Change Log

2019-07-02 Multiple updates
- Added Pleural Infection chapter
- Pathogen-Directed Therapy for Pneumonia chapter was mistakenly removed during update to CAP chapter, has now been re-released.
- Cleaned up internal references to Vancomycin and Aminoglycoside Dosing and Therapeutic Monitoring documents.
- Acyclovir dosing in BMI>30 changed to adjusted body weight

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.

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. pneumoniae is not through a beta-lactamase mechanism and therefore not impacted by the dosing of clavulanate. Furthermore, H. influenzae 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. pneumoniae 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)