**Appendix 1**

Example template\* for the empiric treatment of patients hospitalized with community-acquired pneumonia

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| **Hospitalized community-acquired pneumonia (CAP)** |
| **Choice for initial empiric treatment** | **Choice for switching from IV to oral treatmente** | **Total durationf** |
| **Non-severe CAPa,b,c** | **Severe CAPb,c,d** |
| *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* |
| aObtain pretreatment Gram stain and culture of lower respiratory secretions, as well as blood cultures in patients who are being empirically treated for MRSA or *P. aeruginosa*; were previously infected with MRSA or *P. aeruginosa*; or were hospitalized and received parenteral antibiotics in the last 90 days.bInitiate empiric antibiotic therapy in patients with clinically suspected and radiographically confirmed CAP regardless of initial serum procalcitonin levelcCover for MRSA or *P. aeruginosa* only if locally validated risk factors for either pathogen are present; if treating on the basis of published risk factors without local etiological data, continue empiric coverage while obtaining culture data to establish if these pathogens are presentdObtain pretreatment Gram stain and culture of lower respiratory secretions, as well as blood cultures eUse either the same agent or the same drug classfUse a validated measure of clinical stability (resolution of vital sign abnormalities [heart rate, respiratory rate, blood pressure, oxygen saturation, andtemperature], ability to eat, and normal mentation) to guide duration of therapy, continuing antibiotic therapy until the patient achieves stability for ≥ 5 days or 7 days for MRSA or *P. aeruginosa* |
| **\*This is a template only. The table must be filled and adapted based on local/hospital patterns of resistance and antibiotic availability. Recommendations in the footnote are based on the IDSA/ATS treatment guidelines and should be adapted as appropriate*** **Refer to local guidelines if available. Online link to the IDSA/ATS CAP treatment guidelines:** www.idsociety.org/practice-guideline/community-acquired-pneumonia-cap-in-adults/
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ATS, American Thoracic Society; ICU, intensive care unit; IDSA, Infectious Diseases Society of America; IV, intravenous; MRSA, methicillin-resistant *Staphylococcus aureus*; *P. aeruginosa*, *Pseudomonas aeruginosa*

**Reference:** Metlay JP, et al. Diagnosis and treatment of adults with community-acquired pneumonia. An official clinical practice guideline of the American Thoracic Society and Infectious Diseases Society of America. *Am J Respir Crit Care Med* 2019;200:e45-e67.

**Appendix 2**

Example template\* for the empiric treatment of hospital-acquired pneumonia and ventilator-associated pneumonia

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| **Hospital-acquired pneumonia (HAP) and ventilator-associated pneumonia (VAP)**  |
| **Choice for initial empiric treatment** | **Choice for oral treatment (conversion or** **de-escalation)** | **Total duration**  |
| **HAPa** | **VAPb,c** |
| **No ventilatory support** | **Ventilatory support** |
| *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* |  *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* |
| aPneumonia not incubating at the time of hospital admission and occurring ≥48 hours after admission**b**Pneumonia occurring >48 hours after endotracheal intubation**c**Suggest including two antipseudomonal antibiotics from different classes only when risk factors for antimicrobial resistance are present (eg, prior IV antibiotic use within 90 days, septic shock at the time of VAP, ≥5 days of hospitalization before VAP), patients in units where >10% of Gram-negative isolates are resistant to the agent being considered for monotherapy, and patients in an ICU where local antimicrobial susceptibility is not known |
| **\*This is a template only. The table must be filled and adapted based on local/hospital patterns of resistance and antibiotic availability. Recommendations in the footnote are based on the IDSA/ATS treatment guidelines and should be adapted as appropriate*** **Refer to local guidelines if available. Online link to the IDSA/ATS CAP treatment guidelines:** www.idsociety.org/practice-guideline/hap\_vap/
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ATS, American Thoracic Society; IDSA, Infectious Diseases Society of America; IV, intravenous

**Reference:** Kalil AC, et al. Management of adults with hospital-acquired and ventilator-associated pneumonia: 2016 clinical practice guidelines by the Infectious Diseases Society of America and the American Thoracic Society. *Clin Infect Dis* 2016;63:e61-e111.

**Appendix 3**

Example template\* for the empiric treatment of patients hospitalized with skin and soft tissue infections

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| **Hospitalized skin and soft tissue infections (SSTIs)** |
| **Choice for initial empiric IV treatment** | **Duration of therapy and conversion to oral therapy** |
| **Cellulitisa,b** | **Necrotizing fasciitisc** | **Surgical site infectionsa,d,e** |
| Moderate infection | Severe infection | *[To be filled based on local patterns of resistance and antibiotic availability]* | Operations of the head, trunk, extremity | Operations of the GI tract or female genital tract  | Cellulitis | Necrotizing fasciitis | Surgical site infections |
| *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* |
| **a**Patients with systemic signs of infection (eg, temperature >38°C, heart rate >90 beats/min, respiratory rate >24 breaths/min)**b**Patients with mild cellulitis (no systemic signs of infection) should receive oral outpatient therapy with an antistreptococcal agent**c**Modify antibiotic therapy once definitive microbiological results have been obtained**d**Surgical patients with <5 cm of erythema and induration with minimal systemic signs of infection do not require antibiotics**e**Suggest using an agent effective against MRSA when MRSA risk factors are present (eg, prior MRSA infection, recent antibiotics) |
| **\*This is a template only. The table must be filled and adapted based on local/hospital patterns of resistance and antibiotic availability. Recommendations in the footnote are based on the IDSA SSTI treatment guidelines and should be adapted as appropriate*** **Refer to local guidelines if available. Online link to the IDSA SSTI treatment guidelines:** www.idsociety.org/practice-guideline/skin-and-soft-tissue-infections/
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GI, gastrointestinal; IDSA, Infectious Diseases Society of America; IV, intravenous; MRSA, methicillin-resistant *Staphylococcus aureus*

**Reference:** Stevens DL, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 Update by the Infectious Diseases Society of America. *Clin Infect Dis* 2014;59:e10-e52.

**Appendix 4**

Example template\* for the empiric treatment of intra-abdominal infections

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| **Intra-abdominal infections (IAIs)** |
| **Choice for initial IV empiric treatment** | **Conversion to oral therapy** | **Total duration** |
| **Community-acquired IAIa,b,c** | **Healthcare-associated IAId** |
| Single-agent therapy | Combination regimens**c** | Single-agent therapy | Combination therapy | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* |
| *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* | *[To be filled based on local patterns of resistance and antibiotic availability]* |
| aFor patients with mild-to-moderate community-acquired infections, regimens without substantial antipseudomonal activity are preferredbEmpiric use of broad-spectrum regimens against Gram-negative organisms is recommended for patients with severe community-acquired IAI. This should be tailored once culture and susceptibility reports are availablecIIn high-risk community-acquired IAI, quinolones should not be used unless hospital surveys indicate >90% susceptibility of *Escherichia coli* to quinolonesdEmpiric therapy for healthcare-associated IAI should be driven by local microbiology. Multidrug regimens may be needed to achieve empiric coverage of likely pathogens – broad-spectrum antibiotics should be tailored upon availability of culture and susceptibility reports |
| **\*This is a template only. The table must be filled and adapted based on local/hospital patterns of resistance and antibiotic availability. Recommendations in the footnote are based on the Surgical Infection Society/IDSA treatment guidelines and should be adapted as appropriate*** **Refer to local guidelines if available. Online link to Surgical Infection Society/IDSA guidelines\*\*:** www.idsociety.org/practice-guideline/alphabetical-guidelines/
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IDSA, Infectious Diseases Society of America; IV, intravenous

**Reference:** Solomkin JS, et al. Diagnosis and management of complicated intra-abdominal infection in adults and children: Guidelines by the Surgical Infection Society and the Infectious Diseases Society of America. *Clin Infect Dis* 2010;50:133-164.

*\*\*Updated guidelines for IAIs are currently in development (as of August 2022)*