

INFECTION	RECOMMENDED DURATION	GUIDELINE/SOURCE	COMMENTS
CENTRAL NERVOUS SYSTEM			
Bacterial Meningitis (non-neonates)			Guidelines are not standardized and duration of therapy may need to be individualized on the basis of the patient's clinical response with longer courses necessary for parenchymal brain infection
<i>Streptococcus pneumoniae</i>	10-14 days	IDSA (CID, 2004;39: 1267-1284)	
<i>Neisseria meningitidis</i>	5-7 days	IDSA (CID, 2004;39: 1267-1284)	
<i>Haemophilus influenzae</i>	7-10 days	IDSA (CID, 2004;39: 1267-1284)	
Bacterial Meningitis (neonates)			
Group B Streptococcus (<i>Streptococcus agalactiae</i>)	14 days	IDSA (CID, 2004;39: 1267-1284)	
Gram-negative bacilli	21 days	IDSA (CID, 2004;39: 1267-1284)	Duration in the neonate is two weeks beyond the first sterile CSF Cx or ≥3 weeks, whichever is longer
<i>Listeria monocytogenes</i>	21 days	IDSA (CID, 2004;39: 1267-1284)	
Brain abscess, subdural empyema, spinal epidural abscess	6 weeks	CMI, 2017;23:614-620	No consensus guideline; duration depends on source control. May be >6 weeks if inadequate drainage of the abscess.
Encephalitis (HSV)	21 days	IDSA (CID, 2008;47:303-327)	Some experts suggest repeat lumbar puncture to document CSF sterility
UPPER RESPIRATORY TRACT			
Acute otitis media			
<2 years old	10 days	NEJM, 2016; 2446-2456	
2-5 years old	7 days	Pediatrics, 2013; 131 (3) e964-e999	*In children >2 years old with mild-moderate symptoms, observation only is acceptable but should F/u in 24-48 hours
>6 years old	5 days	Pediatrics, 2013; 131 (3) e964-e999	
Pharyngitis (GAS)	10 days	IDSA (CID, 2012;55:e86-e102)	Amox=10d, IM Benz PCN G=1d
Ventilator Associated Tracheitis	3-5 days	CID, 2011; 52: 1324-1331	prolonged therapy (>7 days) was not protective against progression to HAP or VAP compared with short course (<7days)
Mastoiditis	2-4 weeks		Duration depending on adequate debridement, intracranial extension, extent of osteomyelitis, and associated thrombosis
Sinusitis			
Acute	5-7 days	IDSA (CID, 2012;54:1041-1045)	
Chronic (>12 weeks symptoms)	2-3 weeks	Laryngo Investig Oto, 2017; 2 (3) 104-108	CPG is not available; not extensively studied in children
Abscess			
Tonsillar or peritonsillar	10-14 days	Consensus multiple institutions	VCH Deep Neck Infection CPG
Retro- or parapharyngeal	14 days	Consensus multiple institutions	CPG not available, not extensively studied
Lymphadenitis			
	5-7 days		
Orbital or periorbital cellulitis			
Periorbital cellulitis	5-7 days	American Acad Ophth + Aus CPG	VUMC CPG in final stages
Orbital cellulitis	14-21 days		May need longer duration if insufficient source control; may extend to 3-4 wk with extensive bone involvement
LOWER RESPIRATORY TACT			
Acute Chest Syndrome			
	7 days (5d azithro)		CPG not available, not extensively studied
Pneumonia			
Uncomplicated (Outpatient)	5 days	Scout CAP abstract	
Uncomplicated (Inpatient)	10 days	IDSA (CID, 2011;53 (7) e25-e77)	10 days best studied, more recent data indicate 5-7 days may be adequate
Atypical	5 days	IDSA (CID, 2011;53 (7) e25-e77)	Azithromycin (7-10d if Levo or Doxy)
Parapneumonic Effusion or Empyema	14-28 days	IDSA (CID, 2011;53 (7) e25-e77)	Dependent upon adequacy of drainage + clinical response
Influenza	5 days	IDSA (CID, 2011;53 (7) e25-e77)	Oseltamivir
Hospital-acquired/ventilator-associated pneumonia	7 days	IDSA (CID, 2016;63(5) e61-e111)	

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Lung abscess or necrotizing pneumonia	14-28d (widely variable)	IDSA (CID, 2011;53 (7) e25-e77)	Duration dependent on clinical response, complications, organism isolated
COVID-19 LRTI	5 days (antiviral)	VUMC Adult Treatment Guidelines	Do not need to finish course if clinical improvement and ready for discharge; also treated with steroid (+taper)
SKIN, SOFT TISSUE, & MUSCULOSKELETAL			
Purulent and Nonpurulent skin and soft tissue infections			
Cellulitis, folliculitis	5-7 days	IDSA (CID, 2014;59 (2) e10-e52)	
Impetigo	7 days	IDSA (CID, 2014;59 (2) e10-e52)	Treat orally with numerous lesions, outbreaks affecting several people, or with ecthyma
HSV mucocutaneous lesions (non-neonate)	5-7 days	Consensus multiple institutions	CPG not available, not extensively studied
Bite wound (animal or human)			
Preemptive early antimicrobial therapy	3-5 days	IDSA (CID, 2014;59 (2) e10-e52)	Only for immunocomp, asplenic, advanced liver disease, hand or face involvement, penetration of periosteum or joint capsule
Infected bite	5 days	IDSA (CID, 2014;59 (2) e10-e52)	Duration dependent on organism isolated and source control
Tick Borne Illness			
RMSF	5-7 days	CDC	>3d after fever resolution
Ehrlichiosis	5-7 days	CDC	>3d after fever resolution
Anaplasmosis	10-14 days	CDC	>3d after fever resolution
Bacterial arthritis	14 days	Clin Infect Dis, 2009; 48 (9) 1201-10	Some would recommend extending to 21 days if concern for osteomyelitis
Osteomyelitis (uncomplicated)	3-4 weeks	Observational studies comparing 3-4 wk courses to 4-6 wk courses (PIDS guideline in draft)	Early switch to oral route encouraged with clinical improvement, even for patients with transient bacteremia (fever resolution, decreased inflammation, improved exam, tolerating PO). Final duration dependent upon clinical improvement at course completion (evaluate prior to stopping).
Pyomyositis	2-3 weeks	IDSA (CID, 2014;59 (2) e10-e52)	
GENITOURINARY TRACT			
Candiduria			
Asymptomatic	14 days*	Clinical Practice Guideline for the Management of Candidiasis: 2016 Update by the IDSA	*Only treat neutropenic, VLBW (<1500 g), and urologic manipulation (low quality evidence). Other asymptomatic candida cystitis do not require treatment.
Symptomatic	14 days	Clinical Practice Guideline for the Management of Candidiasis: 2016 Update by the IDSA	
Acute Uncomplicated Cystitis	3-5 days	2010 IDSA Acute Uncomplicated Cystitis/Pyelo in Women	Duration dependent on antibiotic (Bactrim x 3 days, Nitrofurantoin 5-7 days, Beta-lactams 3-5 days)
Pelvic Inflammatory Disease	14 days	2015 CDC STD Treatment Guidelines	
Pyelonephritis	7-10 days	2010 IDSA Acute Uncomplicated Cystitis/Pyelo in Women	Extend course with complication such as renal abscess; Avoid nitrofurantoin for upper urinary tract infection or bacteremia
Bacteremic UTI in infants	14 days	Parenteral antibiotic therapy Duration in Young Infants with Bacteremic Urinary Tract Infections (Multicenter retrospective cohort study of 115 infants, published in Pediatrics)	Limited evidence supports shorter course IV (<7 days) vs longer IV (>7 days) followed by oral in healthy infants with bacteremic UTI without meningitis
GASTROINTESTINAL/ABDOMINAL			
Abdominal abscess or abdominal infection	4-7 days	Diagnosis and Management of Complicated Intra-abdominal Infection in Adults and Children: Guidelines by the Surgical Infection Society and the IDSA (2010)	With adequate surgical drainage. Longer course will be required if not able to obtain adequate source control.

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C. difficile diarrhea	Nonsevere first episode or first recurrence: metronidazole PO or vanc PO x 10 days	Clinical Practice Guidelines for Clostridium difficile Infection in Adults in Children: 2017 Update by IDSA and SHEA (Table 2)	
	Severe first episode: vanc PO x10 days, w/ or w/out metronidazole IV x10 days		
	Second recurrence: Vanc taper OR vanc x10d with rifamixin x20d OR fecal transplantation		
Non-Typhoid Salmonella gastroenteritis (w/ or w/o bacteremia)	7- to 10- day total course		Recommended tx only for infants younger < 3 months and people with chronic GI tract disease, malignant neoplasms, hemoglobinopathies, HIV infection, or other immunosuppressive illnesses or therapies; ; can transition from IV to PO after blood cx has cleared and focal disease excluded
DEVICE-RELATED INFECTIONS			
Catheter-associated peritonitis	14 days*	Consensus Guideliens for the Prevention and Treatment of Catheter-Related Infections and Peritonitis in Pediatric Patients Receiving Peritoneal Dialysis: 2012 Update *MSSA/MRSA 21 days	Consider catheter removal for fungal peritonitis, tunnel infection, refractory bacterial peritonitis
Catheter-associated urinary tract infection	7 days	Diagnosis, Prevention, and Treatment of Catheter-Associated UTI in Adults: 2009 International Clinical Practice Guidelines from the IDSA	
Catheter-related bloodstream infection	7 days if catheter removed. 10 days of systemic and lock therapy if catheter retained. 14 days for Staph aureus and Candida if catheter removed. If complicated by septic arthritis, endocarditis, osteomyelitis: 4-8 wks.	Clinical Practice Guidelines for the Diagnosis and Management of Intravascular Catheter-Related Infection: 2009 Update by the IDSA	VCH CAUTI CPG
CSF shunt infection	10 days	2017 IDSA Clinical Practice Guideliens for Healthcare-Associated Ventriculitis and Meningitis	Infected CSF shunts should be removed and replaced with external ventricular drain. Duration longer than 10 days if infection is complicated.
CARDIOVASCULAR			
Endocarditis	4-6 weeks	AHA Infective Endocarditis in Childhood: 2015 Update	Longer duration if prosthetic valves present
		2015 Infective endocarditis in Adults: Diagnosis, Antimicrobial Therapy, and Management of Complications, Endorsed by the Infectious Diseases Society of America	