

Table. Alternatives to IV Sulfamethoxazole/Trimethoprim in Selected Clinical Situations⁵⁻¹⁷

Infectious Organism ^a	Alternatives and Adult Dosing	Comments
<p><i>P. jiroveci</i> (formerly <i>P. carinii</i>) pneumonia in immunocompromised patients or HIV-infected patients, treatment</p>	<p><i>Mild to moderate infections</i> Sulfamethoxazole/trimethoprim 1,600 mg/320 mg (2 double-strength tablets) orally every 8 hours for 21 days.^{7,14}</p> <p>Atovaquone 750 mg orally twice daily for 21 days.^{5,7,14}</p> <p>Clindamycin 300 – 450 mg orally every 6 hours + primaquine 15 mg/day orally for 21 days.^{7,14}</p> <p>Dapsone 100 mg/day orally + trimethoprim 5 mg/kg orally 3 times daily for 21 days.^{5,7,14}</p> <p><i>Severe infections</i> Sulfamethoxazole/trimethoprim 15 – 20 mg/kg/day (based on trimethoprim content) orally given in 3 – 4 divided doses for 21 days.^{5,7,14}</p> <p>Clindamycin 600 mg IV every 8 hours + primaquine 30 mg/day orally for 21 days.^{5,7,14}</p> <p>Pentamidine isoethionate 4 mg/kg/day IV or IM for 14 – 21 days.^{5,7,14}</p>	<p>Sulfamethoxazole/trimethoprim is considered the drug of first choice for this indication.^{6,14}</p> <p>In patients with severe infections, give concomitant corticosteroids, starting 15 – 30 minutes before first antimicrobial dose. For oral therapy, administer prednisone 40 mg twice daily for 5 days, then 40 mg/day for 5 days, then 20 mg/day for 11 days. For patients who cannot take oral therapy, methylprednisolone may be given IV at 75% of the prednisone dose.^{7,14}</p>

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<i>Nocardia</i> infections	<p><i>Cutaneous infections</i> Sulfamethoxazole/trimethoprim 5 – 10 mg/kg/day (based on trimethoprim content) orally given in 2 – 4 divided doses.^{5,7}</p> <p>Linezolid 600 mg orally twice daily for 2 – 3 months.^{10,11}</p> <p><i>Severe infections</i> Sulfamethoxazole/trimethoprim 15 mg/kg/day (based on trimethoprim content) orally given in 2 – 4 divided doses for 3 – 4 weeks, then 10 mg/kg/day (based on trimethoprim content) orally given in 2 – 4 doses. Treatment is usually continued for an average of 7 months.⁵⁻⁷</p> <p>Brain abscess: Linezolid 600 mg orally twice daily for at least 3 months (12 months for immunocompromised patients).^{7,10,11}</p> <p>Pneumonia: Imipenem/cilastatin 500 mg IV every 6 hours + amikacin 7.5 mg/kg IV every 12 hours for 3 – 4 weeks, then switch to oral sulfamethoxazole/trimethoprim for at least 3 months (6 months for immunocompromised patients).⁷</p>	<p>Although the optimal agents for these infections is unclear, sulfamethoxazole/trimethoprim is often recommended.^{5,7}</p> <p>Consider conserving sulfamethoxazole/trimethoprim injection for use in patients with life-threatening <i>Nocardia</i> central nervous system infections. Initiate therapy with IV administration, then may switch to oral administration after 3 – 6 weeks.⁵⁻⁷</p>
<i>S. maltophilia</i> infections	<p>Other antimicrobials may be considered based on the results of susceptibility testing and local antibiograms.^{5,16}</p> <p>Levofloxacin 750 mg IV every 24 hours^{5-7,18}</p> <p>Minocycline 200 mg IV X 1 dose, then 100 mg IV every 12 hours.^{5-7,17}</p> <p>Ticarcillin/clavulanate 3.1 g (of combination product) IV every 4 hours, alone or combined with aztreonam^b 1 – 2 g IV every 6 – 8 hours.^{5-7,17}</p>	<p>Sulfamethoxazole/trimethoprim is considered the drug of first choice for this indication.^{5,17}</p> <p>Consider conserving sulfamethoxazole/trimethoprim injection for empiric use in patients with life-threatening <i>S. maltophilia</i> infections. Other antimicrobials may be considered based on the results of susceptibility testing.^{5,16}</p>

Infectious Organism ^a	Alternatives and Adult Dosing	Comments
<p><i>Burkholderia</i> infections, especially melioidosis</p>	<p><i>Patients without cystic fibrosis</i></p> <p><u>Initial therapy</u></p> <p>Ceftazidime 30 – 50 mg/kg (up to 2 g) IV every 8 hours for 10 – 14 days, then switch to oral therapy (see below).^{5,7,15}</p> <p>Imipenem/cilastatin 20 mg/kg (up to 1 g) IV every 6 hours or 25 mg/kg (up to 1 g) IV every 8 hours for 10 – 14 days, then switch to oral therapy (see below).^{5,7,15}</p> <p>Meropenem 25 mg/kg (up to 1 g) IV every 8 hours for 10 – 14 days, then switch to oral therapy (see below).^{5,7,15}</p> <p><u>Oral therapy (after IV therapy)</u></p> <p>Chloramphenicol 10 mg/kg orally every 6 hours for 8 weeks.⁷</p> <p>Doxycycline 2 mg/kg orally twice daily for 20 weeks.^{7,12}</p> <p>Sulfamethoxazole/trimethoprim 5 – 8 mg/kg (based on trimethoprim content) orally twice daily for 12 – 20 weeks.^{7,12,15}</p> <p><i>Pulmonary exacerbation of cystic fibrosis</i></p> <p>Chloramphenicol 15 – 20 mg/kg IV or orally every 6 hours.⁷</p>	<p>For melioidosis, initiate therapy with IV administration for 10 – 14 days, then may switch to oral antimicrobial therapy and continue for another 12 – 20 weeks.^{7,12,15}</p>
<p><i>Cyclospora</i> infections</p>	<p>Sulfamethoxazole/trimethoprim 800 mg/160 mg (1 double-strength tablet) orally twice daily for 7 – 10 days.^{5,7}</p> <p>Ciprofloxacin 500 mg orally twice daily for 7 days, then 500 mg orally 3 times weekly for 2 – 10 weeks.^{7,13}</p> <p>Nitazoxanide 500 mg orally every 12 hours for 7 days.^{7,9}</p>	<p>The Centers for Disease Control and Prevention (CDC) considers sulfamethoxazole/trimethoprim the drug of first choice for this indication. The CDC states that there are no consistently effective alternatives for these infections.⁸</p>

^a Organisms are listed in order from most commonly to least commonly treated with sulfamethoxazole/trimethoprim.

^b Some presentations of aztreonam are currently in short supply.¹⁹⁻²¹