



CefdiNEVER?

When should cefdinir be used in children?

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Things to know about cefdinir



Low oral absorption

16–25% absorbed



High protein binding

60–70% protein bound



Short half-life

Spends less time above the target for infection

Bottom line



These pharmacokinetic properties mean there is less drug in the body to reach the site of infection.

Not all oral cephalosporins are created equal.

Cefdinir is easy to give (twice daily) and inexpensive, but it is not always the best choice for common pediatric infections.

Common pediatric indications

Urinary tract infections



✗ Not preferred

- Low drug concentration in urine in children (2.7–12.7%)

✓ Preferred agent: Cephalexin

- Excellent coverage of common UTI pathogens
- Inexpensive
- High drug concentration in urine (>90%)

Acute otitis media



✓ Acceptable for initial therapy in penicillin-allergic patients

✗ Not recommended after failure of amoxicillin or amoxicillin-clavulanate

- Does not reach concentrations high enough to treat penicillin-resistant *Streptococcus pneumoniae*

✓ Preferred agent after failing amoxicillin or amox/clav:

- If failed amoxicillin, use amoxicillin/clavulanate
- If failed amoxicillin/clavulanate, use ceftriaxone, clindamycin plus cefuroxime or cefpodoxime

Pneumonia



✗ Not a treatment option

✓ Preferred agent: High-dose (80–100 mg/kg/day) amoxicillin

- Amoxicillin achieves higher concentrations in the lungs needed to treat *S. pneumoniae* compared to cefdinir.

Acute bacterial sinusitis



✗ Not recommended

✓ Preferred agent: Amoxicillin or amoxicillin/clavulanate

✓ For penicillin allergy:

- Cefpodoxime, cefuroxime, cefixime plus clindamycin, or levofloxacin.

For complete antibiotic recommendations, refer to the
Children's Mercy Antibiotic Handbook.

