Pan Arab Rhinology Society
PARS news

TOWARDS RHINOLOGY BEST PRACTICE (TREATMENT OF ABRS)

3

❑When Should Empiric Antimicrobial Therapy Be Initiated in Patients With Signs and Symptoms Suggestive of acute bacterial rhinosinusitis ABRS? [1-9]

It is recommended that empiric antimicrobial therapy be initiated as soon as the clinical diagnosis of ABRS is established as listed in previous best clinical practice

❑Should Amoxicillin Versus Amoxicillin-Clavulanate Be Used for Initial Empiric Antimicrobial Therapy of (ABRS) in Children and Adults? [1-9]

- Amoxicillin-clavulanate rather than amoxicillin alone is recommended as empiric antimicrobial therapy for ABRS in children for 10-14 days and for 5-7 days in adults.
-"High-dose" (2 g orally twice daily or 90 mg/kg/day orally twice daily) amoxicillin-clavulanate is recommended for :

1.children and adults with ABRS from geographic regions with high endemic rates (10%) of invasive penicillin-nonsusceptible (PNS) S. pneumoniae,

2. severe infection (e.g, evidence of systemic toxicity with fever of 39C or higher, and threat of suppurative complications),

3.Attendance at daycare and ages less than 2 or more than 65 years,

4. Recent hospitalization, antibiotic use within the past month, or immunocompromised

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❑Which is the most appropriate Second-line antimicrobial therapy for ABRS in Children or Adults? [1-9]

-Either doxycycline (not suitable for children) or a respiratory fluoroquinolone (levofloxacin or moxifloxacin) is recommended as an alternative agent for empiric antimicrobial therapy in adults who are allergic to penicillin

-Combination therapy with clindamycin plus a third-generation oral cephalosporin (cefixime or cefpodoxime) is recommended in children with a history of non–type I hypersensitivity to penicillin

-Macrolides (clarithromycin and azithromycin) are not recommended for empiric therapy due to high rates of resistance among S. pneumoniae (30%)

-Trimethoprim-sulfamethoxazole (TMP/SMX) is not recommended for empiric therapy because of high rates of resistance among both S. pneumoniae and Haemophilus influenzae (30%–40%) .

-Second-and third-generation oral cephalosporins are no longer recommended for empiric monotherapy of ABRS due to variable rates of resistance among S. pneumoniae.

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❑Other treatment modalities in ABRS [1-9] :

Is Saline Irrigation of the Nasal Sinuses of Benefit as Adjunctive Therapy in Patients With ABRS?

Intranasal saline irrigation with either physiologic or hypertonic saline is recommended
as an adjunctive treatment in adults with ABRS

Are Intranasal Corticosteroids Recommended as an Adjunct to Antimicrobial Therapy in Patients With ABRS?

Intranasal corticosteroids (INCSs) are recommended as an adjunct to antibiotics in the empiric treatment of ABRS, primarily in patients with a history of allergic rhinitis

Should Topical or Oral Decongestants or Antihistamines Be Used as Adjunctive Therapy in Patients With ABRS?

Neither topical nor oral decongestants and/or antihistamines are recommended as adjunctive treatment in patients with ABRS

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