Change Log

2023-01-24

- Revised *Clostridioides difficile* infection (CDI) chapter. Additional content and decision support algorithm for new two-step lab testing.
- Added Tuberculosis (TB) chapter.

2022-12-08

- Revised Community-acquired pneumonia (CAP) chapter. Minor revision to clarify validated clinical stability criteria to discontinue therapy after 3 or 5 days of therapy.

2022-12-01

- Revised Pediatric Guidelines

2022-09-20

- Revision of Urinary Tract Infections (UTI) chapter.

2021-11-26

- Revision of Community-acquired pneumonia (CAP) chapter. Added Commentary document to detail changes and updates.

2021-08-17

- Complete revision of Intra-abdominal infections (IAI) chapter. Content is now divided into 4 sections:
    - Intra-abdominal and biliary tract infections – general principles
    - Cholecystitis
    - Cholangitis
    - Intra-abdominal infection

2021-06-29

- Added Sepsis – Obstetrics chapter [FIRSTLINE ONLY]

2020-11-04

- Revised Aminoglycoside Dosing and Therapeutic Monitoring chapter to remove pregnancy as a contraindication for extended-interval dosing.

2020-07-21 Updates

- Added Bacteremia – S. aureus chapter
- Added Bacteremia – Enterococcus chapter

2020-05-12 Update

- Added Sepsis in Known or Suspected CPO Infections

2020-04-06 Update

- Added Coronavirus Disease (COVID-19) chapter [FIRSTLINE ONLY]

2020-02-18 Updates

- Added Central Nervous System Infections chapter
- Added Colistin dosing chapter
- Updated dosing for oseltamivir and vancomycin

2020-01-20 Updates
- Added COPD Exacerbation chapter
- Added Pneumonia in Long Term Care chapter

2019-09-17 Revised Pediatric Guidelines

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.
- 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)