

# Red Book®:

## 2024–2027 REPORT OF THE COMMITTEE ON INFECTIOUS DISEASES

### Errata

(07/24/2024)

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**Erratum Date: 7/24/2024**

**Page 813:** [https://doi.org/10.1542/9781610027373-S3\\_018\\_013](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  $\leq 0.5$ . The updated table appears below and a revised page 813 appears on page 2 of this Errata.

**Table 3.68. Minimum Inhibitory Concentration Breakpoints ( $\mu\text{g/mL}$ ) for *Streptococcus pneumoniae*, by Susceptibility Category, as per the Clinical and Laboratory Standards Institute**

	Susceptibility category MIC ( $\mu\text{g/mL}$ )		
	Susceptible	Intermediate	Resistant
<b>PENICILLIN</b>			
<b>Breakpoints</b> (by clinical syndrome and administered route)			
Nonmeningitis, oral penicillin	$\leq 0.06$	0.12–1	$\geq 2$
Nonmeningitis, IV penicillin	$\leq 2$	4	$\geq 8$
Meningitis, IV penicillin	$\leq 0.06$	—	$\geq 0.12$
<b>CEFOTAXIME OR CEFTRIAXONE</b>			
<b>Breakpoints</b> (by clinical syndrome and administered route)			
Nonmeningitis	$\leq 1$	2	$\geq 4$
Meningitis	$\leq 0.5$	1	$\geq 2$

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.

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 asymptotically 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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<b>CEFOTAXIME OR CEFTRIAOXONE</b>			
<b>Breakpoints</b> (by clinical syndrome and administered route)			
Nonmeningitis	$\leq 1$	2	$\geq 4$
Meningitis	$\leq 0.5$	1	$\geq 2$

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.