

Table 2**Appropriate Antibiotic Use in Adults**

Diagnosis	CDC Principles of Appropriate Use
Upper respiratory tract infections, not otherwise specified	<ol style="list-style-type: none"> 1. Use a diagnosis of “nonspecific upper respiratory tract infection” or “acute rhinopharyngitis” to denote acute infection that is typically viral in origin and in which sinus, pharyngeal, and lower airway symptoms, although frequently present, are not prominent. 2. Antibiotic treatment of adults with nonspecific upper respiratory tract infection does not enhance illness resolution or prevent complications and is, therefore, not recommended. 3. Purulent secretions in the nares and throat (commonly reported and seen in patients with an uncomplicated upper respiratory tract infection) neither predict bacterial infection nor benefit from antibiotic treatment.
Acute Pharyngitis	<ol style="list-style-type: none"> 1. Group A b-hemolytic Streptococcus (GABHS) is the causative agent in approximately 10% of cases of pharyngitis in adults. The large majority of adults with acute pharyngitis have a self-limited illness, which would do well with supportive care only. 2. The benefits of antibiotic treatment of pharyngitis in adults are limited to those patients with GABHS infection. Offer all patients with pharyngitis appropriate doses of analgesics and antipyretics as well as other supportive care. 3. Limit antibiotic prescriptions to those patients with highest likelihood of having a GABHS infection. <ol style="list-style-type: none"> A. Clinically screen all adult patients with pharyngitis for the presence of the following criteria: <ul style="list-style-type: none"> • History of fever. • Tonsillar exudates. • Absence of cough. • Tender anterior cervical lymphadenopathy (lymphadenitis). B. Do not test and do not treat patients with none or only 1 of these criteria. These patients are unlikely to have GABHS infection. C. For patients with 2 or more criteria, the following strategies are appropriate: <ul style="list-style-type: none"> • Test patients with 2, 3, or 4 criteria using a rapid antigen test. Limit antibiotic therapy to patients with a positive test result. • Test patients with 2 or 3 criteria using a rapid antigen test. Limit antibiotic therapy to patients with a positive test result or patients with 4 criteria. D. Do not use any diagnostic tests. Limit antibiotic therapy to patients with 3 or 4 criteria. 4. Throat cultures are not recommended for the routine primary evaluation of adults with pharyngitis or for the confirmation of negative rapid antigen test results. Throat cultures may be indicated as part of investigations of outbreaks of GABHS disease, for monitoring the development and spread of antibiotic resistance, or when pathogens such as <i>Gonococcus</i> are being considered. 5. The preferred antibiotic for treatment of acute GABHS pharyngitis is penicillin, or erythromycin in a penicillin-allergic patient.
Rhinosinusitis	<ol style="list-style-type: none"> 1. Most cases of acute rhinosinusitis diagnosed in ambulatory care represent uncomplicated viral upper respiratory tract infections. 2. Bacterial and viral rhinosinusitis are difficult to differentiate on clinical grounds. The clinical diagnosis of acute bacterial rhinosinusitis should be reserved for patients with rhinosinusitis symptoms lasting 7 days or more and who have maxillary facial/tooth pain or tenderness (especially when unilateral) and purulent nasal secretions. Patients who have rhinosinusitis symptoms for less than 7 days are unlikely to have a bacterial infection. 3. Sinus radiographs are not recommended for diagnosis in routine cases. 4. Acute bacterial rhinosinusitis resolves without antibiotic treatment in the majority of cases. Symptomatic treatment and reassurance is the preferred initial management strategy for patients with mild symptoms. Reserve antibiotic therapy for patients who meet the criteria for clinical diagnosis of acute bacterial rhinosinusitis who have moderately severe symptoms and for those with severe rhinosinusitis symptoms—especially those with unilateral face pain—regardless of duration of illness. Initial treatment should be with the most narrow-spectrum agent that is active against such likely pathogens as <i>Streptococcus pneumoniae</i> and <i>Haemophilus influenzae</i>.
Bronchitis	<ol style="list-style-type: none"> 1. For adults with an acute cough illness or with a presumptive diagnosis of uncomplicated acute bronchitis, focus the evaluation on ruling out pneumonia. In the healthy, nonelderly adult, pneumonia is uncommon in the absence of vital sign abnormalities or asymmetric lung sounds, and chest radiography is usually not indicated. In patients with cough lasting 3 weeks or longer, chest radiography is warranted in the absence of other known causes. 2. Routine antibiotic treatment of uncomplicated bronchitis is not recommended, regardless of duration of cough. In the unusual circumstance when pertussis is suspected, perform a diagnostic test and initiate antimicrobial therapy. 3. Patient satisfaction with care for acute bronchitis is most dependent on physician-patient communication, rather than on whether an antibiotic is prescribed.