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2024–2027 Report of the Committee on Infectious Diseases

Errata

(02/26/2025)

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Erratum Date: 7/24/2024

Page 813: https://doi.org/10.1542/9781610027373-S3_018_013

In Table 3.68 in the "*Streptococcus pneumoniae* (Pneumococcal) Infections" chapter, the breakpoint for CEFOTAXIME OR CEFTRIAXONE in the Meningitis listing under the first column, "Susceptible" has been corrected from <0.5 to ≤0.5. The updated table appears below and a revised page 813 appears on page 3 of this Errata.:

Table 3.68. Minimum Inhibitory Concentration Breakpoints (μg/mL) for *Streptococcus pneumoniae*, by Susceptibility Category, as per the Clinical and Laboratory Standards Institute

	Susceptibility category MIC (μg/mL)		
	Susceptible	**Intermediate**	**Resistant**
PENICILLIN			
Breakpoints (by clinical syndrome and administered route)			
Nonmeningitis, oral penicillin	≤0.06	0.12–1	≥2
Nonmeningitis, IV penicillin	≤2	4	≥8
Meningitis, IV penicillin	≤0.06	—	≥0.12
CEFOTAXIME OR CEFTRIAXONE			
Breakpoints (by clinical syndrome and administered route)			
Nonmeningitis	≤1	2	≥4
Meningitis	≤0.5	1	≥2

IV indicates intravenous; MIC, minimal inhibitory concentration; —, no intermediate category for meningitis.

From Clinical and Laboratory Standards Institute (CLSI). Performance Standards for Antimicrobial Testing; 29th Informational Supplement. Wayne, PA: Clinical and Laboratory Standards Institute; 2019. CLSI document M100-S29.

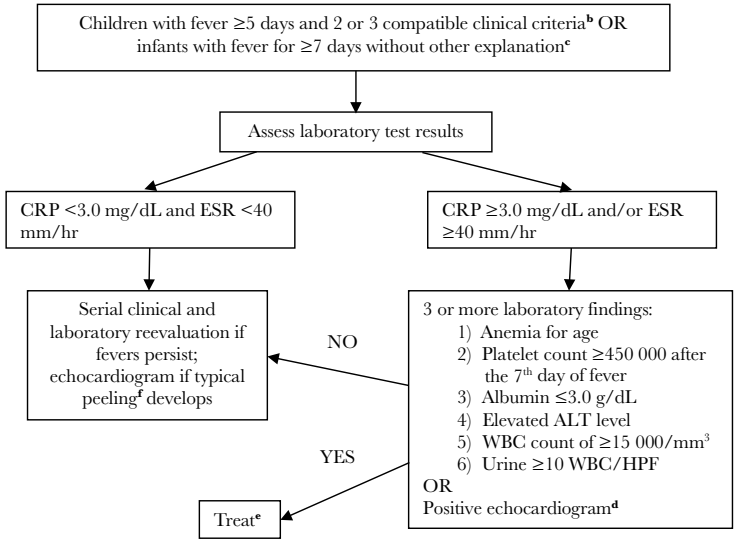
Erratum Date: 2/26/2025

Page 524: https://doi.org/10.1542/9781610027373-S3_010_001

In Figure 3.13 in the "Kawasaki Disease" chapter, the box that reads: CRP ≥3.0 mg/dL and ESR ≥40 mm/hr has been updated to read: CRP ≥3.0 mg/dL and/or ESR ≥40 mm/hr.

The updated figure appears below and a revised page 524 appears on page 4 of this Errata.:

Fig 3.13. Evaluation of suspected incomplete Kawasaki disease[a]



CRP indicates C-reactive protein; ESR, erythrocyte sedimentation rate; ALT, alanine aminotransferase; WBC, white blood cell; HPF, high-powered field.

[a] In the absence of a "gold standard" for diagnosis, this algorithm cannot be evidence based but rather represents the informed opinion of the expert committee. Consultation with an expert should be sought anytime assistance is needed.

[b] See text for clinical findings of Kawasaki disease.

[c] Infants ≤6 months of age are the most likely to develop prolonged fever without other clinical criteria for Kawasaki disease; these infants are at particularly high risk of developing coronary artery abnormalities.

[d] Echocardiography is considered positive for purposes of this algorithm if any of 3 conditions are met: Z score of left anterior descending coronary artery or right coronary artery ≥2.5; coronary artery aneurysm is observed; or ≥3 other suggestive features exist, including decreased left ventricular function, mitral regurgitation, pericardial effusion, or Z scores in left anterior descending coronary artery or right coronary artery of 2 to 2.5.

[e] Treatment should be given within 10 days of fever onset. See text for indications for treatment after the tenth day of fever.

[f] Typical peeling begins under the nail beds of fingers and toes.

Source: McCrindle BW, Rowley AH, Newburger JW, et al; American Heart Association Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee of the Council on Cardiovascular Disease in the Young; Council on Cardiovascular and Stroke Nursing; Council on Cardiovascular Surgery and Anesthesia; and Council on Epidemiology and Prevention. Diagnosis, treatment, and long-term management of Kawasaki disease: a scientific statement for health professionals from the American Heart Association. *Circulation.* Published online March 29, 2017; **www.ahajournals.org/doi/full/10.1161/CIR.0000000000000484**

Detection of C-polysaccharide (common to all pneumococci) in urine for diagnosis of pneumococcal pneumonia may have some utility in adults but is generally not useful in children, because asymptomatically colonized children may have positive test results. Similarly, commercially available antigen detection tests performed on CSF or blood are not recommended for routine use because of low sensitivity.

Susceptibility Testing. All *S pneumoniae* isolates from normally sterile body fluids should be tested for antimicrobial susceptibility to determine the minimum inhibitory concentration (MIC) of penicillin, cefotaxime or ceftriaxone, and clindamycin. Susceptibility threshold breakpoints of *S pneumoniae* isolated from blood differ for CSF isolates (Table 3.68) as defined by the Clinical and Laboratory Standards Institute (CLSI). CSF isolates also should be tested for susceptibility to vancomycin, meropenem, and rifampin. Nonsusceptible strains can also be evaluated for susceptibility to erythromycin, trimethoprim-sulfamethoxazole, levofloxacin, and linezolid to treat various pneumococcal infections.

TREATMENT:

***Bacterial Meningitis Possibly or Proven to Be Caused by* S pneumoniae.** For children with bacterial meningitis possibly or known to be caused by *S pneumoniae*, vancomycin should be administered in addition to third-generation cephalosporin because of the possibility of *S pneumoniae* organisms that are nonsusceptible to penicillin and third-generation cephalosporins. In neonates, when cefotaxime is not available then ceftazidime or cefepime can be used in addition to vancomycin. Vancomycin should be stopped if susceptibility to third-generation cephalosporins is documented (using central nervous system [CNS] breakpoints for thresholds of susceptibility, as defined in Table 3.68), if another

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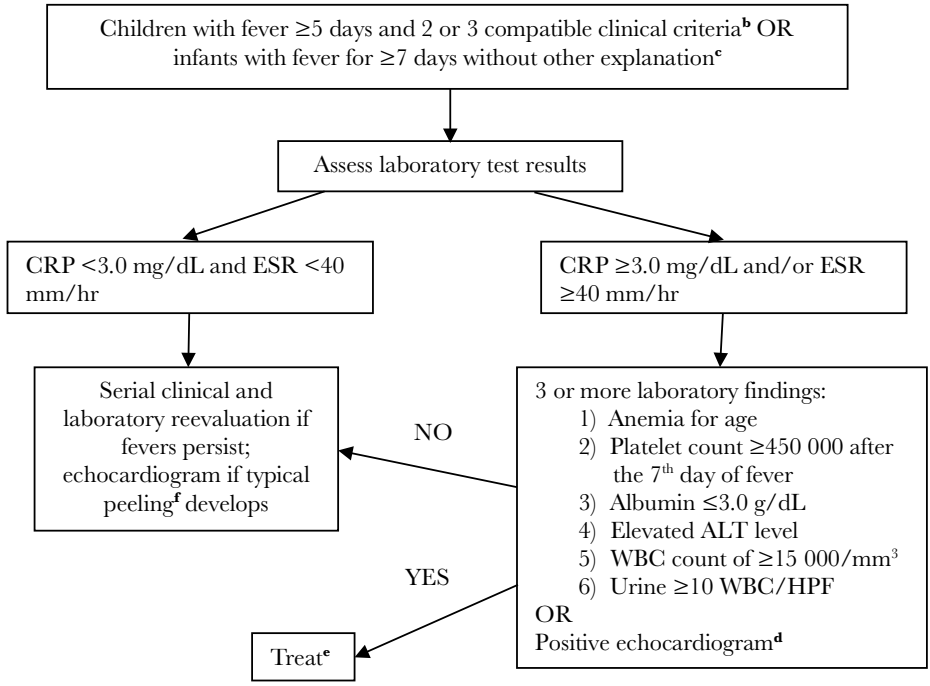

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echocardiography in all infants with 7 days of fever without another source. Other presentations of Kawasaki disease include infants and children with a shock-like syndrome in whom an inciting infection is not confirmed and those with presumed bacterial cervical lymphadenitis or para- or retropharyngeal phlegmon that fail to respond to appropriate antibiotic therapy.