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Appendix

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Chang AB, Bell SC, Torzillo PJ, et al; and the extended voting group. Chronic suppurative lung disease and bronchiectasis in children and adults in Australia and New Zealand: Thoracic Society of Australia and New Zealand guidelines. *Med J Aust* 2015; 202: 21-23. doi: 10.5694/mja14.00287.

Box-3

	Mild-moderate exacerbation (oral therapy)^	**Moderate to severe exacerbation (IV therapy)^**
Initial empiric therapy*	Children: amoxycillin, amoxycillin-clavulanate Adults: amoxycillin, amoxycillin-clavulanate or doxycycline† Children and adults: ciprofloxacin if *P. aeruginosa* in recent cultures.	Children and adults: ampicillin, cefotaxime or ceftriaxone (amoxycillin, amoxycillin-clavulanate, or cefuroxime‡) Children and adults: piperacillin-tazobactam, ticarcillin-clavulanate, or ceftazidime ± tobramycin§ if severe or *P. aeruginosa* in recent cultures.
Specific pathogens		
H. influenzae β-lactamase–ve β-lactamase +ve	 amoxycillin amoxycillin-clavulanate or doxycycline†	 ampicillin (amoxycillin‡) cefotaxime or ceftriaxone (amoxycillin-clavulanate or cefuroxime‡),
S. pneumoniae	amoxycillin	benzylpenicillin G, ampicillin (amoxycillin‡)
M. catarrhalis	amoxycillin-clavulanate	cefotaxime or ceftriaxone (amoxycillin-clavulanate, or cefuroxime‡)
S. aureus MRSA	di-/flucloxacillin seek specialist advice¶	flucloxacillin seek specialist advice¶
P. aeruginosa	ciprofloxacin (max 14 days)	Children and adults: piperacillin-tazobactam, ticarcillin-clavulanate, or ceftazidime ± tobramycin§
NTM	seek specialist advice ¶	seek specialist advice¶

*In addition to clinical severity, initial empiric therapy is also guided by previous lower airway culture results (sputum, BAL/bronchoscopy washings), local antibiotic susceptibility patterns and prior responses to antibiotic treatments. In children too young to expectorate sputum and when no previous lower airway culture results are available, prescribed empiric antibiotic therapy should be active against *H. influenzae, S. pneumoniae and M. catarrhalis*.
^Seek local specialist advice if a history of antibiotic hypersensitivity or severe adverse antibiotic effects exists and when serious drug interactions may occur. Aminoglycosides, macrolides and fluoroquinolones in particular should be used with care in the elderly. †Doxycycline is used only in adults and adolescents; ‡Available only in New Zealand; §Although treating *P. aeruginosa* bacteraemia with combined beta-lactam and aminoglycoside antibiotic therapy provides no additional clinical benefit and is associated with more adverse events than using a single beta-lactam agent, the role of single beta-lactam therapy for non-bacteraemic *P. aeruginosa* pneumonia and other respiratory infections is unproven. Combination therapy should still be used when multi-resistant *P. aeruginosa* strains are detected. ¶Specialist advice is required for treating MRSA in accordance with local susceptibility patterns and infection control policies. The decision of when to treat NTM and what agents to use is complicated by the high levels of antibiotic resistance shown by these strains and the need for prolonged therapeutic courses involving multiple drug combinations that risk serious toxicity and drug interactions.