MedStar Health

Management of Bronchitis in Adults

Clinical Practice Guideline
MedStar Health
Antibiotic Stewardship

"These guidelines are provided to assist physicians and other clinicians in making decisions regarding the care of their patients. They are not a substitute for individual judgment brought to each clinical situation by the patient's primary care provider-in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication but should be used with the clear understanding that continued research may result in new knowledge and recommendations."

Diagnostic Evaluation and Treatment for Acute Bronchitis:

1. The evaluation of adults with acute cough or with presumptive diagnosis of uncomplicated acute bronchitis should focus on ruling out pneumonia with chest radiography.
2. Consider for chest radiography:
    a. Fever (temperature greater than 100.3 F or 38.0 C)
    b. Tachycardia (heart rate > 100 bpm)
    c. Tachypnea (respiratory rate 24 breaths per minute or higher)
    d. Hypoxemia (pulse oxygenation < 95%)
    e. Asymmetrical lung sounds (rales, egophony, fremitus)
    f. Cough lasting 3 weeks or longer.
3. Empiric antibiotic therapy:
    a. Acute Uncomplicated Bronchitis: Routine antibiotic treatment of uncomplicated bronchitis is not recommended, regardless of duration of cough.
    b. COPD: appropriate antibiotics and adjunct therapies should be prescribed as outlined in the COPD management guideline.
    c. Complicated Presentations: Consider empiric treatment for pneumonia in high-risk clinical scenarios, including geriatric patients, immunocompromised patients, patients with abnormal vital signs and an abnormal pulmonary examination
4. Consider/Manage Alternative Diagnoses:
    a. Influenza – when influenza is suspected, appropriate diagnostic testing and treatment should be utilized as clinically indicated.
    b. Pertussis – when pertussis infection is suspected, empiric antimicrobial therapy should be initiated with a macrolide (azithromycin 500 mg on day 1 followed by 250 mg on days 2-5 or clarithromycin 500 mg bid for 7 days). For patients unable to tolerate a macrolide, trimethoprim-sulfamethoxazole one DS tablet bid for 14 days is acceptable.
    c. COVID 19—when covid 19 is suspected, appropriate testing should be performed if available. The patient should be advised to self-isolate, treat symptomatically and monitor for clinical worsening.
5. Symptomatic therapy:
    a. Non-pharmacologic therapy such as throat lozenges, tea, honey
    b. OTC medications such as dextromethorphan and guaifenesin

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6. Smoking cessation: All smokers should receive smoking cessation counseling and interventions.

MEDCONNECT RESOURCES

A bronchitis specific power plan is present in MedConnect to facilitate appropriate treatment orders:

PATIENT EDUCATION

Choosing Wisely: https://www.choosingwisely.org/clinician-lists/infectious-diseases-society-antbiotics-for-upper-respiratory-infections/

DEFINITIONS

Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration. Antimicrobial stewards seek to achieve optimal clinical outcomes related to antimicrobial use, minimize toxicity and other adverse events, reduce the costs of health care for infections, and limit the selection for antimicrobial resistant strains. - See more at: http://www.idsociety.org/stewardship_policy/#sthash.SM1baBaC.dpuf

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- Society for Healthcare Epidemiology of America (SHEA), 2015. Antimicrobial Stewardship. Retrieved from http://www.shea- online.org/PriorityTopics/AntimicrobialStewardship.aspxusitis in Adults: Treatment.

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