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Keep a “Watch and Wait” Approach for Acute Sinusitis

Updated guidelines suggest “watchful waiting” for even more adult patients with acute bacterial rhinosinusitis (ABRS).

We know that antibiotics aren’t often needed for acute UNcomplicated sinusitis (cases without spread to the brain, eyes, etc).

Most sinusitis cases are viral...and resolve on their own in a week or so. But suspect a bacterial cause if symptoms persist for at least 10 days without improvement or start to worsen after initially improving.

Before, antibiotics were sometimes started ASAP for ABRS with SEVERE symptoms (fever of 102ºF or higher, purulent nasal discharge, etc).

Now, new guidelines recommend watchful waiting for 3 to 5 days withOUT antibiotics in most healthy adults after ABRS diagnosis, regardless of severity...with assurance of follow-up.

For patients hesitant about waiting, explain that antibiotics carry risks...*C. diff*, drug interactions, resistance, etc. In the meantime, encourage supportive measures (analgesics, fluids, nasal steroids, etc).

Lean toward oxymetazoline nasal spray in patients wanting to try a decongestant. It has more data than pseudoephedrine...but the evidence isn’t strong for either. Remind patients to limit use to 3 days or less.

If antibiotics are needed, stick with prescribing amoxicillin or amoxicillin/clavulanate first. Both cover *S. pneumoniae*.

Consider amoxicillin for most healthy patients with mild to moderate symptoms...since amoxicillin/clavulanate has more GI side effects.

But go with amoxicillin/clavulanate for moderate to severe symptoms, immunocompromised patients, or if there’s a chance of bacterial resistance (beta-lactamase producing *H. influenzae* or *M. catarrhalis*, etc).

Reserve high-dose amoxicillin/clavulanate XR (2 g/125 mg po bid) for patients at risk of penicillin-resistant *S. pneumoniae* infections (severe symptoms, age over 65, recent hospitalization or antibiotic use, etc).

Stick with doxycycline if patients have anaphylaxis to penicillins. And consider cefixime or cefpodoxime...with or without clindamycin...for milder reactions (rash, etc).

Save respiratory quinolones (levofloxacin, moxifloxacin) as a last resort...due to QT prolongation, tendon rupture, etc. And continue to avoid macrolides or TMP/SMX...due to increased *S. pneumoniae* resistance.

Favor treating 5 to 7 days instead of 10...success rates are similar and side effects are less likely. Post our resource, *Antibiotic Therapy: When Are Shorter Courses Better?* as a quick reference.

Key References:

-Payne SC, McKenna M, Buckley J, et al. Clinical Practice Guideline: Adult Sinusitis Update. Otolaryngol Head Neck Surg. 2025 Aug;173 Suppl 1:S1-S56.
-Cleveland Clinic. Sinus Infection (Sinusitis). March 3, 2023. https://my.clevelandclinic.org/health/diseases/17701-sinusitis (Accessed September 4, 2025).

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