Infectious disease society of america guidelines lyme

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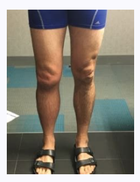
CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION



CLOSTRIDIUM DIFFICILE GUIDELINES
IDSA/SHEA 2018

Who to test?	**Patients with UNEXPLAINED and new-onset ≥3 unformed stools in 24 hours are the preferred target population for testing for CDI** (weak recommendation, very low evidence)		
Which test to use?	**Use a stool toxin test as part of a multistep algorithm (ex: NAAT plus toxin) rather than a NAAT alone for all specimens** (weak recommendation, low evidence).		
Repeat testing	**Do not perform repeat testing (within 7 days) during the same episode of diarrhea and do not test stool from asymptomatic patients, except for epidemiological studies** (strong recommendation, moderate evidence).		
Testing children?	**Only test children ≥2 years of age with prolonged or worsening diarrhea and risk factors (eg, underlying inflammatory bowel disease or immunocompromising conditions) or relevant exposures** (weak recommendation, moderate evidence		
Do I really have to wash my hands with soap?	**Wash hands with soap and water or alcohol based sanitizer after removing gloves** (strong recommendation, moderate quality of evidence) **unless touching areas with risk for direct contact with feces, then wash hands with soap and water** (good practice recommendation).		
C diff prevention	**Minimize the frequency and duration of antibiotics** (strong recommendation, moderate evidence) **Restriction of fluoroquinolones, clindamycin, and cephalosporins (except for surgical antibiotic prophylaxis) should be considered** (strong recommendation, moderate evidence). **Insufficient evidence for the use of probiotics to prevent primary infection**		
Treatment	**Initial, non severe**	WBC ≤15K creatinine <1.5 mg/dL	**Vancomycin 125 mg PO 4x/day for 10 days** *or* **Fidaxomicin 200 mg PO 2x/day for 10 days** *or* **Metronidazole 500 mg PO 3x/day for 10 days if above unavailable** (lower cure rate but only $21 vs $1000 for vancomycin or $3000 for fidaxomicin)
	Initial, severe	WBC >15K, Cr>1.5	**Same as above except no metronidazole**
	Initial, fulminant	Hypotension or shock, ileus, megacolon	**Vancomycin 500 mg PO 4x/day (AND rectal if ileus)** *And* **Metronidazole 500 mg IV 3x/day** **May need subtotal colectomy or diverting ileostomy**
	Recurrence	**1st: metronidazole or Vancomycin PO** **2nd: vancomycin or fidaxomicin PO, consider fecal transplant**	

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COMMUNITY ACQUIRED PNEUMONIA
IDSA/ATS 2019 Guidelines

ANTIBIOTICS	**Outpatient**	**Healthy**	**Amoxicillin 1 g TID** **Or** **Doxycycline 100 mg BID** **Or** **Azithromycin 500 mg 1st day then 250 mg QD ONLY if resistance <25%**
		Comorbidities (alcoholism, malignancy, chronic liver/renal/lung disease, diabetes, asplenia	**Amoxicillin/clauvulanate 875 mg/125mg BID or cephalosporin** **AND** **Macrolide (azithromycin) or Doxycycline 100 mg BID** **OR** **Respiratory fluoroquinolone Monotherapy (levofloxacin / moxifloxacin / gemifloxacin)**
	Inpatient	**Severe or non-severe CAP but no risk factors for MRSA / pseudomonas (empirically treated, history of prior MRSA/ pseudomonas infection, or hospitalized w/IV antibiotics in past 90 days).**	**Beta-lactam + Macrolide (e.g. ceftriaxone + azithromycin)** **OR** **Respiratory fluoroquinolone Monotherapy (levofloxacin / moxifloxacin / gemifloxacin)** **OR** **Beta-lactam + Doxycycline**
		Inpatient with locally validated risk factors for MRSA or pseudomonas	**MRSA - vancomycin** **Pseudomonas - piperacillin-tazobactam or cefipime**
		Suspected aspiration	**Do not routine add anaerobic coverage unless lung abscess or empyema suspected**
Steroids	**Inpatient**	**Not routinely recommended in non-severe CAP (strong recommendation, high quality evidence) or severe CAP (conditional recommendation, moderate quality evidence)**	

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Social impact of lyme disease. Is lyme disease recognized by the cdc. Infectious disease society of america lyme guidelines. Infectious agent of lyme disease. Infectious disease society of america cap guidelines.

Untreated Lyme disease can produce a wide range of symptoms, depending on the stage of infection. These include fever, rash, facial paralysis, and arthritis. Early Signs and Symptoms (3 to 30 Days After Tick Bite) Fever, chills, headache, fatigue, muscle and joint aches, and swollen lymph nodes may occur in the absence of rash Erythema migrans (EM) rash: Occurs in approximately 70 to 80 percent of infected persons Begins at the site of a tick bite after a delay of 3 to 30 days (average is about 7 days) Expands gradually over several days reaching up to 12 inches or more (30 cm) across May feel warm to the touch but is rarely itchy or painful Sometimes clears as it enlarges, resulting in a target or “bull’s-eye” appearance May appear on any area of the body Does not always appear as a “classic” erythema migrans rash Later Signs and Symptoms (days to months after tick bite) Severe headaches and neck stiffness Additional EM rashes on other areas of the body Facial palsy (loss of muscle tone or droop on one or both sides of the face) Arthritis with severe joint pain and swelling, particularly the knees and other large joints. Intermittent pain in tendons, muscles, joints, and bones Heart palpitations or an irregular heart beat (Lyme carditis) Episodes of dizziness or shortness of breath Inflammation of the brain and spinal cord Nerve pain Shooting pains, numbness, or tingling in the hands or feet Signs and symptoms of untreated Lyme disease Looking for a bull's-eye rash? What should I do if I think I might have Lyme disease? If you believe you may have Lyme disease, consult with a healthcare provider for evaluation and diagnosis. If you have the tick that was attached to you, bring it with you to your appointment as the physician may be able to properly identify it. Alternatively, Michigan Department of Health and Human Services can also identify the tick(s) at no cost (see below). How is Lyme disease diagnosed? Lyme disease is diagnosed based on signs and symptoms in addition to a history of possible exposure to infected blacklegged ticks. A healthcare provider may order laboratory blood tests for those individuals experiencing symptoms of Lyme disease in order to assist in proper diagnosis. Additionally, Michigan Department of Health and Human Services offers testing at no cost to Michigan citizens, when ordered through their healthcare provider (see link below for information), MDHHS BOL Mosquito-Borne and Tick-Borne Disease Testing What should I do if I have a tick that I want to have identified? Knowing what kind of tick bit you may be important in knowing what your risk of disease is. The Michigan Department of Health and Human Services (MDHHS) provides tick identification at no charge to Michigan citizens. There are two ways to have a tick identified, 1) By submitting a photo of your tick, or, 2) by sending the tick to the MDHHS for microscopic identification. Click HERE for instructions on how to submit a photo of your tick for identification Click HERE for instructions on how to ship a tick to the MDHHS for microscopic identification MDHHS Bureau of Laboratories - Lab Services Guide Lyme disease information for clinicians For guidelines, a webinar, and resources please see our Lyme information webpage. Early diagnosis and proper antibiotic treatment of Lyme disease is important and can help prevent late Lyme disease. The following treatment regimens reflect CDC’s interpretation of the most current data for four important manifestations of Lyme disease. These regimens are consistent with guidance published by the by the Infectious Disease Society of America, American Academy of Neurology, and American College of Rheumatology. Erythema migrans Neurologic Lyme disease Lyme carditis Lyme arthritis Some patients report persistent symptoms of pain, fatigue, or difficulty thinking even after treatment for Lyme disease. The state of the science relating to persistent symptoms associated with Lyme disease is limited, emerging, and unsettled. Additional research is needed to better understand how to treat, manage, and support people with persistent symptoms associated with Lyme disease. In light of these research gaps, recommendations for treatment of persistent symptoms in people previously treated for Lyme disease are not provided here. Incidence Most common tick borne disease in North America Cases in U.S. in 1994: 13,000 Cases in U.S. in 1999: 16,000 Cases in U.S. in 2006: 20,000 Cases in U.S. in 2014: 19,985 Annual Incidence in endemic areas: 0.5% Peak occurrence in North America: May to August DemographicsGender: Much more common in malesAge: Bimodal peak distribution (ages 5-9 and 55-59 years old) Geographic areas involvedWorldwide cases have occurred in Canada, Europe, AsiaU.S. cases clustered in Northeast and Upper Midwest (90% of U.S. cases)High-Risk StatesConnecticut (Nantucket County: 1198 case/100,000)DelawareMarylandNew JerseyNew YorkPennsylvaniaRhode IslandWisconsinModerate-Risk StatesMaineMassachusettsMinnesotaNew HampshireVermontReference(1995) MMWR Morb Mortal Wkly Rep 44:459-62 [PubMed] Concurrent Lyme and Babesiosis is common (n=1156) 1975: Lyme Disease first reported in Lyme, ConnecticutCluster of new cases of Arthritis in children 1981: Borrelia Burgdorferi identified as cause Borrelia BurgdorferiCausative Spirochete organismCarried by white tail deerTransmitted by Deer TicksNatural reservoirsWhite-footed mouse and other small mammals Deer Ticks or Black Legged Tick Deer Ticks have two year life cycle:Egg to LarvaLarva to NymphNymph to Adult In endemic areas:Nymphs infected: 12-30%Adult ticks infected: 28-65% Nymphs outnumber adult ticks 10:1Nymphs are responsible for 90% of Lyme Disease casesTransmission relies on the time it takes for Borrelia to migrate from tick midgut to its Salivary GlandsNymphs must attach for >36-48 hours for transmissionAdult ticks must attach for >48-72 hours for transmission Lyme urine AntigenHigh False Positive Rate and not recommended Borrelia Burgdorferi IgG and IgMPersists for years following effective antibiotic treatmentPositive test after treatment does not indicate failed antibiotics or chronic infection Consider Lyme Disease in unexplained symptoms (Arthralgias, focal weakness) despite lack of bite history Information based on IDSA and CDC guidelinesIDSA: Infectious Disease Society of AmericaIDSA is considered standard of care recommendationsTertiary centers (e.g. Mayo) follow these guidelines Other guidelines (e.g. ILADS) are not reviewed hereILADS: International Lyme and Associated DiseasesILADS guidelines are considered controversial Antibiotic treatment risks Jarisch-Herxheimer Reaction (affects 15% of patients) Doxycycline (Avoid in pregnancy and under age 9 years)Preferred oral agent due to cross-coverage of other tick-borne infectionsAdult: 100 mg orally twice daily for 10 to 21 days (typically 14 days per CDC)Child (age >8): 4 mg/kg orally divided twice daily (max 100 mg/dose) for 10-21 days (typically 14 days per CDC) Amoxicillin Adult: 500 mg orally three times daily for 14 to 21 days (typically 21 days per CDC) Child: 50 mg/kg/day divided three times daily (max 500 mg/dose) for 14 to 21 days (typically 21 days per CDC) Cefuroxime (Ceftin)Adult: 500 mg orally twice daily for 14 to 21 daysChild: 30 mg/kg/day divided twice daily (max: 500 mg/dose) for 14 to 21 days Macrolides have lower efficacy (consider other agents above if possible)Use only if allergic to above agentsAzithromycinAdult: 500 mg daily for 10 daysChild: 10 mg/kg daily for 10 daysClarithromycinAdult: 500 mg orally twice daily for 21 daysChild: 7.5 mg/kg (max: 500 mg/dose) orally twice daily for 21 daysErythromycinAdult: 500 mg orally four times daily for 21 daysChild: 12.5 mg/kg (max 500 mg/dose) orally four times daily for 21 days If suspect Cellulitis versus Erythema MigransAugmentin 50 mg/kg/day divided bid or tid (up to 875 mg twice daily)Cefuroxime 30 mg/kg/day divided twice daily (up to 500 mg twice daily)Doxycycline 4 mg/kg divided twice daily (up to 100 mg twice daily) Antibiotics to avoid (not indicated) Post-Lyme Disease Syndrome Criteria (reported in 10-20% of cases)Persistent vague symptoms >6 months after completing treatment CausesIdiopathic in most casesUntreated comorbid tickborne illness (e.g. Babesiosis)Comorbid unrelated medical condition ManagementProlonged antibiotic use is not recommended (beyond specific indications as above) May 20, 2021 Lyme disease symptoms can affect any system in the body and can mimic symptoms of many different diseases. There is significant controversy in science, medicine, and public policy regarding Lyme disease. Two medical societies hold widely divergent views on the best approach to diagnosing and treating Lyme disease. The conflict makes it difficult for patients to be properly diagnosed and receive treatment.One medical society, the Infectious Diseases Society of America (IDSA), regards Lyme disease as “hard to catch and easy to cure” with a short course of antibiotics. IDSA claims that spirochetal infection cannot persist in the body after a short course of antibiotics. The group also denies the existence of chronic Lyme disease.In contrast, the International Lyme and Associated Diseases Society (ILADS), regards Lyme disease as often difficult to diagnose and treat, resulting in persistent infection in many patients. ILADS recommends individualized treatment based on the severity of symptoms, the presence of tick-borne coinfections and patient response to treatment.LDo believes that patients and their doctors should make Lyme disease treatment decisions together. This requires that patients be given sufficient information about the risks and benefits of different treatment options. Then, patient and health care provider can collaborate to reach an informed decision, based on the patient’s circumstances, beliefs and preferences.LDo endorses the ILADS guidelines, which allow greater exercise of clinical discretion by physicians and provide patients with more treatment options. It is the doctor’s responsibility to tell patients about the different treatment options so that patients can make an informed choice.Early Lyme Disease TreatmentILADS doctors are likely to recommend more aggressive and longer antibiotic treatment for patients. They may, for instance, treat “high risk” tick bites where the tick came from an endemic area, was attached a long time, and was removed improperly. They may treat a Lyme rash for a longer period of time than the IDSA recommends, to ensure that the disease does not progress. They are unlikely to withhold treatment pending laboratory test results.Late or Chronic Lyme Disease TreatmentExperts agree that the earlier you are treated the better, since early treatment is often successful. Unfortunately, a substantial portion of patients treated with short-term antibiotics continue to have significant symptoms. The quality of life of patients with chronic Lyme disease is similar to that of patients with congestive heart failure. Doctors don’t agree about the cause of these ongoing symptoms. The primary cause of this debate is flawed diagnostic testing. There is currently no test that can determine whether a patient has active infection or whether the infection has been eradicated by treatment.The IDSA thinks Lyme disease symptoms after treatment represent a possibly autoimmune, “post-Lyme syndrome” that is not responsive to antibiotics. The IDSA essentially regards Lyme disease as an acute infection like strep throat that can be treated with a short course of antibiotics. The IDSA guidelines are now eight years old and do not reflect recent science.ILADS physicians believe that ongoing symptoms probably reflect active infection, which should be treated until the symptoms have resolved. These physicians use treatment approaches employed for persistent infections like tuberculosis, including a combination of drugs and longer treatment durations. The ILADS guidelines have just recently been updated using a rigorous review of the medical literature.The ideal antibiotics, route of administration and duration of treatment for persistent Lyme disease are not established. No single antibiotic or combination of antibiotics appears to be capable of completely eradicating the infection, and treatment failures or relapses are reported with all current regimens, although they are less common with early aggressive treatment.All medical treatments have risks associated with them. While the safety profile of antibiotics is generally quite good, only the patient (in consultation with his or her physician) can determine whether the risks outweigh the potential benefits of any medical treatment.An ILADS doctor may consider the possibility of tick-borne coinfections, particularly if a patient does not respond to treatment or relapses when treatment is terminated. Other factors to consider are immune dysfunction caused by Lyme; silent, opportunistic infections enabled by the immune dysfunction; hormonal imbalance caused by Lyme; and other complications.Considerations while on Lyme treatmentAntibiotics can wipe out beneficial intestinal flora, leading to a wide variety of additional health problems. It is important to take probiotics while on antibiotics to maintain a healthy balance of gut bacteria. Furthermore, antibiotics may interact with other drugs, supplements or food. The National Institutes of Health’s MedLinePlus website gives information about drug interactions.

Lyme disease is caused by the bacterium Borrelia burgdorferi and is transmitted by the blacklegged tick. It is the most commonly reported vector-borne disease in the United States and it is spreading across the state of Michigan. ... These regimens are consistent with guidance published by the by the Infectious Disease Society of America ... Wormser GP, Dattwyler RJ, Shapiro ED, Halperin JJ, Steere AC, Klempner MS et al. The clinical assessment, treatment, and prevention of Lyme disease, human granulocytic anaplasmosis, and babesiosis: clinical practice guidelines by the Infectious Diseases Society of America. Clin Infect Dis 2006;43(9):1089-1134. 01/03/2022 · Neurologic Lyme disease; Lyme carditis; Lyme arthritis; Some patients report persistent symptoms of pain, fatigue, or difficulty thinking even after treatment for Lyme disease. The state of the science relating to persistent symptoms associated with Lyme disease is limited, emerging, and unsettled. 27/03/2018 · Furthermore, in the 2020 Guidelines for the Prevention, Diagnosis, and Treatment of Lyme, updated in February 2021 in Neurology, the Infectious Diseases Society of America, American Academy of ... 28/07/2022 · Antibiotic treatment risks Jarisch-Herxheimer Reaction (affects 15% of patients). Borrelia is a Spirochete with potential for similar reaction to antibiotics as for Syphilis; Manifests as increased Temperature,

myalgias and Arthralgias in first 24 hours of treatment; Doxycycline (Avoid in pregnancy and under age 9 years). Preferred oral agent due to cross-coverage of ... 01/03/2011 · Most Popular Guidelines. Surviving Sepsis Campaign: Management of Sepsis and Septic Shock 2021 . NEW. ... Disease-Modifying Therapies For Adults With Multiple Sclerosis ... PUBLISHED BY: AMERICAN SOCIETY OF REGIONAL ANESTHESIA AND PAIN MEDICINE PUBLISHED DATE: AUGUST 19, 2021 . SUMMARY. Diagnosis and Management of Non ... Lancet Infectious Disease. Published Online: 05 February 2016. ... page last reviewed: June 16, 2015. ↑ 3.0 3.1 3.2 Clinical Practice Guidelines by the Infectious Diseases Society of America, American Academy of Neurology, and American College of Rheumatology 2020 Guidelines for the Prevention, Diagnosis, and Treatment of Lyme Disease. Lantos ... 14/11/2009 · The selection of a physician should be made by you after careful consideration. There are two approaches in the treatment of Lyme disease. Our list contains physicians who generally follow more flexible treatment approaches than those advocated by the Infectious Diseases Society of America (IDSA).

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