General

Guideline Title

Clinical practice guideline for the diagnosis and management of acute bacterial sinusitis in children aged 1 to 18 years.

Bibliographic Source(s)


Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical practice guideline: management of sinusitis. Pediatrics. 2001 Sep;108(3):798-808. [79 references]

All clinical practice guidelines from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Definitions for the quality of the evidence (A-D, X) and the strength of the recommendation (strong recommendation, recommendation, option) are provided at the end of the "Major Recommendations" field.

Key Action Statement (KAS) 1

Clinician should make a presumptive diagnosis of acute bacterial sinusitis when a child with an acute upper respiratory tract infection (URI) presents with the following:

Persistent illness (i.e., nasal discharge [of any quality] or daytime cough or both lasting more than 10 days without improvement)

OR

Worsening course (i.e., worsening or new onset of nasal discharge, daytime cough, or fever after
Initial improvement)  
OR

Severe onset (i.e., concurrent fever [temperature ≥39°C/102.2°F] and purulent nasal discharge for at least 3 consecutive days) (Evidence Quality: Grade B; Recommendation)

**KAS Profile 1**

Aggregate evidence quality: B  
Benefit: Diagnosis allows decisions regarding management to be made. Children likely to benefit from antimicrobial therapy will be identified.  
Harm: Inappropriate diagnosis may lead to unnecessary treatment. A missed diagnosis may lead to persistent infection or complications.  
Cost: Inappropriate diagnosis may lead to unnecessary cost of antibiotics. A missed diagnosis leads to cost of persistent illness (loss of time from school and work) or cost of caring for complications.  
Benefits-harm assessment: Preponderance of benefit  
Value judgments: None  
Role of patient preference: Limited  
Intentional vagueness: None  
Exclusions: Children aged <1 year or older than 18 years and with underlying conditions  
Strength: Recommendation

**Key Action Statement 2A**

Clinicians should not obtain imaging studies (plain films, contrast-enhanced computed tomography [CT], magnetic resonance imaging [MRI], or ultrasonography) to distinguish acute bacterial sinusitis from viral URI (Evidence Quality: Grade B; Strong Recommendation).

**KAS Profile 2A**

Aggregate evidence quality: B; overwhelmingly consistent evidence from observational studies  
Benefit: Avoids exposure to radiation and costs of studies. Avoids unnecessary therapy for false-positive diagnoses.  
Harm: None  
Cost: Avoids cost of imaging  
Benefits-harm assessment: Exclusive benefit  
Value judgments: Concern for unnecessary radiation and costs  
Role of patient preference: Limited. Parents may value a negative study and avoidance of antibiotics as worthy of radiation but panel disagrees.  
Intentional vagueness: None  
Exclusions: Patients with complications of sinusitis  
Strength: Strong recommendation

**Key Action Statement 2B**

Clinicians should obtain a contrast-enhanced CT scan of the paranasal sinuses and/or an MRI with contrast whenever a child is suspected of having orbital or central nervous system complications of acute bacterial sinusitis (Evidence Quality: Grade B; Strong Recommendation).

**KAS Profile 2B**

Aggregate evidence quality: B; overwhelmingly consistent evidence from observational studies  
Benefit: Determine presence of abscesses, which may require surgical intervention; avoid sequelae because of appropriate aggressive management.  
Harm: Exposure to ionizing radiation for CT scans; need for sedation for MRI  
Cost: Direct cost of studies  
Benefits-harm assessment: Preponderance of benefit  
Value judgments: Concern for significant complication that may be unrecognized and, therefore, not
treated appropriately
Role of patient preference: Limited
Intentional vagueness: None
Exclusions: None
Strength: Strong recommendation

Key Action Statement 3

Initial Management of Acute Bacterial Sinusitis

3A: "Severe onset and worsening course" acute bacterial sinusitis. The clinician should prescribe antibiotic therapy for acute bacterial sinusitis in children with severe onset or worsening course (signs, symptoms, or both) (Evidence Quality: Grade B; Strong Recommendation).

KAS Profile 3A

Aggregate evidence quality: B; randomized controlled trials with limitations
Benefit: Increase clinical cures, shorten illness duration, and may prevent suppurative complications in a high-risk patient population.
Harm: Adverse effects of antibiotics
Cost: Direct cost of therapy
Benefits-harm assessment: Preponderance of benefit
Value judgments: Concern for morbidity and possible complications if untreated
Role of patient preference: Limited
Exclusions: None
Strength: Strong recommendation

3B: "Persistent illness." The clinician should either prescribe antibiotic therapy OR offer additional outpatient observation for 3 days to children with persistent illness (nasal discharge of any quality or cough or both for at least 10 days without evidence of improvement) (Evidence Quality: Grade B; Recommendation).

KAS Profile 3B

Aggregate evidence quality: B; randomized controlled trials with limitations
Benefit: Antibiotics increase the chance of improvement or cure at 10 to 14 days (number needed to treat, 3–5); additional observation may avoid the use of antibiotics with attendant cost and adverse effects.
Harm: Antibiotics have adverse effects (number needed to harm, 3) and may increase bacterial resistance. Observation may prolong illness and delay start of needed antibiotic therapy.
Cost: Direct cost of antibiotics as well as cost of adverse reactions; indirect costs of delayed recovery when observation is used.
Benefits-harm assessment: Preponderance of benefit (because both antibiotic therapy and additional observation with rescue antibiotic, if needed, are appropriate management).
Value judgments: Role for additional brief observation period for selected children with persistent illness sinusitis, similar to what is recommended for acute otitis media, despite the lack of randomized trials specifically comparing additional observation with immediate antibiotic therapy and longer duration of illness before presentation.
Role of patient preference: Substantial role in shared decision-making that should incorporate illness severity, child's quality of life, and caregiver values and concerns.
Intentional vagueness: None
Exclusions: Children who are excluded from randomized clinical trials of acute bacterial sinusitis, as defined in the text
Strength: Recommendation

Key Action Statement 4
Clinicians should prescribe amoxicillin with or without clavulanate as first-line treatment when a decision has been made to initiate antibiotic treatment of acute bacterial sinusitis (Evidence Quality: Grade B; Recommendation).

**KAS Profile 4**

Aggregate evidence quality: B; randomized controlled trials with limitations
Benefit: Increase clinical cures with narrowest spectrum drug; stepwise increase in broadening spectrum as risk factors for resistance increase
Harm: Adverse effects of antibiotics including development of hypersensitivity
Cost: Direct cost of antibiotic therapy
Benefits-harm assessment: Preponderance of benefit
Value judgments: Concerns for not encouraging resistance if possible
Role of patient preference: Potential for shared decision-making that should incorporate the caregiver's experiences and values.
Intentional vagueness: None
Exclusions: May include allergy or intolerance
Strength: Recommendation

**Key Action Statement 5A**

Clinicians should reassess initial management if there is either a caregiver report of worsening (progression of initial signs/symptoms or appearance of new signs/symptoms) OR failure to improve (lack of reduction in all presenting signs/symptoms) within 72 hours of initial management (Evidence Quality: Grade C; Recommendation).

**KAS Profile 5A**

Aggregate evidence quality: C; observational studies
Benefit: Identification of patients who may have been misdiagnosed, those at risk of complications, and those who require a change in management
Harm: Delay of up to 72 hours in changing therapy if patient fails to improve
Cost: Additional provider and caregiver time and resources
Benefits-harm assessment: Preponderance of benefit
Value judgments: Use of 72 hours to assess progress may result in excessive classification as treatment failures if premature; emphasis on importance of worsening illness in defining treatment failures.
Role of patient preferences: Caregivers determine whether the severity of the patient's illness justifies the report to clinician of the patient's worsening or failure to improve.
Intentional vagueness: None
Exclusions: Patients with severe illness, poor general health, complicated sinusitis, immune deficiency, previous sinus surgery, or coexisting bacterial illness
Strength: Recommendation

**Key Action Statement 5B**

If the diagnosis of acute bacterial sinusitis is confirmed in a child with worsening symptoms or failure to improve in 72 hours, then clinicians may change the antibiotic therapy for the child initially managed with antibiotic OR initiate antibiotic treatment of the child initially managed with observation (Evidence Quality: Grade D; Option based on expert opinion, case reports, and reasoning from first principles).

**KAS Profile 5B**

Aggregate evidence quality: D; expert opinion and reasoning from first principles
Benefit: Prevention of complications, administration of effective therapy
Harm: Adverse effects of secondary antibiotic therapy
Cost: Direct cost of medications, often substantial for second-line agents
Benefits-harm assessment: Preponderance of benefit
Value judgments: Clinician must determine whether cost and adverse effects associated with change in antibiotic is justified given the severity of illness.
Role of patient preferences: Limited in patients whose symptoms are severe or worsening but caregivers of mildly affected children who are failing to improve may reasonably defer change in antibiotic.
Intentional vagueness: None
Exclusions: None
Strength: Option

Definitions:

Definitions for Evidence-Based Statements

<table>
<thead>
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<th>Definition</th>
<th>Implication</th>
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<td>Strong recommendation</td>
<td>A strong recommendation in favor of a particular action is made when the anticipated benefits of the recommended intervention clearly exceed the harms (as a strong recommendation against an action is made when the anticipated harms clearly exceed the benefits) and the quality of the supporting evidence is excellent. In some clearly identified circumstances, strong recommendations may be made when high-quality evidence is impossible to obtain and the anticipated benefits strongly outweigh the harms.</td>
<td>Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.</td>
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<td>Clinicians would be prudent to follow a recommendation but should remain alert to new information and sensitive to patient preferences.</td>
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<td>Options define courses that may be taken when either the quality of evidence is suspect or carefully performed studies have shown little clear advantage to 1 approach over another.</td>
<td>Clinicians should consider the option in their decision-making, and patient preference may have a substantial role.</td>
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<td>No recommendation indicates that there is a lack of pertinent published evidence and that the anticipated balance of benefits and harms is presently unclear.</td>
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Evidence Quality

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Clinical Algorithm(s)
None provided

Scope

Disease/Condition(s)
Acute bacterial sinusitis

Guideline Category
Diagnosis
Evaluation
Management
Treatment

Clinical Specialty
Allergy and Immunology
Family Practice
Infectious Diseases
Otolaryngology
Pediatrics
Preventive Medicine

Intended Users
Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians
Guideline Objective(s)
To update the American Academy of Pediatrics clinical practice guideline regarding the diagnosis and management of acute bacterial sinusitis in children and adolescents

Target Population
Children, aged 1 to 18 years, with acute bacterial sinusitis

Note: This guideline does not consider neonates and children younger than 1 year or children with anatomic abnormalities of the sinuses, immunodeficiencies, cystic fibrosis, or primary ciliary dyskinesia.

Interventions and Practices Considered

Diagnosis/Evaluation
- Physical examination and evaluation of symptoms
- Contrast-enhanced computed tomography (CT) or magnetic resonance imaging (MRI) when child is suspected of having orbital or central nervous system complications

Management
- Outpatient observation for 3 days
- Antibiotic therapy
  - Amoxicillin with or without clavulanate
  - High-dose amoxicillin-clavulanate
  - Clindamycin and cefixime OR linezolid and cefixime OR levofloxacin
- Reassess initial management if worsening or failure to improve reported

Major Outcomes Considered
- Symptom severity
- Child's quality of life
- Cost of antibiotics
- Ease of administration
- Caregiver concerns about potential adverse effects of antibiotics
- Persistence of respiratory symptoms, or development of complications

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Searches of PubMed were performed by using the same search term as in the 2001 report. All searches were limited to English-language and human studies. Three separate searches were performed to maximize retrieval of the most recent and highest-quality evidence for pediatric sinusitis. The first limited results to all randomized controlled trials (RCTs) from 1966 to 2009, the second to all meta-analyses from 1966 to 2009, and the third to all pediatric studies (limited to ages <18 years) published since the last technical report (1999–2009). Additionally, the Web of Science was queried to identify studies that
cited the original American Academy of Pediatrics (AAP) guidelines. This literature search was replicated in July 2010 and November 2012 to capture recently published studies. The complete results of the literature review are published separately in the technical report (see the “Availability of Companion Documents”).

17 randomized studies of sinusitis in children were identified and reviewed. Only 3 trials met inclusion criteria. Because of significant heterogeneity among these studies, formal meta-analyses were not pursued.

**Number of Source Documents**

17 randomized studies of sinusitis in children were identified and reviewed. Only 3 trials met inclusion criteria.

**Methods Used to Assess the Quality and Strength of the Evidence**

**Weighting According to a Rating Scheme (Scheme Given)**

**Rating Scheme for the Strength of the Evidence**

**Evidence Quality**

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<td>C. Observational studies (case-control and cohort design)</td>
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<td>D. Expert opinion, case reports, reasoning from first principles</td>
<td>Option</td>
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<td>X. Exceptional situations where validating studies cannot be performed and there is a clear preponderance of benefit or harm</td>
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**Methods Used to Analyze the Evidence**

Systematic Review

**Description of the Methods Used to Analyze the Evidence**

The results from the literature review were used to guide development of the key action statements included in this document. These action statements were generated by using BRIDGE-Wiz (Building Recommendations in a Developers Guideline Editor, Yale School of Medicine, New Haven, CT), an interactive software tool that leads guideline development through a series of questions that are intended to create a more actionable set of key action statements. BRIDGE-Wiz also incorporates the quality of available evidence into the final determination of the strength of each recommendation.
Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

In June 2009, the American Academy of Pediatrics (AAP) convened a new subcommittee to review and revise the clinical practice guideline published by the AAP in 2001. It was developed by a subcommittee of the Steering Committee on Quality Improvement and Management that included physicians with expertise in the fields of primary care pediatrics, academic general pediatrics, family practice, allergy, epidemiology and informatics, pediatric infectious diseases, pediatric otolaryngology, radiology, and pediatric emergency medicine.

The AAP policy statement "Classifying Recommendations for Clinical Practice Guidelines" was followed in designating levels of recommendations. Definitions of evidence-based statements are provided (see the "Rating Scheme for the Strength of the Recommendations" field).

Rating Scheme for the Strength of the Recommendations

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Cost Analysis
The guideline developers reviewed published cost analyses.

Method of Guideline Validation
External Peer Review
Internal Peer Review

Description of Method of Guideline Validation
This guideline was reviewed by multiple groups in the American Academy of Pediatrics (AAP) and 2 external organizations. Comments were compiled and reviewed by the subcommittee, and relevant changes were incorporated into the guideline.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations
The type of supporting evidence is specifically stated for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits
Accurate diagnosis of acute bacterial sinusitis, appropriate use of imaging procedures, and judicious use of antibiotics

Potential Harms
- Adverse effects of antibiotic therapy, including hypersensitivity, allergic reactions and bacterial resistance
- Observation may prolong illness and delay start of needed antibiotic therapy.
- Exposure to ionizing radiation for computed tomography (CT) scans and the need for sedation for magnetic resonance imaging (MRI)
- Inappropriate diagnosis may lead to unnecessary treatment. A missed diagnosis may lead to persistent infection or complications.

Qualifying Statements

Qualifying Statements
The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)


Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2001 Sep (revised 2013 Jul)

Guideline Developer(s)

American Academy of Pediatrics - Medical Specialty Society

Source(s) of Funding

The American Academy of Pediatrics (AAP) has neither solicited nor accepted any commercial involvement in the development of the content of this publication. Only money from the AAP was used to fund the development of the guideline.
Guideline Committee
Subcommittee on Management of Sinusitis

Composition of Group That Authored the Guideline

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*Consultant:* Richard N. Shiffman, MD, FAAP

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Financial Disclosures/Conflicts of Interest

All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors.

None of the participants had financial conflicts of interest.

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Guideline Availability


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Availability of Companion Documents

The following is available:


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Patient Resources
NGC Status

This summary was completed by ECRI on November 16, 2001. The information was verified by the guideline developer as of December 5, 2001. This summary was updated by ECRI Institute on September 13, 2013. This summary was updated by ECRI Institute on May 18, 2016 following the U.S. Food and Drug Administration advisory on Fluoroquinolone Antibacterial Drugs. This summary was updated by ECRI Institute on February 15, 2017 following the U.S. Food and Drug Administration advisory on general anesthetic and sedation drugs.

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