TABLE 3 – SUGGESTED DURATION OF ANTIBIOTIC THERAPY IN IMMUNOCOMPETENT PATIENTS[1,2]

CLINICAL SITUATION		DURATION OF THERAPY (Days)
SITE	**CLINICAL DIAGNOSIS**	
Bacteremia	Bacteremia with removable focus (no endocarditis)	10–14 *(CID 14:75, 1992) (See Table 1A)*
Bone	Osteomyelitis, adult; acute	42
	adult; chronic	Until ESR normal (often > 3 months)
	child; acute; staph. and enterobacteriaceae[3]	21
	child; acute; strep, meningococci, haemophilus[3]	14
Ear	Otitis media with effusion	<2 yr: 10 (or 1 dose ceftriaxone).; ≥2 yr: 5–7
	Recent meta-analysis suggests 3 days of azithro *(JAC 52:469, 2003)* or 5 days of "short-acting" antibiotics effective for uncomplicated otitis media *(JAMA 279:1736, 1998)*, but may be inadequate for severe disease *(NEJM 347:1169, 2002)*.	
Endocardium	Infective endocarditis, native valve	
	Viridans strep	14 or 28 *(See Table 1A, page 25)*
	Enterococci	28 or 42 *(See Table 1A, page 26)*
	Staph. aureus	14 (R-sided only) or 28 *(See Table 1A, page 26)*
Gastrointestinal *Also see Table 1A*	Bacillary dysentery (shigellosis)/traveler's diarrhea	3
	Typhoid fever (S. typhi): Azithro	5 (children/adolescents)
	Ceftriaxone	14*
	FQ	5–7
	Chloramphenicol	14
		*[Short course ↑ effective *(AAC 44:450, 2000)*]
	Helicobacter pylori	10–14. For triple-drug regimens, 7 days probably adequate *(AIM 147:553, 2007)*.
	Pseudomembranous enterocolitis (C. difficile)	10
Genital	Non-gonococcal urethritis or mucopurulent cervicitis	7 days doxy or single dose azithro
	Pelvic inflammatory disease	14
Heart	Pericarditis (purulent)	28
Joint	Septic arthritis (non-gonococcal) Adult	14–28 *(Ln 351:197, 1998)*
	Infant/child	Rx as osteomyelitis above. Recent study suggests 10-14 days of therapy sufficient *(CID 48:1201, 2009)*, but not complete agreement on this *(CID 48:1211, 2009)*.
	Gonococcal arthritis/disseminated GC infection	7 *(See Table 1A, page 20)*
Kidney	Cystitis (bladder bacteriuria)	3 (Single dose extended-release cipro also effective) *(AAC 49:4137, 2005)*
	Pyelonephritis	14 (7 days if CIP used; 5 days if levo 750 mg)
	Recurrent (failure after 14 days rx)	42
Lung	Pneumonia, pneumococcal	Until afebrile 3–5 days (minimum 5 days)
	Community-acquired pneumonia	Minimum 5 days and afebrile for 2-3 days *(CID 44:S55, 2007; AJM 120:783, 2007)*
	Pneumonia, enterobacteriaceae or pseudomonal	21, often up to 42
	Pneumonia, staphylococcal	21–28
	Pneumocystis carinii, in AIDS;	21
	other immunocompromised	14
	Legionella, mycoplasma, chlamydia	7–14
	Lung abscess	Usually 28–42[4]
Meninges[5] *(CID 39:1267, 2004)*	N. meningitidis	7
	H. influenzae	7
	S. pneumoniae	10–14
	Listeria meningoencephalitis, gp B strep, coliforms	21 (longer in immunocompromised)
Multiple systems	Brucellosis *(See Table 1A, page 55)*	42 (add SM or gent for 1st 7–14 days)
	Tularemia *(See Table 1A, pages 41, 55)*	7–14
Muscle	Gas gangrene (clostridial)	10
Pharynx Also see Pharyngitis, *Table 1A, page 45*	Group A strep pharyngitis	10 O Ceph 2/3, azithromycin effective at 5 days *(JAC 45, Topic TI 23, 2000; JIC 14:213, 2008)*. 3 days less effective *(Inf Med 18:515, 2001). See also 2009 Cochrane Review (www.thecochranelibrary.com).*
	Diphtheria (membranous)	7–14
	Carrier	7
Prostate	Chronic prostatitis (TMP/SMX)	30–90
	(FQ)	28–42
Sinuses	Acute sinusitis	5–14[6]
Skin	Cellulitis	Until 3 days after acute inflamm disappears
Systemic	Lyme disease	*See Table 1A, page 54*
	Rocky Mountain spotted fever *(See Table 1A, page 55)*	Until afebrile 2 days

[1] Early change from IV to po regimens (about 72 hs) is cost-effective with many infections, i.e., intra-abdominal *(AJM 91:462, 1991)*.
[2] The recommended duration is a minimum or average time and should not be construed as absolute.
[3] These times are with proviso: sx & signs resolve within 7 days and ESR is normalized *(J.D. Nelson, APID 6:59, 1991)*.
[4] After patient afebrile 4-5 days, change to oral therapy.
[5] In children relapses seldom occur until 3 days or more after termination of rx. For meningitis in children, *see Table 1A, page 7.*
[6] Duration of therapy dependent upon agent used and severity of infection. Longer duration (10-14 days) optimal for beta-lactams and patients with severe disease. For sinusitis of mild-moderate severity shorter courses of therapy (5-7 days) effective with "respiratory FQ's" (including gemifloxacin, levofloxacin 750 mg), azithromycin. Courses as short as 3 days reported effective for TMP-SMX and azithro and one study reports effectiveness of single dose extended-release azithro. Authors feel such "super-short" courses should be restricted to patients with mild-mod disease *(JAMA 273:1015, 1995; AAC 47:2770, 2003; Otolaryngol-Head Neck Surg 133:194, 2005; Otolaryngol-Head Neck Surg 127:1, 2002; Otolaryngol-Head Neck Surg 134:10, 2006).*