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Upper respiratory tract infection (URTI) Guidelines

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المظلة هيلثكير مانجمنت
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HEALTHCARE MANAGEMENT

Introduction

URT infection

Upper respiratory tract infection (URI) represents the most common acute illness evaluated in the outpatient setting

Bronchitis

Bronchitis is the inflammation of the bronchial tubes (bronchi)

Signs and symptoms:

1. Cough (the most observed symptom)
2. Sputum production (clear, yellow, green, or even blood-tinged)
3. Fever (relatively unusual; in conjunction with cough, suggestive of influenza or pneumonia)
4. Nausea, vomiting, and diarrhoea (rare)
5. General malaise and chest pain (in severe cases)
6. Dyspnea and cyanosis (only seen with underlying chronic obstructive pulmonary disease [COPD] or another condition that impairs lung function)
7. Sore throat
8. Runny or stuffy nose
9. Headache
10. Muscle aches
11. Extreme fatigue

Diagnosis of bronchitis :

1. Microbiology test: Usually not needed; consider testing for Influenza virus or SARS-CoV-2(e.g. during influenza season or outbreaks based on local epidemiological (risk/situation/protocols)
2. Laboratory test: Not indicated (CBC, CRP, ESR)
3. radiology test: Not indicated (e.g., chest X ray)

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Treatment for adult:

1. Bronchodilators (in case of wheezing),
2. no indicated for antibiotic
3. Symptomatic treatment e.g.
 - * Ibuprofen 200-400mg q6-8h (Max 2.4 g/day) or Paracetamol (acetaminophen) 500 mg-1 g q4-6h (max 4 g/day)
 - * in case of hepatic impairment /cirrhosis: max 2 g/day

Treatment for child:

1. Bronchodilators (in case of wheezing)
2. not indicated for antibiotic
3. Symptomatic treatment e.g.

Ibuprofen (do not use if <3 months of age)

* Pain control/antipyretic: 5-10 mg/kg q6-8h

* Oral weight bands:

6-<10 kg 50 mg q8h

10-<15 kg 100 mg q8h

15-<20 kg 150 mg q8h

20-<30 kg 200 mg q8h

≥30 kg 200-400 mg q6-8h

(Max 2.4 g/day)

Or

Paracetamol (acetaminophen)

* Pain control/antipyretic: 10-15mg/kg q6h

* Oral weight bands:

3-<6 kg 60 mg q6h

6-<10 kg 100 mg q6h

10-<15 kg 150 mg q6h

15-<20 kg 200 mg q6h

20-<30 kg 300 mg q6h

≥30 kg 500 mg-1 g q4-6h

(Max 4 g/day or 2 g/day in case hepatic impairment / cirrhosis)

Acute Otitis Media

Acute inflammation of the middle ear

Signs and symptoms:

Although the history of AOM varies with age, including the following:

1. Neonates: Irritability or feeding difficulties may be the only indication of a septic focus
2. Older children: This age group begins to demonstrate a consistent presence of fever and otalgia, or ear tugging
3. Older children and adults: Hearing loss becomes a constant feature of AOM and otitis media with

effusion (OME); ear stuffiness is noted before the detection of middle ear fluid

Diagnosis:

1. Otoscopy Required for definitive diagnosis if available: (Bulging, inflamed/congested tympanic membrane (may be opaque/show decreased mobility)
2. Laboratory test Not indicated unless a complication is suspected.
3. Imaging No indicated unless complication (e.g mastoiditis, brain abscess) (MRI, CT BRAIN)
4. Microbiology test: Not indicated unless a complication is suspected
 - Cultures of pus from perforated ear drums should not be used to guide treatment
 - (presence of AOM caused by nontypeable H influenzae,)

Treatment for adult:

Clinical considerations

1. Most non-severe cases can be managed symptomatically with no antibiotic treatment
 - Instruct patients to monitor symptoms and report back in case they worsen/persist after few days. Antibiotics should be considered if: (Severe symptoms (e.g. systemically very unwell, ear pain despite analgesics, fever ≥ 39.0°C)

Symptomatic Treatment

1. Ibuprofen 200-400 mg q6-8h (Max 2.4 g/day) or Paracetamol (acetaminophen) 500 mg-1 g q4-6h (max 4 g/day)

Hepatic impairment/cirrhosis: Max 2 g/day

Antibiotic Treatment durations: 5 days

Antibiotic treatment is not required in the great majority of cases (see "Clinical Considerations" when antibiotics may be indicated) All dosages are for normal renal function First Choice

1- Amoxicillin 500 mg q8h ORAL

2- Amoxicillin + clavulanic acid 500 mg+125 mg q8h ORAL

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Treatment for children:

Symptomatic Treatment

1- Ibuprofen (do not use if <3 months of age)

- Pain control /antipyretic:
 - 5-10 mg/kg q6-8h
- Oral weight bands:
 - 6-<10 kg 50mg q8h
 - 10-<15 kg 100mg q8h
 - 15-<20 kg 150mg q8h
 - 20-<30 kg 200mg q8h
 - ≥30 kg 200-400mg q6-8h
 - (Max 2.4 g/day)

2- Paracetamol(acetaminophen)

- Pain control/antipyretic:
 - 10-15 mg/kg q6h
- Oral weight bands:
 - 3-<6 kg 60mg q6h
 - 6-<10 kg 100mg q6h
 - 10-<15 kg 150mg q6h
 - 15-<20 kg 200mg q6h
 - 20-<30 kg 300mg q6h
 - ≥30 kg 500mg-1 g q4-6h
 - (Max 4 g/day or 2 g/day if hepatic impairment/cirrhosis)

Antibiotic Treatment Duration: 5 days

Antibiotic treatment is not required in the great majority of cases (see "Clinical Considerations" when antibiotics may be indicated) All dosages are for normal renal function.

1- Amoxicillin 80-90 mg/kg/day ORAL

- Oral weight bands:
 - 3-<6 kg 250mg q12h
 - 6-<10 kg 375mg q12h
 - 10-<15 kg 500mg q12h
 - 15-<20 kg 750mg q12h
 - ≥20 kg 500mg q8h or 1 g q12h

2- Amoxicillin + clavulanic acid 80-90 mg/kg/day of amoxicillin component ORAL

- Oral weight bands:
 - 3-<6 kg 250mg of amox/dose q12h
 - 6-<10 kg 375mg of amox/dose q12h
 - 10-<15 kg 500mg of amox/dose q12h
 - 15-<20 kg 750mg of amox/dose q12h
 - ≥20 kg 500mg of amox/dose q8h or 1 g of amox/dose q12h

Pharyngitis

Pharyngitis is an infection or irritation of the pharynx or tonsils, The etiology is usually infectious, with most cases being of viral origin and most bacterial cases attributable to group A streptococci (GAS)

Signs & Symptoms:

1. GAS infection is most common in children aged 4-7 years
2. Sudden onset is consistent with GAS pharyngitis; pharyngitis after several days of coughing or rhinorrhea is more consistent with a viral etiology
3. Contact with others who have GAS or rheumatic fever with symptoms consistent with GAS raises the likelihood of GAS pharyngitis
4. Headache is consistent with GAS infection
5. Cough is not usually associated with GAS infection
6. Vomiting is associated with GAS infection, though not exclusively so Recent orogenital contact suggests possible gonococcal pharyngitis.
7. A history of rheumatic fever is important

Center criteria for GAS pharyngitis include the following:

- A. Fever >38.0c
- B. Anterior cervical lymphadenopathy
- C. Tonsillar exudate
- D. Absence of cough

Treatment of central criteria of GAS according to stage:

1. Score 0-2
 - Symptomatic treatment only
2. Score 3-4
 - In case of low risk of RF (e.g., countries with low prevalence of RF) •Antibiotic treatment can be withheld even in cases of likely GAS pharyngitis.
3. Score 3-4
 - In case of high risk of RF (e.g., countries with med/high prevalence of RF) •Antibiotic treatment recommended.

Diagnosis:

1. Microbiology test:
 - Lower likelihood to be caused by Group A Streptococcus (GAS) (Center score 0-2): Tests usually not needed

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- Higher likelihood to be caused by GAS (Centorscore 3-4): Rapid antigen test or throat culture could be considered, especially in countries where rheumatic fever (RF) and rheumatic heart disease is frequent
 - Negative rapid antigen test could be confirmed with a throat culture if available
2. Laboratory Tests Blood test usually not indicated.
 3. Imaging Usually not needed unless a complication is suspected.

Treatment

Symptomatic:

Medicines are listed in alphabetical order and should be considered equal treatment options.

- Ibuprofen 200-400 mg q6- 8h (Max 2.4 g/day)

OR

- Paracetamol (acetaminophen) 500 mg-1 g q4-6h (max 4 g/day) Hepatic impairment/cirrhosis: Max 2 g/day)

Antibiotic Treatment Duration: Depending on the local prevalence or previous history of rheumatic fever:

Low Risk of RF: 5 days

High Risk of RF: 10 days

Note: when clarithromycin or cefalexin are used treatment duration is always 5 days.

- * All dosages are for normal renal function. Antibiotics are listed in alphabetical order and should be considered equal treatment options unless otherwise indicated.

- 1- Amoxicillin 500 mg q8h ORAL or Phenoxyethylpenicillin (as potassium) 500 mg (800 000 IU) q6h ORAL
- 2- Cefalexin 500 mg q8h ORAL or Clarithromycin 500 mg q12h ORAL

Treatment for pharyngitis in children

- 1- Symptomatic Treatment

Ibuprofen (do not use if <3 months of age)

- Pain control /antipyretic: 5-10 mg/kg q6-8h

• Oral weight bands:

6-<10 kg 50mg q8h

10-<15 kg 100mg q8h

15-<20 kg 150mg q8h

20-<30 kg 200mg q8h

≥30 kg 200-400mg q6-8h

(Max 2.4 g/day)

OR

Paracetamol (acetaminophen)

- Pain control/antipyretic: 10-15 mg/kg q6h

• Oral weight bands:

3-<6 kg 60mg q6h

6-<10 kg 100mg q6h

10-<15 kg 150mg q6h

15-<20 kg 200mg q6h

20-<30 kg 300mg q6h

≥30 kg 500mg-1 g q4-6h

(Max 4 g/day or 2 g/day if hepatic impairment/cirrhosis)

*Antibiotic Treatment Duration

Depending on the local prevalence or previous history of rheumatic fever: • Low Risk of RF: 5 days • High Risk of RF: 10 days Note: when clarithromycin or cefalexin are used treatment duration is always 5 days.

- 1- Amoxicillin 80-90 mg/kg/day ORAL

Oral weight bands:

3-<6 kg 250mg q12h

6-<10 kg 375mg q12h

10-<15 kg 500mg q12h

15-<20 kg 750mg q12h

≥20 kg 500mg q8h or 1 g q12h

OR

Phenoxyethylpenicillin (as potassium): 10-15 mg/kg/dose (16 000-24 000 IU/kg/dose) q6-8h ORAL

- 2- Cefalexin 25 mg/kg/dose q12h

ORAL. Oral weight bands:

3-<6 kg 125mg q12h

6-<10 kg 250mg q12h

10-<15 kg 375mg q12h

15-<20 kg 500mg q12h

20-<30 kg 625mg q12h

≥30 kg 500mg q8h

OR

Clarithromycin 7.5 mg/kg/dose q12h ORAL

Community Acquired Pneumonia (in Adults)

Diagnosis:

1. Microbiology Tests

A. Mild cases: usually not needed

B. Severe cases (to guide antimicrobial treatment): blood cultures, urinary antigens for *L. pneumophila* and *S. pneumoniae*

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- C. Selected cases (depending on epidemiology and risk factors): sputum rapid molecular test for M. tuberculosis, nasopharyngeal swab for influenza viruses and SARS-CoV-2, HIV testing in settings with high HIV prevalence and in case of recurrent and/or severe pneumonia

2- Laboratory Tests

1. Determine disease severity: blood urea nitrogen (see CURB-65 Scoring System box), blood pH and gases, white blood cell count.
2. Differentiate bacterial and viral (taking into account pretest probability): C-reactive protein and/or procalcitonin Note: tests depend on availability and clinical severity (e.g. blood gases will only be done in severe cases)

3- Imaging

- A. Chest X-ray not necessary in mild cases
- B. Infiltrate may not always be evident (e.g. dehydration) and non-infectious etiologies may mimic infiltrates (e.g. lung edema, pulmonary embolism)
- C. Radiologic appearance cannot be used to accurately predict pathogen

CURB-65 Severity Scoring System

Signs & Symptoms (1 point each)

- A. Presence of Confusion (new onset)
- B. Urea > 19 mg/dL (or > 7 mmol/L) *
- C. Respiratory rate > 30/min
- D. Systolic BP < 90 mmHg (<12 kPa) or Diastolic BP ≤ 60 mmHg (<8 kPa)
- E. Age ≥ 65 year

1-Score 0-1

Consider outpatient treatment.

2-score 2

Consider inpatient treatment.

- Consider adding clarithromycin to beta- lactam for atypical coverage
- Perform microbiology tests

3- Score ≥3

- Inpatient treatment (consider ICU)
- Consider adding clarithromycin
- Perform microbiology tests

Treatment:

Duration:

Treat for 5 days If severe disease, consider longer treatment and look for complications such as empyema,

if patient not clinically stable at day 5

Mild or moderate cases:

All dosages are for normal renal function.

1. Amoxicillin 1 g q8h ORAL or Phenoxyethylpenicillin (as potassium) 500 mg (800 000 IU) q6h ORAL
2. Amoxicillin+clavulanic acid 875 mg+125 mg q8h ORAL or Doxycycline 100 mg q12h ORAL

Severe cases

All dosages are for normal renal function.

- A. Cefotaxime 2 g q8h IV/IM or Ceftriaxone 2 g q24h IV (1 g q24h IM*) IF CURB-65 ≥2 CONSIDER ADDING Clarithromycin 500 mg q12h ORAL (or IV)
- B. Amoxicillin+clavulanic acid 1 g+200 mg q8h IV A higher daily dose can be considered: 1 g+200 mg q6h

IF CURB-65 ≥2, CONSIDER ADDING Clarithromycin 500 mg q12h ORAL (or IV)

Community Acquired Pneumonia (in Children)

Diagnosis:

1-Microbiology Tests:

- Mild cases: usually not needed
- Severe cases (to guide antimicrobial treatment): blood cultures
- Tests for COVID-19 and influenza can be considered if clinically indicated and available

2-Laboratory Tests:

- No test clearly differentiates viral or bacterial CAP Consider: full blood count and C-reactive protein
- Note: tests depend on availability and clinical severity (e.g. blood gases will only be done in severe cases)

3-Imaging:

- Chest X-ray not necessary in mild cases
- Look for lobar consolidation or pleural effusion
- Radiologic appearance cannot be used to accurately predict pathogen

Severity Assessment and Consideration:

- Children with pneumonia: Should be treated with oral amoxicillin at home with home care advice

Pneumonia is diagnosed on either:

- Fast breathing (respiratory rate > 50 breaths/minute

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- in children aged 2-11 months; resp rate > 40 breaths/min in children aged 1-5 years)
- Chest indrawing
- Children with severe pneumonia (or a child with pneumonia who cannot tolerate oral antibiotics):

Should be admitted to hospital and treated with intravenous antibiotics

- Severe pneumonia is characterized by signs of pneumonia:
 1. Fast breathing (+/- chest indrawing) PLUS
 2. A general danger sign:
- Inability to breastfeed or drink
- Convulsions
- Lethargy or reduced level of Consciousness

Treatment:

Duration:

- 3 days: in areas of low HIV prevalence and no chest indrawing
- 5 days: in areas of high HIV prevalence and the child has chest indrawing

If severe disease, consider longer treatment and look for complications such as empyema, if patient not clinically stable at day 5

1-Mild to moderate cases:

All dosages are for normal renal function.

1-Amoxicillin 80-90 mg/kg/day ORAL Oral weight bands:

- 3-<6 kg
- 6-<10 kg
- 10-<15 kg
- 15-<20 kg
- ≥20 kg
- 250mg q12h
- 375mg q12h
- 500mg q12h
- 750mg q12h
- 500 mg q8h or
- 1 g q12h

2-severe cases:

All dosages are for normal renal function.

1. Amoxicillin 50 mg/kg/dose IV/IM ≤1wk of life: q12h >1wk of life: q8h or Ampicillin 50 mg/kg/dose IV/IM ≤1wk of life: q12h >1wk of life: q8h or Benzylpenicillin 30 mg/kg/dose (50 000 IU/kg/dose) q8h IV Combined with Gentamicin IV/IM Neonates: 5 mg/kg/dose q24h Children: 7.5 mg/kg/dose q24h

(If HIV positive and <1 yr old to treat potential pneumocystis jirovecii pneumonia ,ADD)

Sulfamethoxazole+trimethoprim 40 mg/kg SMX+8 mg/kgTMP q8h IV/ORAL for 3 weeks

2. If NO Clinical Response to First Choice after 48-72 hours

Cefotaxime 50 mg/kg/dose q8h IV/IM or Ceftriaxone 80 mg/kg/dose q24h IV/IM

Hospital Acquired pneumonia in adult:

Diagnosis:

1-Microbiology Tests:

- Mild cases: usually not needed.
- Severe cases (to guide antimicrobial treatment): blood cultures, urinary antigens for L. pneumophila and S. pneumoniae
- Selected cases (depending on epidemiology and risk factors): sputum rapid molecular test for M. tuberculosis, nasopharyngeal swab for influenza viruses and SARS-CoV- 2, HIV testing in settings with high HIV prevalence and in case of recurrent and/or severe pneumonia

2-Laboratory test:

- Determine disease severity: blood urea nitrogen (see CURB-65 Scoring System box), blood pH and gases, white blood cell count
- Differentiate bacterial and viral (considering pretest probability): C-reactive protein and/or procalcitonin Note: tests depend on availability and clinical severity (e.g. blood gases will only be done in severe cases)

3-Imaging:

- Chest X-ray not necessary in mild cases
- Infiltrate may not always be evident (e.g. dehydration) and non-infectious etiologies may mimic infiltrates (e.g. lung edema, pulmonary embolism)
- Radiologic appearance cannot be used to accurately predict pathogen

CURB-65 Severity Scoring System :

Signs & Symptoms (1 point each)

- Presence of Confusion (new onset)
- Urea > 19 mg/dL (or > 7 mmol/L)
- Respiratory rate > 30/min
- Systolic BP < 90 mmHg (<12 kPa) or Diastolic BP ≤ 60 mmHg (<8 kPa) · Age ≥ 65 years

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Score 0-1

- Consider outpatient treatment

Score 2

- Consider inpatient treatment
- Consider adding clarithromycin to beta- lactam for atypical coverage ·Perform microbiology tests

Score ≥ 3

- Inpatient treatment (consider ICU) ·Consider adding clarithromycin ·Perform microbiology tests

Treatment:

Duration:

Treat for 5 days If severe disease, consider longer treatment and look for complications such as empyema, if patient not clinically stable at day 5

1-Mild to Moderate Case

All dosages are for normal renal function.

a- Amoxicillin 1 g q8h ORAL or

Phenoxymethylpenicillin (as potassium) 500 mg (800 000 IU) q6h ORAL

b- Amoxicillin+clavulanic acid 875 mg+125 mg q8h ORAL or Doxycycline 100 mg q12h ORAL

2- Severe Cases:

All dosages are for normal renal function.

a -Cefotaxime 2 g q8h IV/IM or Ceftriaxone 2 g q24h IV (1 g q24h IM) IF CURB-65 ≥ 2 , CONSIDER ADDING Clarithromycin 500 mg q12h ORAL (or IV)

b -Amoxicillin+clavulanic acid 1 g+200 mg q8h IV

A higher daily dose can be considered: 1 g+200 mg q6h IV CURB-65 ≥ 2 , CONSIDER ADDING Clarithromycin 500 mg q12h ORAL (or IV)

Hospital Acquired Pneumonia (in Children)

Diagnosis:

1-Microbiology Tests:

- Mild cases: usually not needed
- Severe cases (to guide antimicrobial treatment): blood cultures
- Tests for COVID-19 and influenza can be considered if clinically indicated and available

2-Laboratory Tests:

- No test clearly differentiates viral or bacterial CAP Consider: full blood count and C-reactive protein
- Note: tests depend on availability and clinical

- severity (e.g. blood gases will only be done in severe cases)

3-Imaging:

- Chest X-ray not necessary in mild cases
- Look for lobar consolidation or pleural effusion
- Radiologic appearance cannot be used to accurately predict pathogen

Severity Assessment and Consideration:

- Children with pneumonia: Should be treated with oral amoxicillin at home with home care advice
- Pneumonia is diagnosed on either:
- Fast breathing (respiratory rate > 50 breaths/minute in children aged 2-11 months; resp rate > 40 breaths/min in children aged 1-5 years)
- Chest indrawing
- Children with severe pneumonia (or a child with pneumonia who cannot tolerate oral antibiotics):
- Should be admitted to hospital and treated with intravenous antibiotics
- Severe pneumonia is characterized by signs of pneumonia:
- Fast breathing (+/- chest indrawing) PLUS
- A general danger sign:
- Inability to breastfeed or drink
- Convulsions
- Lethargy or reduced level of Consciousness

Treatment:

Duration:

- 3 days: in areas of low HIV prevalence and no chest indrawing
- 5 days: in areas of high HIV prevalence and the child has chest indrawing

If severe disease, consider longer treatment and look for complications such as empyema, if patient not clinically stable at day 5

1-Mild to moderate cases:

All dosages are for normal renal function.

1-Amoxicillin 80-90 mg/kg/day ORAL Oral weight bands:

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- 3-<6 kg
- 6-<10 kg
- 10-<15 kg
- 15-<20 kg
- ≥20 kg
- 250mg q12h
- 375mg q12h
- 500mg q12h
- 750mg q12h
- 500 mg q8h or
- 1 g q12h

2-severe cases:

All dosages are for normal renal function.

1. Amoxicillin 50 mg/kg/dose IV/IM ≤1wk of life: q12h
>1wk of life: q8h or Ampicillin 50 mg/kg/dose IV/IM ≤
1wk of life: q12h >1wk of life: q8h or Benzylpenicillin 30
mg/kg/dose (50 000 IU/kg/dose) q8h IV
Combined with Gentamicin IV/IM Neonates:
5mg/kg/dose q24h Children: 7.5 mg/kg/dose q24h

(If HIV positive and <1 yr old to treat potential
pneumocystis jirovecii pneumonia ,ADD)

Sulfamethoxazole+trimethoprim 40 mg/kg SMX+8
mg/kgTMP q8h IV/ORAL for 3 weeks If NO Clinical
Response to First Choice after 48-72 hours

2. Cefotaxime 50 mg/kg/dose q8h IV/IM or Ceftriaxone
80 mg/kg/dose q24h IV/IM

Acute Sinusitis

THE inflammation of the lining of the paranasal sinuses

Signs and symptoms :

- Redness of nose, cheeks, or eyelids
- Tenderness to pressure over the floor of the frontal
sinus immediately above the inner canthus
- Referred pain to the vertex, temple, or occiput.
- Postnasal discharge
- A blocked nose
- Persistent coughing or pharyngeal irritation
- Facial pain
- Hyposmia

Diagnosis:

1. Microbiology test: Not indicated
2. Laboratory Tests: Not indicated

3. Imaging Usually not needed unless a complication
or an alternative diagnosis is suspected

Treatment for adult:

1. No antibiotic care:
Treatment is to improve symptoms, but antibiotics
have minimal impact on symptom duration in most
cases. Symptomatic treatment includes antipyretic
and analgesic medications, nasal irrigation with a
saline solution and topical intranasal glucocorticoids
or decongestants.
Most guidelines recommend using disease severity
(duration and intensity of symptoms) to direct
treatment.

- Mild to Moderate Presentation (<10 days duration
and improving):
- Watchful waiting approach with symptom relief
and no antibiotic treatment

2. Symptomatic Treatment:

- Ibuprofen 200-400 mg q6- 8h (Max 2.4 g/day) or
Paracetamol (acetaminophen) 500 mg-1 g q4-6h
(max 4 g/day) Hepatic impairment/cirrhosis: Max 2
g/day

3. Clinical Considerations:

Antibiotics should be considered if: Severe onset of
symptoms - Fever ≥39.0 °C & purulent nasal
discharge or facial pain for at least 3- 4 consecutive
days.

Patients at increased risk of complications e.g., those
with chronic underlying comorbid diseases
(deciding on a case- by-case basis)

- “Red flag” signs/symptoms suggestive of
complicated infection such as systemic toxicity,
persistent fever ≥39.0°C, periorbital redness and
swelling, severe headache, or altered mental
status
4. Antibiotic treatment duration: 5 days
Antibiotic treatment is not required in the great
majority of cases (see “Clinical Considerations” when
antibiotics may be indicated)
All dosages are for normal renal function.
1-Amoxicillin 1 g q8h ORAL or Amoxicillin+clavulanic
acid 500 mg+125 mg q8h ORAL

Treatment for children:

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1-Symptomatic Treatment:

1-buprofen (do not use if <3 months of age)

• Pain control /antipyretic: 5-10 mg/kg q6-8h

• Oral weight bands:

6-<10 kg 50mg q8h

10-<15 kg 100mg q8h

15-<20 kg 150mg q8h

20-<30 kg 200mg q8h

≥30 kg 200-400mg q6-8h

(Max 2.4 g/day)

OR

Paracetamol (acetaminophen)

• Pain control/antipyretic: 10-15 mg/kg q6h

• Oral weight bands:

3-<6 kg 60mg q6h

6-<10 kg 100mg q6h

10-<15 kg 150mg q6h

15-<20 kg 200mg q6h

20-<30 kg 300mg q6h

≥30 kg 500mg-1 g q4-6h

(Max 4 g/day or 2 g/day if hepatic impairment/cirrhosis)

2-Antibiotic treatment duration:

5 days Antibiotic treatment is not required in the great majority of cases (see "Clinical Considerations" when antibiotics may be indicated)

All dosages are for normal renal function.

1-Amoxicillin 80-90 mg/kg/day

ORAL

Oral weight bands:

3-<6 kg 250mg q12h

6-<10 kg 375mg q12h

10-<15 kg 500mg q12h

15-<20 kg 750mg q12h

≥20 kg 500mg q8h or 1 g q12h

OR

Amoxicillin+clavulanic acid 80-90 mg/kg/day of amoxicillin component ORAL

Oral weight bands:

• 3-<6 kg 250mg of amox/dose q12h

• 6-<10 kg 375mg of amox/dose q12h

• 10-<15 kg 500mg of amox/dose q12h

• 15-<20 kg 750mg of amox/dose q12h

• ≥20 kg 500mg of amox/dose q8h or 1 g of amox/dose q12h

ICD codes

| Category | ICD-10 Code | Description |
|----------|-------------|--|
| J00 | J00 | Acute nasopharyngitis (common cold) |
| J00.0 | J00.0 | Acute nasopharyngitis, unspecified |
| J00.1 | J00.1 | Acute maxillary sinusitis |
| J00.2 | J00.2 | Acute frontal sinusitis |
| J00.3 | J00.3 | Acute sphenoidal sinusitis |
| J00.4 | J00.4 | Acute pansinusitis |
| J00.8 | J00.8 | Other acute upper respiratory infections of multiple sites |
| J00.9 | J00.9 | Acute upper respiratory infection, unspecified |
| J01 | J01 | Acute sinusitis |
| J01.0 | J01.0 | Acute maxillary sinusitis |
| J01.00 | J01.00 | Acute maxillary sinusitis, unspecified |
| J01.01 | J01.01 | Acute recurrent maxillary sinusitis |
| J01.8 | J01.8 | Other acute sinusitis |
| J01.9 | J01.9 | Acute sinusitis, unspecified |

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|-------|-------|--|
| J02 | J02 | Acute pharyngitis |
| J02.0 | J02.0 | Streptococcal pharyngitis |
| J02.8 | J02.8 | Acute pharyngitis due to other specified organisms |
| J02.9 | J02.9 | Acute pharyngitis, unspecified |
| J03 | J03 | Acute tonsillitis |
| J03.0 | J03.0 | Streptococcal tonsillitis |
| J03.8 | J03.8 | Acute tonsillitis due to other specified organisms |
| J03.9 | J03.9 | Acute tonsillitis, unspecified |
| J04 | J04 | Acute laryngitis and tracheitis |
| J04.0 | J04.0 | Acute laryngitis |
| J04.1 | J04.1 | Acute tracheitis |

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