertise. Information is offered as clinical decision support, is advisory in nature and is not intended to replace local healthcare decision-making or provision. Final clinical decisions are the sole responsibility of the healthcare provider.

Acute Bacterial Rhinosinusitis (*S. pneumoniae*, *H. influenzae*, *M. catarrhalis*)

Mild: Afebrile, no purulent nasal discharge, no facial pain longer than 3-4 days. Severe: Fever, purulent nasal discharge, facial pain longer than 3-4 consecutive days, or worsening symptoms after 5-6 days (“double sickening”)

	Treatment	Renal Dose Adjustment	Feeding Tube Compatible	Duration	
Mild	No antimicrobial treatment warranted empirically. “Watchful waiting” with symptomatic management is recommended. Most sinusitis is viral and will spontaneously improve. <i>If no improvement after 10 Days of symptomatic treatment/supportive care:</i>				
	Preferred	Amoxicillin/Clavulanate 2000/125 mg BID*	Yes	No	5 Days
	Alternative	Amoxicillin/Clavulanate 875/125 mg BID OR Doxycycline 100 mg BID OR Cefpodoxime 200 mg BID	Yes No Yes	Yes Yes Yes	5 Days
Severe	Treat empirically with antibiotics, “watchful waiting” NOT indicated				
	Preferred	Amoxicillin/Clavulanate 2000/125 mg BID*	Yes	No	5-7 Days
	Alternative	Amoxicillin/Clavulanate 875/125 mg BID OR Doxycycline 100 mg BID OR Cefpodoxime 200 mg BID	Yes No Yes	Yes Yes Yes	

*High-dose amoxicillin-clavulanate is preferred in those with a risk of a poor outcome include patients ≥65 years, recently hospitalized, antibiotic use in 30 days, immunocompromised or in areas with >10% resistance to *S. pneumoniae*. When amoxicillin-clavulanate (Augmentin XR™ 1000/62.5 mg) is not available or accessible, amoxicillin/clavulanate 875/125 mg BID is preferred over alternative options.

Acute Bacterial Pharyngitis (Group A Strep, *Streptococcus* spp.)

Treatment is not recommended for patients with viral pharyngitis

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Penicillin V 500 mg BID OR Amoxicillin 500 mg BID	Yes	Yes	10 Days
Alternative	Cephalexin 500 mg BID OR Clindamycin 300 mg TID	Yes No	Yes Yes	10 Days

Non-purulent Cellulitis (*Streptococcus pyogenes*, also known as Group A Strep)

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Cephalexin 1,000 mg TID OR Amoxicillin 875 mg BID	Yes Yes	Yes Yes	5 Days
Alternative	Sulfamethoxazole/Trimethoprim 1600/320 mg (2 DS) BID OR Dicloxacillin 500 mg four times daily	Yes Yes	Yes Yes	5 Days
Alternative, IV	Cefazolin 1 g IV Q8H*	Yes	N/A	5 Days

*For patients ≥120 kg consider use of 2 g cefazolin

Abscess or Purulent Cellulitis (*Staphylococcus aureus*, including MRSA and MSSA)

Prioritize incision and drainage for primary treatment of abscess. Antimicrobials not always recommended if small and drained

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Doxycycline 100 mg BID	No	Yes	7 Days
Alternative	Sulfamethoxazole/Trimethoprim 1600/320 mg (2 DS) BID OR Clindamycin 450 mg TID	Yes No	Yes Yes	7 Days
Alternative, IV	Vancomycin (Follow facility specific dosing and monitoring) OR Clindamycin 600 mg IV Q8H	Yes No	N/A N/A	7 Days

Mild Diabetic Foot Wound

Diabetic or non-healing wounds do not always require treatment with antibiotics. Diagnosis of soft tissue diabetes-related infections should be based on the presence of local or systemic signs/symptoms of inflammation. Local wound findings may include: penetrating wound, rapidly progressing cellulitis or signs of induration, crepitus, bullae, discoloration, necrosis, gangrene, ecchymosis, petechiae or new pain

		Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Low risk MRSA	Cephalexin 1,000 mg TID/four times daily	Yes	Yes	7-14 Days
	High risk MRSA	Sulfamethoxazole/Trimethoprim 1600/320 mg (2 DS) BID OR Doxycycline 100 mg BID	Yes No	Yes	7-14 Days
Alternative, IV	Low risk MRSA	Cefazolin 1,000 mg IV Q8H	Yes	N/A	7-14 Days
	High risk MRSA	Vancomycin IV (Follow facility specific dosing and monitoring)	Yes	N/A	7-14 Days

Evaluate severity and rule out deeper involvement (i.e. bone/joint). Longer treatment and surgical management may be necessary for resolution

Uncomplicated UTI (uUTI) (*E. coli*, *Klebsiella spp.*, *Proteus spp.*)

Uncomplicated: men and women with local bladder signs/symptoms (dysuria, urgency, frequency or suprapubic pain). uUTI patients may have underlying urologic abnormalities, immunocompromising factors, and/or have diabetes. Recurrent UTI considered uncomplicated

		Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred		Nitrofurantoin 100 mg BID (only if CrCl >30 mL/min)	No	Yes	5 Days
Alternative		Cephalexin 500 mg BID OR	Yes	Yes	5 Days
		Sulfamethoxazole/Trimethoprim 800/160 mg (1 DS) BID OR	Yes	Yes	3 Days
		Fosfomycin trometamol 3,000 mg x1 dose	No	Yes	1 Day
Alternative, IV		Ceftriaxone 1 g IV once daily	No	N/A	3-5 Days
		Gentamicin 5 mg/kg IV or IM x1 dose	No	N/A	1 Day

*For gentamicin, use adjusted body weight in patients with total body weight >20% than ideal body weight. Single doses of gentamicin generally do not require renal dose adjustments

$$\text{AdjBW} = \text{IBW} + [0.4 \times (\text{TBW} - \text{IBW})]$$

$$\text{IBW (male)} = 50 \text{ kg} + 2.3 \text{ kg for each inch over 5 feet}$$

$$\text{IBW (female)} = 45 \text{ kg} + 2.3 \text{ kg for each inch over 5 feet}$$

Complicated UTI (cUTI) (*E. coli*, *Klebsiella spp.*, *Proteus spp.*)

Complicated: UTI with signs/symptoms of infection extending beyond the bladder such as fever, flank pain, and/or signs of systemic illness (chills, hemodynamic instability, and/or significant fatigue). Pyelonephritis, febrile UTI, catheter-associated UTI, and bacteremia are included

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Gentamicin 5 mg/kg IV/IM once OR Ceftriaxone 1 g IV/IM x1 dose followed by Sulfamethoxazole/Trimethoprim 800/160 mg (1 DS) BID	No Yes	N/A Yes	7 Days
Alternative	Gentamicin 5 mg/kg IV/IM once OR Ceftriaxone 1 g IV/IM x1 dose followed by Amoxicillin/Clavulanate 875/125 mg BID OR Cefpodoxime 200 mg BID OR Ciprofloxacin 750 mg BID	No Yes Yes Yes	N/A Yes Yes Avoid*	7 Days total
Alternative, IV	Ceftriaxone 1 g IV once daily	No	N/A	7 Days

Note: Catheterized patients will be colonized with bacteria within 24 hours of placement. Culturing/urinalysis ought to be considered only in patients with suprapubic tenderness, fever or signs of systemic infection. Changes in mental status are more suggestive of polypharmacy. Single doses of gentamicin generally do not require renal dose adjustments. *Poor absorption with quinolones observed when given via feeding tubes. See above uUTI table for recommendations on gentamicin dosing

Community Acquired Bacterial Pneumonia (*S. pneumoniae*, *H. influenzae*, *M. catarrhalis*)

Comorbidities include: Chronic heart, lung, liver, renal disease, alcohol use disorder, malignancy, or asplenia

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Amoxicillin 1,000 mg TID	Yes	Yes	5 Days
Alternative	Doxycycline 100 mg BID OR Cefpodoxime 200 mg BID	No Yes	Yes Yes	5 Days
Patients with Comorbidities, Oral	Amoxicillin/Clavulanate 875 mg/125 BID Plus Azithromycin 500 mg x1 then 250 mg thereafter	Yes No	Yes Yes	5 Days
Patients with Comorbidities, IV	Ampicillin/Sulbactam 3 g IV Q6H Plus Azithromycin 500 mg x1 then 250 mg thereafter	Yes No	N/A N/A	5 Days

Acute Exacerbation of COPD (*C. pneumoniae*, *M. pneumoniae*, *S. pneumoniae*, *M. catarrhalis*, *H. influenzae*)

AECOPD treatment involves steroids and bronchodilators, but does not routinely require antibiotics. Antibiotics are indicated for patients with the following 3 cardinal symptoms: increased dyspnea, sputum production, and sputum purulence. If increased sputum purulence is present, then treatment is indicated if only 2 symptoms are present.

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Doxycycline 100 mg BID OR	No	Yes	5 Days
	Azithromycin 500 mg x1 dose then 250 mg OR	No	Yes	5 Days
	Azithromycin 500 mg daily	No	Yes	3 Days
Recent Treatment, Oral	Amoxicillin/Clavulanate 875/125 mg BID OR	Yes	Yes	5 Days
	Cefpodoxime 200 mg BID OR	Yes	Yes	5 Days
	Cefuroxime 500 mg BID	Yes	Yes	5 Days
Recent Treatment, IV	Ampicillin/Sulbactam 3 g Q6H OR	Yes	N/A	5 Days
	Ceftriaxone 1 g IV once daily	No	N/A	5 Days
History of <i>P. aeruginosa</i>	Levofloxacin 750 mg once daily	Yes	Avoid*	5 Days

*Poor absorption with quinolones observed when given via feeding tubes. See Appendix for more details. Intravenous formulations available

Thrush (Oropharyngeal Candidiasis) *Candida albicans* and other yeast

	Antimicrobial	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Preferred	Clotrimazole Troche 10 mg five times daily	No	N/A	7-14 Days
Alternative	Nystatin Suspension (100,000 units/mL) 4-6 mL four times daily	No	N/A	7-14 Days
Moderate/Severe	Fluconazole 200 mg daily	Yes	Yes	7-14 Days
Fluconazole, Refractory	Itraconazole 200 mg once daily	No	Yes	Up to 4 weeks

Denture-related candidiasis: disinfection of dentures recommended in addition to antifungal therapy

Coronavirus Disease 2019 (COVID-19)

High Risk of Progression: ≥65 years, asthma, BMI ≥30 kg/m², cardiovascular disease, CKD, diabetes, HIV or immunosuppressed, chronic lung disease, cancer, unvaccinated or prolonged duration since last vaccination

	Antiviral	Renal Dose Adjustment	Feeding Tube Compatible	Duration
High Risk of Progression to Severe Disease	Remdesivir 200 mg once followed by 100 mg IV daily OR Ritonavir-boosted nirmatrelvir (Paxlovid) 300/100 mg BID	No Yes	N/A See Below	3 Days 5 Days

Ritonavir-boosted Nirmatrelvir (Paxlovid) interacts with many medications. See [here](#) for a list of common medications known to interact. No data exists on administering Ritonavir-boosted Nirmatrelvir (Paxlovid) via a feeding tube and therefore cannot be routinely recommended. Use of ritonavir-boosted Nirmatrelvir (Paxlovid) may have little benefit in vaccinated individuals and use should be used judiciously.

Influenza (Flu A, Flu B)

Vaccination: Inactivated Influenza Vaccine recommended for all residents. If ≥65 years, high-dose flu vaccines recommended annually before flu season

	Antiviral	Renal Dose Adjustment	Feeding Tube Compatible	Duration
Treatment	Oseltamivir 75 mg BID	Yes	Yes	5 Days
Prophylaxis, Post-exposure	Oseltamivir 75 mg once daily within 48 hours of contact Limit use to immunocompromised or severely ill patients within 48 hours of a person with suspected/confirmed influenza	Yes	Yes	1 Week (vaccinated) 2 Weeks (unvaccinated)
Prophylaxis, Outbreak	Oseltamivir 75 mg once daily for all residents in affected unit	Yes	Yes	2-3 Weeks*

*CDC recommends prophylaxis in institutional outbreaks for a minimum of 2 weeks and continuing for at least 7 days after last known laboratory –confirmed case on affected units

Varicella Zoster Virus (VZV, Shingles)

Vaccination: Age 50 years or older: 2-dose series of Shingrix (RZV) given IM. First dose given at month 0 followed by a second dose 2-6 months later

	Antiviral	Renal Dose Adjustment	Feeding Tube Compatible	Duration**
Preferred	Acyclovir 800 mg five times daily	Yes	Yes	7 Days
Alternative	Valacyclovir 1 g TID	Yes	No*	7 Days
Ophthalmologic Disease/Severe	Acyclovir 10 mg/kg IV Q8H	Yes	N/A	7-14 Days

*Consider acyclovir if given through a feeding tube.

**Reasonable to continue treatment beyond 7-14 days if lesions resolve slowly

Mucocutaneous Herpes (HSV-1, HSV-2)

Genital and Orolabial lesions

	Antiviral	Renal Dose Adjustment	Feeding Tube Compatible	Duration
First Episode	Acyclovir 400 mg TID OR	Yes	Yes	7-10 Days
	Valacyclovir 1 g BID	Yes	No*	7-10 Days
Recurrent	Acyclovir 800 mg BID OR	Yes	Yes	5 Days
	Valacyclovir 500 mg BID (Genital) OR	Yes	No*	3 Days
	Valacyclovir 2 g BID (Orolabial)	Yes	No*	1 Day
Suppressive	Acyclovir 400 mg BID OR	Yes	Yes	Variable
	Valacyclovir 1 g daily	Yes	No*	
Prophylaxis - Immunocompromised	Acyclovir 400 mg BID OR	Yes	Yes	Variable
	Valacyclovir 500 mg BID	Yes	No*	

Special Population: Persons with HIV

Initial or Recurrent, Genital or Orolabial	400 mg TID Acyclovir OR 1 g BID Valacyclovir	Yes Yes	Yes No*	7-10 Days**
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*Consider acyclovir if given through a feeding tube. See appendix for additional dosing instructions. **Can be continued until resolution

Trichomoniasis and Bacterial Vaginosis (<i>Trichomonas vaginalis</i> ; Dysbiosis of vaginal flora)					
	Antibiotic		Renal Dose Adjustment	Feeding Tube Compatible	Duration
Trichomoniasis	Female	Metronidazole 500 mg BID	No	Yes	7 Days
	Male	Metronidazole 2,000 mg x 1 dose	No	Yes	1 Day
Bacterial Vaginosis	Oral	Metronidazole 500 mg BID	No	Yes	7 Days
	Topical	Metronidazole 0.75% gel, 5 g vaginally once daily	No	N/A	5 Days
		Clindamycin 2% cream, 5 g vaginally once daily	No	N/A	7 Days

Gonorrhea and Chlamydia					
Presumptive treatment for both Gonorrhea and Chlamydia is recommended if Chlamydia cannot be ruled out					
	Antibiotic		Renal Dose Adjustment	Feeding Tube Compatible	Duration
Gonorrhea, Preferred	<150 kg	Ceftriaxone 500 mg IM x1 dose	No	N/A	1 Day
	≥150 kg	Ceftriaxone 1,000 mg IM x1 dose			
Gonorrhea, Alternative	Gentamicin 240 mg Intramuscular x1 dose plus Azithromycin 2,000 mg x1 dose		No No	N/A Yes	1 Day
Chlamydia, Preferred	Doxycycline 100 mg BID		No	Yes	7 Days
Chlamydia, Alternative	Azithromycin 1,000 mg x1 dose		No	Yes	1 Day
Single doses of gentamicin generally do not require renal dose adjustments					
STI Additional Notes					
Re-testing	Any person who has a positive test for chlamydia or gonorrhea, along with women who have a positive test for trichomonas, should be rescreened 3 months after treatment				
Expedited Partner Therapy (EPT)	CDC supports issuing prescriptions to sex partners of those diagnosed with chlamydia or gonorrhea without the provider first examining the partner. EPT provides facilitation to treat partners with limited healthcare access.				

Vulvovaginal Candidiasis (*Candida albicans*)

Most agents/formulations available OTC. ‘**’ denotes prescription only. Topicals recommended in pregnancy

	Antimicrobial		Duration
Oral	Fluconazole*	150 mg x 1 dose May repeat 72 hours later for those with moderate symptoms	1+ Day(s)
Vaginal Cream	Clotrimazole	1% Vaginal cream, 5 g once daily	7 Days
		2% Vaginal cream, 5 g once daily	3 Days
	Miconazole	2% Vaginal cream, 5 g once daily	7 Days
		4% Vaginal cream, 5 g once daily	3 Days
Vaginal Tablet	Clotrimazole	100 mg vaginally once daily	7 Days
		200 mg vaginally once daily	3 Days
		500 mg vaginally x1 dose	1 Day
Vaginal Suppository	Miconazole	100 mg vaginal suppository once daily	7 Days
		200 mg vaginal suppository once daily	3 Days
Refractory or Alternative	Nystatin suppository* 100,000 units vaginally once daily		14 Days

Pressure Injuries/Ulcers (Including decubitus ulcers)

Localized damage to skin and/or underlying soft tissue as a result of prolonged pressure, shear, immobility, poor nutrition, co-morbidities, perfusion, microclimate, and/or perfusion leading to tissue damage ranging from intact skin to open ulceration.

	Treatment	Duration
Preferred	<p>Systemic antibiotics not routinely recommended for treatment in most pressure injuries.</p> <p>In the presence of a pressure injury, follow appropriate wound care recommendations for management and prevention of worsening injury. Ulceration and exposed bone does not necessarily correlate with acute infection. If superimposed infection is suspected (new cellulitis, abscess, osteomyelitis on imaging/pathology, and/or systemic signs of infection) antimicrobials may be recommended alongside mechanical debridement/drainage to support proper wound healing and attain source control.</p>	N/A

Tracheitis (Ventilator-Associated Tracheobronchitis, VAT)

Fever with no other recognizable cause, with new or increased sputum production, positive endotracheal aspirate (>10⁶ CFU/mL) yielding a new bacteria, and no radiographic evidence of pneumonia.

	Treatment	Duration
Preferred	<p>Treatment Not Recommended. Monitor off antimicrobials.</p> <p>IDSA guidelines recommend AGAINST treatment of VAT. Limited data exists and it is uncertain if treatment improves clinical outcomes. Treatment is met with increased risk of <i>C. difficile</i>, drug adverse events, and selection for multi-drug resistance organisms in an already at-risk population. Rule out new airway obstruction and in the setting of new purulent secretions, correlate with systemic signs of infection, clinical symptoms and imaging to guide a new diagnosis of pneumonia.</p>	N/A

Clostridioides difficile (C. diff)

High Risk Patients: immunocompromised, ≥ 65 years, and/or severe episode

	Antibiotic	Renal Dose Adjustment	Feeding Tube Compatible	Duration
1 st Episode	Vancomycin 125 mg PO Q6H x 10 days	No	Yes	10 Days
Alternative	Fidaxomicin 200 mg PO BID	No	Yes	10 Days
Recurrence	<p>Vancomycin PO taper:</p> <p>125 mg PO four times daily x 14 days followed by</p> <p>125 mg PO TID x 7 days followed by</p> <p>125 mg PO BID x 7 days followed by</p> <p>125 mg PO daily x 7 days followed by</p> <p>125 mg PO once weekly x 7 weeks</p>	No	Yes	12 Weeks

For high-risk 1st episodes, vancomycin taper may be used instead of traditional 10 day course alongside bezlotoxumab IV. Bezlotoxumab is also recommended for recurrent cases. Fidaxomicin and Bezlotoxumab may be cost prohibitive. If multiple recurrences occur consider fecal microbiota transplant (FMT)

Appendix (Note: HD assumes thrice weekly. Time doses after HD sessions when appropriate)

Antimicrobial	Renal Function/CrCl Adjustments				
	>25 mL/min	11-25 mL/min	≤10 mL/min	HD	
Acyclovir	Zoster	800 mg five times daily	800 mg TID	800 mg BID	800 mg daily
	HSV, 1 st Episode	400 mg TID		200 mg BID	
	HSV, Recurrent	800 mg BID		200 mg BID	
	HSV, Suppressive	400 mg BID		200 mg BID	
	Prophylaxis	400 mg BID		200 mg BID	
	Persons with HIV	400 mg TID		200 mg BID	
	Feeding Tube Additional Notes: Open capsule or use oral suspension preferred over crushing tablet				
Amoxicillin	>30 mL/min	10-30 mL/min	<10 mL/min	HD	
	Pneumonia	1 g TID	1 g BID	500 mg BID	500 mg BID
	Standard	500 mg BID/TID or 875 mg BID/TID	500 mg BID	500 mg daily	500 mg daily
Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet/opening capsule					
Amoxicillin/ Clavulanate	>30 mL/min	10-30 mL/min	<10 mL/min	HD	
	875/125 mg BID	500/125 mg BID	500/125 mg daily		
Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet/opening capsule. Do not crush XR formulation and avoid Augmentin XR in renal insufficiency (use standard formulations).					
Ampicillin/ Sulbactam	>30 mL/min	15-30 mL/min	<15 mL/min	HD	
	3 g every 6 hours	3 g every 12 hours	3 g every 24 hours		
Feeding Tube Additional Notes: N/A					
Azithromycin	No renal dose adjustment				
	Feeding Tube Additional Notes: Crush tablet preferred				
Cefazolin	>30 mL/min	11-30 mL/min	<11 mL/min	HD	
	<120 kg	1 g every 8 hours	1 g every 12 hours	1 g every daily	1 g every daily
	>120 kg	2 g every 8 hours	2 g every 12 hours	2 g every daily	
Feeding Tube Additional Notes: N/A					

Appendix (Note: HD assumes thrice weekly. Time doses <u>after</u> HD sessions when appropriate)					
Cefuroxime	>30 mL/min	10-30 mL/min	<10 mL/min	HD	
	500 mg BID	500 mg every 24 hours	250 mg every 24 hours		
	Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet/opening capsule (Bitter taste from tablet).				
Cefpodoxime	>30 mL/min	10-30 mL/min	HD		
	200 mg BID	200 mg daily			
	Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet/opening capsule.				
Ceftriaxone	No renal dose adjustment				
	Feeding Tube Additional Notes: N/A				
Cephalexin		>30 mL/min	15-30 mL/min	<15 mL/min	HD
	Standard	1 g TID/QID	500 mg TID	500 mg every other day	500 mg daily
	Uncomplicated UTI	500 mg BID	500 mg daily		
	Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet/opening capsule				
Ciprofloxacin, PO		≥30 mL/min	<30 mL/min	HD	
	Standard	750 mg BID	500 mg BID	500 mg daily	
	Uncomplicated UTI	250 mg BID	250 mg daily		
	Feeding Tube Additional Notes: Diminished bioavailability. Avoid use. Give at least 2 hours before OR 6 hours after taking multivalent cations or antacids				
Clindamycin	No renal dose adjustment				
	Feeding Tube Additional Notes: Open capsule				
Dicloxacillin	No consensus on renal dose adjustment. Consider empiric dose adjustment in severe renal disease.				
	Feeding Tube Additional Notes: Open capsule				

Appendix (Note: HD assumes thrice weekly. Time doses after HD sessions when appropriate)

Doxycycline	No renal dose adjustment				
	Feeding Tube Additional Notes: Open capsules. Do not crush film coated tablet or slow release dosage form. Give at least 2 hours before OR 4 hours after iron, calcium, antacids/minerals.				
Fidaxomicin	No renal dose adjustment				
	Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet				
Fluconazole		≥50 mL/min	<50 mL/min	HD	
	Thrush	200 mg daily	100 mg daily		
	Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet				
Gentamicin	Variable dosing strategies exist				
	Feeding Tube Additional Notes: N/A				
Levofloxacin		>50 mL/min	<20-50 mL/min	10-19 mL/min	HD
	Standard	750 mg daily	750 mg every other day	750 mg x1 then 500 mg every other day	
	Uncomplicated UTI	250 mg daily		250 mg every other day	
	Feeding Tube Additional Notes: Preferred over ciprofloxacin if an alternative cannot be used. Avoid multivalent cations and antacids within 2 hours of administration				
Nitrofurantoin		>30 mL/min	10-30 mL/min	HD	
		100 mg BID	Avoid use if CrCL <30 mL/min		
	Feeding Tube Additional Notes: Use oral suspension. Difficult to crush tablet				
Oseltamivir		>60 mL/min	30-60 mL/min	10-29 mL/min	HD
	Treatment	75 mg BID	75 mg daily	75 mg every other day	
	Prophylaxis	75 mg daily	75 mg every other day	75 mg every other HD session	
	Feeding Tube Additional Notes: Oral suspension preferred over opening capsule				
Remdesivir		>30 mL/min	10-30 mL/min	HD	
		200 mg x1 then 100 mg BID	Caution use if CrCL <30 mL/min		
	Feeding Tube Additional Notes: N/A				

Appendix (Note: HD assumes thrice weekly. Time doses after HD sessions when appropriate)

	>60 mL/min	30-60 mL/min	<30 mL/min	HD	
Ritonavir-boosted Nirmatrelvir	300/100 mg BID	150/100 mg BID	See note*	300/100 mg x1 then 150/100 mg daily	
	*Use is not recommended for CrCl <30 mL/min, but low risk of toxicity expected with a 5-day course. It is reasonable to consider 150/100 mg BID for 5 days if use is desired. Ritonavir is high-risk for drug-drug interactions. Recommend running interactions prior to prescribing. Feeding Tube Additional Notes: Avoid crushing tablet if possible due to limited data.				
	>30 mL/min	10-30 mL/min	<10 mL/min	HD	
Sulfamethoxazole/Trimethoprim	Standard	1600/320 mg (2 DS) BID	1600/320 mg (2 DS) once daily	Avoid Use	
	UTI	800/160 mg (1 DS) BID	800/160 mg (1 DS) once daily	Avoid Use	
Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet					
	≥50 mL/min	30-49 mL/min	10-29 mL/min	<10 mL/min	HD
Valacyclovir	Zoster/Shingles	1 g TID	1 g BID	1 g daily	500 mg daily
	Orolabial HSV, Initial/Recurrent (Given for 1 day)	2 g BID	1 g BID	500 mg BID	500 mg x1 dose
	Genital HSV, Initial	1 g BID		1 g daily	500 mg daily
	Genital HSV, Recurrent	500 mg BID		500 mg daily	
	HSV, Suppressive	500 mg BID		500 mg daily	
	Prophylaxis	500 mg BID		500 mg daily	
	HIV, Initial/Recurrent (Genital/Orolabial)	1 g BID		1000 mg daily	500 mg daily
	Feeding Tube Additional Notes: Consider acyclovir over Valacyclovir in setting of feeding tube				
Vancomycin, IV	Variable dosing strategies exist				
	Additional Notes: IV vancomycin is for systemic infections only, NOT for treatment of <i>C. difficile</i> (see below)				
Vancomycin, PO	No renal dose adjustment				
	Feeding Tube Additional Notes: Oral suspension preferred over crushing tablet PO vancomycin is for infections caused by <i>C. difficile</i> only. Oral vancomycin formulations have minimal systemic absorption.				

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