

INCLUSION CRITERIA

Patients aged ≥ 24 months presenting with any of the following symptoms: rhinorrhea, congestion, or cough with or without fever and a suspicion of sinusitis

EXCLUSION CRITERIA

- Signs of lower respiratory infection
- Complex medical history
- Anatomic abnormality of the sinuses
- Nasal foreign body
- Chronic sinusitis-(90 or more uninterrupted days of respiratory symptoms)
- Recurrent sinusitis- 4 episodes in 1 year
- Toxic appearance
- Respiratory Distress
- Orbital or Neurological symptoms
- Immunocompromised
- Cystic Fibrosis
- Mastoiditis
- Unable to tolerate PO

PATHWAY MEASURES

- Appropriate antibiotic selection

ADJUNCTIVE CARE

- Nasal saline spray/rinse
- Nasal corticosteroids
- Afrin (no longer than 3 days)

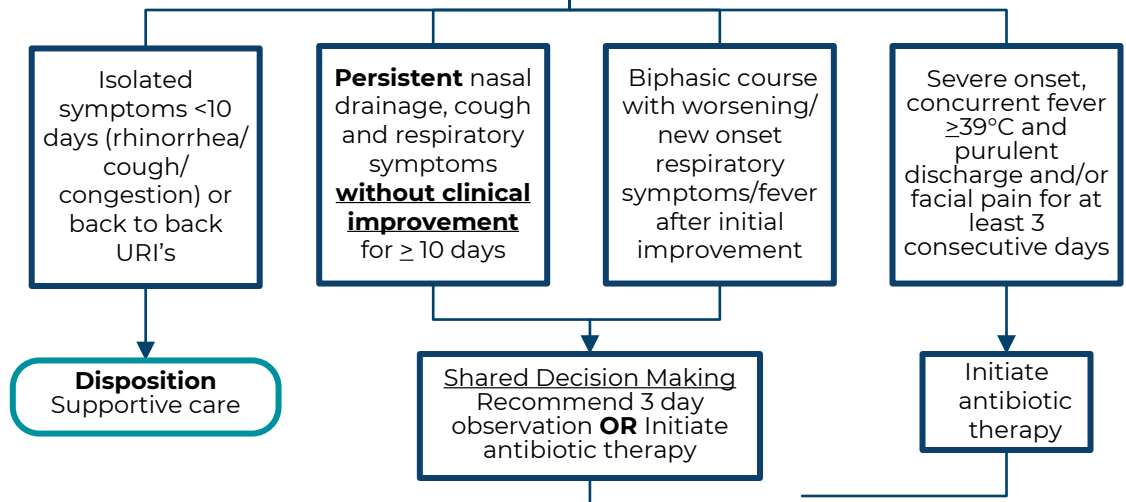
ADDITIONAL CONSIDERATIONS

- Xray imaging is not routinely recommended for uncomplicated acute sinusitis
- Consider nasal foreign body if malodorous unilateral drainage
- Patients who are acutely ill and appear toxic OR severe/intractable headache OR are not improving after 3 days of appropriate antimicrobial therapy should prompt escalation of care, including consideration of imaging (CT/MRI), ENT consultation, and/or intravenous antibiotics

PENICILLIN ALLERGY DEFINITION¹

- Mild PCN allergy type IV: Delayed maculopapular rash without urticaria, blistering, desquamation, mucosal involvement, systemic symptoms)
- Severe PCN allergy (type 1/ IgE mediated): Allergist confirmed history of urticaria, angioedema, wheezing, respiratory distress or anaphylaxis

Initial history and exam



Disposition
Supportive care

Shared Decision Making
Recommend 3 day observation **OR** Initiate antibiotic therapy

Initiate antibiotic therapy

Acute Bacterial Sinusitis: Antibiotic Therapy

First Line:

- PO Amoxicillin
- PO Amoxicillin/Clavulanate: <2 yo, or attends child care, or has been treated with antibiotic recently

Mild type IV PCN Allergy¹:

- PO Levofloxacin (preferred 2ndline agent). May crush tablets
- If mild Type IV reaction AND levofloxacin suspension not covered by insurance AND crushed levofloxacin tablet not appropriate for weight: PO cefdinir

Discharge Patient

- Provide related educational resources
- If symptoms persist for >48 hours, the patient should be re-evaluated by PCP

Antibiotic Duration

Severity	Duration
Persistent or Biphasic	5 days
Severe Onset	7 days

Antibiotic Dosing

Medication	Route	Dosage	Max. per Dose
Amoxicillin	PO	45 mg/kg/dose BID	1500 mg
Amoxicillin-clavulanate (Augmentin®)	PO	ES suspension (amoxicillin 600 mg/clavulanate 42.9 mg/5 mL) 45 mg/kg/dose of amoxicillin BID	1800 mg
	PO	Tablet (amoxicillin 875 mg/clavulanate 125 mg per tablet) for weight ≥ 40 kg 875 mg of amoxicillin BID	875 mg
	PO	Chewable tablet (amoxicillin 400 mg/clavulanate 57 mg per tablet) for weight ≥ 40 kg 800 mg of amoxicillin BID	800 mg
Cefdinir	PO	7 mg/kg/dose BID	300 mg
Levofloxacin	PO	≥ 12 mo to < 5 years 10 mg/kg/dose BID	250 mg
	PO	> 5 years 10 mg/kg/dose Q24H	500 mg

Disclaimer: The clinical pathways are based upon publicly available medical evidence and/or a consensus of medical practitioners at Nemours Children's Health ("Nemours") and are current at the time of publication. These clinical pathways are intended to be a guide for practitioners and may need to be adapted for each specific patient based on the practitioner's professional judgment, consideration of any unique circumstances, the needs of each patient and their family, and/or the availability of various resources at the health care institution where the patient is located.

VERSION MANAGEMENT

- Version 1.0 (5/19/2026): Go Live.

Questions about this pathway should be directed to **clinicalpathways@nemours.org**.

AUTHORS & REFERENCES

Central Florida Authors: Kamal Chavda (Emergency Medicine), Madushree Desiraju (Primary Care), Jeniffer Mills (Emergency Medicine), Morgan Setteducato, (Urgent Care), Chase Carpenter (Pharmacy), Kristina Flathers (Medical Library), Tiara Baez (EPIC), Chris Pierson (EPIC), Dennise Hanna (EPIC), Heather Ammirata (Clinical Pathways Data Specialist), Kenneth Alexander (Infectious Disease), Naara Miguez (Clinical Pathways)

Delaware Valley Authors: Monique Devens (Emergency Medicine), Nicole Green (Emergency Medicine), Kathy Palmer (Emergency Medicine), Amy Renwick (Primary Care), Amudha Boopathi (Primary Care), Rachel Schare (Telehealth), Chellise Cato (Telehealth), Jennifer Vodzak (Infectious Disease), Karen Ravin (Infectious Disease), Matt Mason (Pharmacy), Kailey Grimm (Pharmacy), Jennifer Cooper (Nursing), Kaley Spencer (Nursing), Nicole Aaronson (ENT), Taylor Teplitzky (ENT)

Jacksonville Authors: Evie Landry (ENT) and Deval Patel (Clinical Pathways)

- American Academy of Pediatrics. Principles of appropriate use of antimicrobial therapy for upper respiratory tract infections. In: Kimberlin DW, Banerjee R, Barnett ED, Lynfield R, Sawyer MH, eds. *Red Book: 2024–2027 Report of the Committee on Infectious Diseases*. 33rd ed. American Academy of Pediatrics; 2024. doi:10.1542/9781610027373-S4_003_006
- Chow AW, Benninger MS, Brook I, et al. IDSA clinical practice guideline for acute bacterial rhinosinusitis in children and adults. *Clin Infect Dis*. 2012;54(8):e72-e112. doi:10.1093/cid/cir1043
- Conway SJ, Mueller GD, Shaikh N. Antibiotics for Acute Sinusitis in Children: A Meta-Analysis. *Pediatrics*. 2024;153(5):e2023064244. doi:10.1542/peds.2023-064244
- El Feghaly RE, Jaggi P, Katz SE, Poole NM. "Give Me Five": The Case for 5 Days of Antibiotics as the Default Duration for Acute Respiratory Tract Infections. *J Pediatric Infect Dis Soc*. 2024;13(6):328-333. doi:10.1093/jpids/piae034
- Venturini E, Del Bene M, Fusani L, et al. Treatment of sinusitis in children: an Italian intersociety consensus (SIPPS-SIP-SITIP-FIMP-SIAIP-SIMRI-SIM-FIMMG). *Ital J Pediatr*. 2025;51(1):102. Published 2025 Mar 26. doi:10.1186/s13052-025-01868-1
- Wald ER, Applegate KE, Bordley C, et al. Clinical practice guideline for the diagnosis and management of acute bacterial sinusitis in children aged 1 to 18 years. *Pediatrics*. 2013;132(1):e262-e280. doi:10.1542/peds.2013-1071