Change Log

2019-01-15 Updated Urinary Tract Infections (UTI) chapter

- Revised terminology of acute simple cystitis, acute complicated UTI, and special populations with unique features.
- Revised diagnosis section to improve clarity.
- Added optional one-time dose of parenteral antibiotic before starting oral therapy in non-severely ill acute complicated UTI.
- Revised treatment recommendations for acute complicated UTI – severely ill.
- Revised treatment duration for acute complicated UTI to 7 days in females and 10-14 days in males.
- Limited amoxicillin-clavulanate and piperacillin-tazobactam in ESBL-producing organisms to acute simple cystitis only.

2018-06-13 Multiple additions and updates:

- Added Aminoglycoside Dosing and Therapeutic Monitoring chapter.
- Added Penicillin Allergies chapter.
- Added *C. difficile infection* (CDI) chapter.
- Updated Antimicrobial Dosing in Renal Insufficiency (Adults) chapter to align recommendations with BC Provincial Renal Agency document "Common Oral Antimicrobial Therapy Dosage Adjustments for Renal Function" dated Feb 2018.

2018-03-20 Added Hospital-acquired pneumonia (HAP) & Ventilator-associated pneumonia (VAP) chapters

2017-10-17 Added Intra-abdominal infection (IAI) chapter

2017-08-25 Updated Community-acquired pneumonia (CAP) chapter

- Dosing of amoxicillin changed from 1000 mg TID to 1000 mg BID to simplify dosing options in mild CAP. Amoxicillin-clavulanate 875 mg BID is equivalent to amoxicillin-clavulanate 500 mg TID. Penicillin resistance in *S. pneumonia* is not through a beta-lactamase mechanism and therefore not impacted by the dosing of clavulanate. Furthermore, *H. influenza* is a rare cause of mild CAP (1 in 200) and most isolate are amoxicillin susceptible (75%). Therefore, amoxicillin alone at 1000 mg BID will be equally as effective against *S. pneumonia* and most *H. influenzae* CAP as amoxicillin-clavulanate 875 mg BID.
- Cefuroxime removed from low severity CAP in order to simplify options.
- Role of atypical coverage in moderate and severe CAP has undergone review. Recent randomized controlled trials showed no mortality benefit with addition of a macrolide to beta-lactam therapy. The most recent Cochrane review of the topic showed clinical benefit with atypical coverage only in the subset of patients with *Legionella*. This has resulted in the following changes:
    - Azithromycin recommended only for moderate CAP due to suspected *Legionella*.
    - Azithromycin remains recommended for all severe CAP. Patients with severe CAP are at higher risk of *Legionella*, and higher risk of mortality. These patients have limited reserve to tolerate inadequate initial empiric therapy.
- Doxycycline has been removed as an option given lack of evidence showing demonstrable benefit when added to beta-lactam monotherapy, and limited data for treatment of *Legionella*.
- Guidance on *Legionella* pneumonia added to first page.
- Updated severe CAP with *Pseudomonas* risk factors due to recent availability of levofloxacin PO and IV on unrestricted formulary.
- Clarification to use of vancomycin when MRSA is possible in severe CAP.
- Incorporated antibiotic discontinuation criteria under duration of therapy.
- Guidance added for discontinuation of empiric vancomycin with negative microbiology studies.

2017-08-09 Added Skin and soft tissue infections (SSTI) and Diabetic foot infections (DFI) chapters

2017-07-31 Updated Pediatric Empiric Antibiotic guide

- +/- metronidazole added to mastoiditis (both first choice and penicillin allergy)
- + vancomycin changed to +/- vancomycin for orbital cellulitis (both first choice and penicillin allergy)
- +/- metronidazole added to orbital cellulitis (both first choice and penicillin allergy)