Amoxicillin+clavulanic acid in community acquired pneumonia: Past, present, and future from an Indian perspective

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ABSTRACT

Community acquired pneumonia (CAP) is a major health problem in India with high morbidity and mortality. The threat posed by this infection is further intensified by the continued emergence of resistance to the currently available antibiotics. With a heritage of more than 24 years in India, amoxicillin + clavulanic acid is one of the most common antibiotics used for CAP. It was developed with an intent to sustain the efficacy of amoxicillin which was challenged due to the emergence of the beta-lactamase producing microorganism. Over a period, it has been included in national and international guidelines for the treatment of CAP. To assure the highest probability of clinical cure and to combat development of resistance: It is imperative for amoxicillin + clavulanic acid to reaffirm itself. Optimization of the PK/PD and higher dose of amoxicillin + clavulanic acid will tackle the burden of the future difficult to manage respiratory infections.

Key words: Amoxicillin; Amoxicillin + clavulanic acid; Antimicrobial resistance; Antibiotic resistance; Antimicrobial resistance; CAP; Community acquired pneumonia; Pneumonia

INTRODUCTION

Community-acquired pneumonia (CAP) is a major health issue worldwide, with increased mortality burden on developing countries.1 The annual incidence of CAP in India is 4 million cases, out of which 20% require hospitalization. The mortality rate in the intensive care unit is 25%, while in the outpatient setting, it is 1–5%.2 The morbidity and mortality rates are high due to various factors such as diverse age range, comorbid conditions, patient non-compliance, and diagnostic challenges.3 The overall success rate in positively identifying the causative pathogen in CAP has been <50%.4,5 India contributes nearly 23% of global pneumonia burden and 36% WHO regional burden in patients under 5 years. Cross-sectional studies from tertiary teaching hospitals provide most of the data for adults. A study from Mumbai reported that severe CAP reached 19% of all patients and Streptococcus pneumoniae and Gram-negative bacteria (Pseudomonas aeruginosa and Klebsiella pneumoniae) had increased occurrence in severe pneumonia.6 The most common bacterial cause of the upper and lower RTIs is S. pneumoniae.7 It accounts for two-thirds of all cases of bacterial pneumonia.8

The early administration of antibiotics helps prevent mortality in severe pneumonia.9 Since timing is an important

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consideration while treating CAP; the initial treatment of CAP is empiric. The selection of antibiotics is an important consideration for the treatment. In a joint consensus of Indian Chest Society (ICS) and the National College of Chest Physicians (NCCP), the regimen recommended for non-ICU, inpatient CAP includes β-lactam antibiotics (cefotaxime, ceftriaxone, or amoxicillin+clavulanic acid) plus a macrolide.  

From the late 1960s, antimicrobial resistance in CAP therapy came into existence. Due to alarming increase in antibiotics resistance, combination antibiotic therapies were introduced to achieve a better outcome. From the past decade, amoxicillin+clavulanic acid, a broad-spectrum antibiotic, is included in the empirical treatment of CAP. This combination proved to be a potent broad-spectrum antibiotic with a wide coverage of β-lactamase-producing pathogens and a favorable pharmacokinetic/pharmacodynamics (PK/PD) profile. As per a drug utilization study on antibiotics use conducted in India, amoxicillin+clavulanic acid is one of the most prevalent combination antibiotics used for the lower respiratory tract infection in India.

With a heritage of more than two decades in India, amoxicillin+clavulanic acid is one of the most common antibiotics prescribed, primarily for CAP and recommend amoxicillin+clavulanic as first-line therapy for outpatient CAP. Favorable PK/PD profile of amoxicillin+clavulanic acid demonstrated excellent clinical efficacy against a wide range of bacterial infections. The objective of this article is to review the role of amoxicillin+clavulanic acid in the management of CAP patients by exploring its role in the past, present, and future.

**PAST: DOSAGE DEVELOPMENT OF AMOXICILLIN+CLAVULANIC ACID BASED ON PK/PD RELATIONSHIP**

Amoxicillin: An antibiotic with good oral absorption. The discovery of clavulanic acid, a β-lactamase inhibitor, and its combination with amoxicillin has furthered its clinical application as it can act against organisms that produce β-lactamase enzyme. The adult oral formulation introduced in 1980 in the UK and 1981 in India as clavulanic acid 250 mg/125 mg (2:1), three times daily. This dose achieves maximum concentration in serum (Cmax) of 3.3 mg/L with time (T) > minimum inhibitory concentration (MIC) of 40% dosing interval. For maximum bacteriological efficacy of amoxicillin, a T>MIC of 30–40% of dosing interval is required.

To counteract the increase in pathogen MICs and to maintain T>MIC, an increase in dose unit, dose frequency, and/or improved pharmacokinetics was achieved. In the year 1982 first in Germany and 1986 in the US, amoxicillin+clavulanic acid 500 mg/125 mg (4:1) 3 times daily was registered. The dosage (4:1) achieved Cmax of 7.2 mg/L in 1.5 h, with T>MIC of 43% dosing interval. The formulation showed susceptibility for Haemophilus influenzae and Moraxella catarrhalis, while Gram-negative and Gram-positive anaerobes were found to be resistant.

For better action and control against more severe diseases caused by strains that were non-susceptible to penicillin, amoxicillin+clavulanic acid 875 mg/125 mg (7:1), 3 times daily and 1000 mg/125 mg (8:1), 3 times daily regimen doses were introduced.

In the year 2003, Jacobs et al., established the Alexander Project involving Africa, East Europe, West Europe, Far East countries, Middle East countries, Latin America, and USA for continuing surveillance to test the susceptibility of isolates of S. pneumoniae, H. influenzae, and M. catarrhalis involved in community-acquired respiratory tract infections (CA-RTI). The study reported amoxicillin+clavulanic acid susceptibility of 95.5%, 98.1%, and 100% for S. pneumoniae, H. influenzae (n=8882), H. influenzae (n=8523), and M. catarrhalis (n=874), respectively, based on Clinical and Laboratory Standard Institute (CLSI-formerly NCCLS) guidelines, respectively.

Drug utilization pattern studies were conducted to understand the use of antibiotics for infectious diseases. A study was conducted in outpatient and inpatients of University Hospital in New Delhi. The patients included were taking antibiotics for the upper respiratory tract infections. The most frequently prescribed antibiotics were β-lactams (45.52%) followed by quinolones (26.31%). The study concluded that amoxicillin+clavulanic acid (21.74%) was among widely consumed penicillin. Another similar study showed that the most widely used antibiotic therapy for pediatrics to treat pneumonia was amoxicillin+clavulanic acid. Although there are currently many new antibacterial compounds available, the development of higher dosing regimens and pharmacokinetically-enhanced formulations of amoxicillin+clavulanic acid continues to play an important role in the treatment of a wide range of infections, particularly those of the respiratory tract.

**PRESENT SCENARIO OF AMOXICILLIN+CLAVULANIC ACID IN CAP IN INDIA**

India reports the highest mortality rate globally for children below 5 years of age due to CAP. For outpatient
cases, it is <5%; it rises to 10% in admitted ward patients and can exceed 30% in patients admitted to intensive care unit. The most likely pathogens causing CAP are: S. pneumoniae, H. influenzae, Staphylococcus aureus, Streptococcus Pyogenes, and atypical pneumonia pathogens (Mycoplasma pneumoniae and Chlamydophila pneumoniae). The pathogens responsible for disease in outpatient population are atypical pathogens and H. influenzae, while S. pneumoniae remains the highest.

The major driver for antimicrobial resistance (AMR) is the inappropriate use of antibiotics by the consumers and prescribers. The tripartite interaction between pathogens, antibiotics, and the host can help in determination of drug resistance. The WHO suggests that AMR is occurring due to genetic changes and is getting accelerated due to overuse and misuse of antibiotics. Although pneumococcal resistance is prevailing across the globe; however, in India, penicillin-resistant pneumococci remains on the lesser side. MIC of penicillin for pneumococci resistant strains is 2 µg/mL or more. Among various mechanisms of antibiotic resistance, the mechanism of chromosomal mutations through transformation led to penicillin resistance. Considering the resistance of typical pathogen, that is, S. pneumoniae; Australia reported first penicillin resistant S. pneumoniae (PRSP) in year 1976 and later, reported across the globe. The literature reported PRSP ranges from 4.6% to 50.7% in India for penicillin (oral) based on EUCAST criteria. During PRSP development, the most of the penicillin resistant and susceptible S. pneumoniae strains were susceptible to carbapenems and fluoroquinolones. S. pneumoniae and H. influenzae remain among a major cause of various community-acquired respiratory tract infections. The authors reported the high level of resistance against cotrimoxazole for H. influenzae (67.3%) and S. pneumoniae (81.8%) in Indian school children. A recent review showed mycoplasma being the fastest evolving bacteria with high rate of mutations and has developed resistance to β-lactams, tetracyclines, quinolones, and macrolides.

Chawla et al., conducted a study to evaluate the emerging resistance of S. pneumoniae, the author reported a high level of resistance to cotrimoxazole (36%) followed by tetracycline (38%), cefotaxime (30%), penicillin (14%), ciprofloxacin (14%), and erythromycin (14%). Another study conducted to determine the AMR demonstrated similar trends; maximum resistance to cotrimoxazole (66.4%), followed by erythromycin (35.1%), tetracycline (34.3%), and fluoroquinolones (levofloxacin) with 5.2%. Based on the Asian Network for Surveillance of Resistant Pathogens, an increasing trend of anti-microbial resistance is noted to erythromycin of around 73% against S. pneumoniae. The amoxicillin+clavulanic acid combination remains one of the first-line antimicrobials as recommended by CDC and shows susceptibility against S. pneumoniae with MIC ≤2 mcg/mL. Although amoxicillin+clavulanic acid has been prescribed widely all around the world, it remains susceptible against S. pneumoniae and H. influenzae. Recommended antibiotics for outpatient settings in CAP (Table 1) based on Guidelines for diagnosis and management of community- and hospital-acquired pneumonia in adults: Joint ICS/NCCP(I) recommendations.

For the inpatient population, the recommended regimen is combination of a β-lactam plus a macrolide (preferred β-lactams include cefotaxime, ceftaxime, and amoxicillin/clavulinate acid).

As discussed earlier, increased antimicrobial resistance poses a limited choice of antibiotics for severe infections. Survey of antibiotic resistance during 2012–14 monitored respiratory pathogens and antibiotic resistance in the Middle East, Africa, Latin America, Commonwealth of Independent States, and Asia. A total of 1326 respiratory isolates of S. pneumoniae, S. pyogenes, M. catarrhalis, and H. influenzae (520 from Thailand, 493 from India, 175 from South Korea, and 138 from Singapore) were analyzed, which accounted for 220, 696, and 410 isolates for pediatric, adult, and elderly patients, respectively.

The objective of the survey was to evaluate the susceptibility of community-acquired respiratory tract infection isolates (Table 2). The MIC was determined using gradient strip (E test). MIC susceptibility criteria used were those of CLSI.

S. pneumoniae susceptibility: Intravenous (IV) penicillin (95.4%) followed by amoxicillin+clavulanic acid which demonstrated >90% susceptibility followed by oral

### Table 1: Doses of recommended antibiotics for outpatient setting in CAP in adults

| Antibiotic     | Doses                                                                 |
|----------------|----------------------------------------------------------------------|
| Amoxicillin    | 0.5–1 g thrice daily (orally or IV)                                  |
| Co-amoxiclav   | 625 mg thrice a day or 1 g twice daily (orally)1.2 g trice daily (IV) |
| Azithromycin   | 500 mg daily (orally or IV)                                          |
| Ceftriaxone    | 1–2 g twice daily (IV)                                               |
| Cefotaxime     | 1 g thrice daily (IV)                                                |
| Cefepime       | 1–2 g 2–3 times a day (IV)                                           |
| Cefazidime     | 2 g thrice daily (IV)                                                |
| Piperacillin-tazobactam | 4.5 g 4 times a day (IV)                                 |
| Imipenem       | 0.5–1 g 3–4 times a day (IV)                                         |
| Meropenem      | 1 g thrice daily (IV)                                                |
Table 2: MIC and susceptibility results based on CLSI breakpoints for *S. pneumoniae*, *H. influenzae*, and *M. catarrhalis* in India for different antibiotics\textsuperscript{34}

| Class          | *S. pneumoniae* (%) susceptibility | *H. influenza* (%) susceptibility | *M. catarrhalis* (%) susceptibility |
|----------------|------------------------------------|-----------------------------------|-------------------------------------|
| Cephalosporins | Cefuroxime (75.2%)                 | Cefixime (97.0%)                  | Cefuroxime (81.4%)                  |
|                | Cefpodoxime (67.1%)                | Cefpodoxime (99.3%)               |                                     |
| Penicillin     | Penicillin (oral) (49.3%)          | Ampicillin (91.1%)                | AMC (98.4%)                         |
|                | Pen IV (95.4%)                     |                                   |                                     |
|                | AMC (91.8%)                        |                                   |                                     |
| Macrolides     | Clarithromycin (54.8%)             | Clarithromycin (66.7%)            |                                     |
|                | Erythromycin (57.4%)               | Azithromycin (94.7%)              |                                     |
|                | Azithromycin (66.3%)               |                                   |                                     |
| Quinolones     | Ofloxacin (77.2%)                  | Ciprofloxacin (76.3%)             |                                     |
|                | Levofloxacin (85.8%)               | Levofloxacin (85.2%)              |                                     |
| Other          | SXT (32.9%)                        | SXT (23.0%)                       |                                     |

AMC: Amoxicillin+clavulanic acid, SXT: Cotrimoxazole, *S. pneumonia*: Streptococcus pneumonia, *H. influenzae*: Haemophilus influenzae, *M. catarrhalis*: Moraxella catarrhalis

Another study also analyzed the antibiotic susceptibility pattern of *S. pneumoniae* isolates mostly from cases of CA-RTI, collected from different hospitals in Thanjavur, South India. A total of 105 isolates of *S. pneumoniae* were recovered from January 2014 till June 2014. Table 3 shows MIC and susceptibility results for *S. pneumoniae* for different antibiotics. The results of MIC concluded that amoxicillin+clavulanic acid demonstrated 100% susceptibility (MIC<0.5–0.25).\textsuperscript{42}

Government of India launched a “National Program on Containment of Antimicrobial Resistance” of 5-year plan with an objective to establish AMR surveillance system to generate quality data on AMR.\textsuperscript{43} Indian council of medical research (ICMR) collected data on commonly prescribed antibiotics from eminent physicians and clinical microbiologists across the country. The guidelines recommend amoxicillin+clavulanic acid; first-line therapy for outpatient CAP with/without comorbidities as the pneumococcal resistance in non-meningeal isolates is low in India. The rationale behind the combination therapy is to increase the spectrum, act against atypical pathogens, and decrease mortality.\textsuperscript{45} ICS and NCCP recommended β-lactam (cefotaxime, ceftriaxone, or amoxicillin+clavulanic acid) plus a macrolide for CAP.\textsuperscript{46} As per international guidelines, the empiric treatment includes combination therapy of amoxicillin+clavulanic and macrolides for outpatient adults of CAP with comorbidities.\textsuperscript{47} In 2015, Kotwani et al., listed amoxicillin+clavulanic antibiotic combination to be the most commonly used among the β-lactams Penicillin group, for treating CAP.\textsuperscript{48}

To what started to be a 2:1 ratio of amoxicillin to clavulanic acid, amoxicillin concentration has been increased to 4:1, then to 7:1 for more potent antimicrobial and better pharmacokinetic activity for severe infections and for treating resistant strains.\textsuperscript{49} Amoxicillin+clavulanic acid dose ratios like 4:1 and 7:1 are available in adult and pediatric suspension.\textsuperscript{50} The combination (7:1) was designed to improve convenience and compliance to change the therapy from thrice daily to twice daily and combination is advisable to children aged 2 months and above. The efficacy of many oral drugs has reduced due to drug resistant *S. pneumoniae* isolates. To deal with the issues, pharmacokinetically enhanced formulations of amoxicillin+clavulanic acid was developed as amoxicillin+clavulanic acid extended release (ES) and sustained release.\textsuperscript{47,48}

To simplify the treatment and reduce the volume, amoxicillin+clavulanic acid ES, also known as high-dose pediatric formulation, is recommended to overcome the infections caused due to PRSP and designed with high doses of amoxicillin.\textsuperscript{47} The ES formulation provides...
serum concentrations >4 μg/mL (>40% of the dosing interval). The combination is available in different doses and formulation in India for various age groups. Table 4 presents the dosages and formulations for different age groups in the lower respiratory tract infections (LRTI).

The combination has been prescribed since late 1980s in different dosages and formulations globally. A worldwide survey of clinical experience of combination was conducted by Croydon in 1989 with 9700 patients. The clinical trials reported highest incidence (13.1%) of gastrointestinal events where diarrhea was among most common with an incidence rate of 4.1% followed by nausea (3.0%) and vomiting (1.8%). There are some other adverse reactions reported with amoxicillin+clavulanic acid such as mucocutaneous candidiasis, dizziness, headache, skin rash, urticaria, and a moderate rise in AST and/or ALT. The safety is evaluated and reviewed time to time. The largest review including 32,440 patients revealed a case fatality of 44 patients, however, not related to amoxicillin+clavulanic acid. The most common adverse event reported with an incidence of 8.4% in gastrointestinal system organ class; diarrhea (3.4%) is the most common.

In another meta-analysis including 45 studies involving amoxicillin+clavulanic and amoxicillin with various therapeutic indications demonstrated maximum incidence of diarrhea with amoxicillin+clavulanic acid. Despite increasing dose of amoxicillin in the combination, the drug still holds a better safety profile from its existence to date in the market. Amidst this background, amoxicillin+clavulanic acid has secured an exemplary place. In our opinion, amoxicillin+clavulanic acid has potential to remain an agent of choice for CAP in India as per recently revised guidelines.

**FUTURE OF AMOXICILLIN+CLAVULANIC ACID**

In the present review, we have discussed most common typical and atypical pathogens causing CAP and the recommended treatment options. The atypical pathogens responsible for CAP such as mycoplasma, chlamydia, and legionella contributed to 30–40% disease burden across the globe. The resistance against these organisms along with unresolved challenges of diagnosis and treatment poses future risk on the health-care system and the disease outcome. As per the WHO surveillance report, non-susceptibility to penicillin has been detected in all WHO regions. Globally, the resistance against macrolides has increased since 2000 with emergence in parts of Asia. The development of resistance among macrolides in *S. pneumoniae* is due to methylation of ribosomal macrolide target sites and drug efflux.

Further, antibiotic resistance is a multifaceted issue, and factors such as self-medication, absence of diagnostic tools, over-the-counter use, inadequate storage, or even use of expired drugs contribute to the prevalence. There is an increasing trend in resistance to both first line and broad spectrum-antibiotics. In a recent study conducted in India to assess the pattern of antibiotic resistance in CAP patients (165 respiratory isolates). The study reported that amoxicillin+clavulanic acid and levofloxacin were effective against *S. pneumoniae* with ~20% resistance. The resistance against *H. influenzae* was reported to be 6%, 13%, and 23% in cefuroxime, azithromycin, and amoxicillin+clavulanic acid, respectively. The incidence of β-lactamase production has been reported in 20–35% of the isolates of *H. influenzae*.

Antimicrobial stewardship is defined as a set of coordinated interventions designed to measure and improve the appropriate use of antibiotics by promoting the selection of the optimal choice, dose, duration, and route of the antibiotic which, in turn, lead to improved patient outcomes and decreased adverse effects. ICMR 2019 guidelines focus on steps of rational antibiotic use as mentioned in Table 5.

As discussed earlier in this review, the antibiotics are the mainstay of the treatment of CAP; however, the challenges for a successful outcome are early diagnosis

![Table 4: Amoxicillin+clavulanic acid different dosages and formulations in India](Asian Journal of Medical Sciences | Aug 2022 | Vol 13 | Issue 8)
and start of appropriate medical management. The resistance to amoxicillin+clavulanic acid, although not quantified, might be the due presence of alternate classes of β-lactamases (B, C, and D) that are not susceptible to the inhibitory action of amoxicillin+clavulanic acid and any modification of the protein target of amoxicillin resulting in decreased affinity and therefore reduced response.  

Further, the development and better understanding of PK/PD characteristics led to optimum dosing regimens and to combat the AMR. The β-lactam antibiotics exhibit time-dependent killing without persistent effects. Hence, to maintain the serum drug concentration above MIC for at least 40–50% of dose interval can successfully kill the pathogens. The studies demonstrated that among β-lactams amoxicillin+clavulanic acid, high dose (14:1) achieves MIC ≥ 40% of dosing interval against PRSP. Second, the researchers focused on eradication of pathogens rather than an outcome of clinical cure as a parameter of efficacy of antibacterial agents and a step further to prevent the AMR. In this era of AMR, based on PK/PD parameters and susceptibility data, it is crucial to choose an antimicrobial agent against CAP infections. Optimization of the dose of amoxicillin+clavulanic acid based on PK/PD to maximize bacterial eradication promises the highest probability of clinical cure and it may reduce the development and spread of resistance.  

For majority of oral formulations, the unit dose of clavulanate has remained as 125 mg and 3.2 mg/kg for pediatrics (250–375 mg and 6.4–10 mg/kg daily dose). This strength is adequate to inhibit the clinically relevant target β-lactamases and to protect the amoxicillin component. The researchers reported a good lung penetration of the combination and the amoxicillin achieves enough concentration in lung mucosa to inhibit CAP pathogens.  

To increase convenience and patient compliance over thrice a day regimen, twice daily formulations of 500/125 mg and 875/125 mg regimens are available with T>MIC of 26%. As discussed earlier in this review that PRSP is increasing progressively and to maximize the elimination of PRSP and to increase the efficacy, a target T>MIC of >40% was set. To achieve the desired T>MIC values, few factors were considered: 

1. Increase in the dose of amoxicillin+clavulanic acid  
2. Increase in peak plasma concentration  
3. Improvement in PK.

Community-acquired respiratory tract infections and reduction of susceptibility against key antibiotics posed a significant challenge in the treatment of CAP. In addition, the above-mentioned factors could lead to an increase in adverse events if the dose of amoxicillin+clavulanic acid was increased. To overcome these problems, bilayer tablet was introduced, which had one layer of immediate releasing amoxicillin/clavulanate (562.5 mg amoxicillin and 62.5 mg clavulanate) and another layer of sustained-release amoxicillin (437.5 mg amoxicillin). This pharmacokinetically enhanced, ES, high-dose adult 2000/125 mg (16:1) twice daily formulation has been developed to permit coverage of more bacterial strains as compared to conventional dosing. It is available in US, some EU countries and India for the treatment of CAP, acute bacterial sinusitis, or acute exacerbation of chronic bronchitis due to β-lactamase-producing bacteria (e.g., *H. influenzae* or *M. catarrhalis*) and could be useful in CAP management in India. The recommended dose of ES formulation of amoxicillin+clavulanic acid is 90/6.4 mg/kg/day especially in PRSPs. A study conducted by Prabhudesai et al., assessed the efficacy and safety of ES amoxicillin+clavulanic acid in patients with CAP in India. At the end of the study, ES amoxicillin+clavulanic acid showed 97.16% success rate for *S. pneumoniae* and only 13% patients reported at least one adverse event; diarrhea was most frequent AE. No deaths were reported on, and after therapy and ES amoxicillin/clavulanate was found to be safe.  

Table 5: Steps of rational antibiotic use (2019 ICMR guidelines on antimicrobial use)  

| Steps | Description |
|-------|-------------|
| Step 1 | Making a clinical diagnosis |
| Step 2 | Limiting empiric antibiotic therapy to genuine seriously ill patients |
| Step 3 | Know your bugs |
| Step 4 | Choose the appropriate antibiotic |
| Step 5 | De-escalation/modification |
| Step 6 | Stop antibiotics in the following clinical situations |
| Step 7 | Reduce the duration of therapy |
| Step 8 | Optimize PK-PD parameters |

The table has been adapted from ICMR-AMSP guidelines. AMR: Antimicrobial resistance, DDD: Defined daily dose, DOT: days of therapy, VAP: Ventilator-associated pneumonia, CME: Continuing medical education, AMS: Antimicrobial stewardship, AMSP: Antimicrobial stewardship program, HCP: Health-care professionals. Source: ICMR-AMSP guidelineshttp://iamrsn.icmr.org.in/images/pdf/AMSP_Guidelines_final.pdf
The benefit-risk assessment of amoxicillin+clavulanic acid continues to be favorable, provided official guidelines on appropriate use of antibacterial agents are followed, and consideration is given to the local prevalence of resistance. During the period under review, no withdrawal, revocation, rejection, suspension, or failure to obtain a renewal of a marketing authorization due to safety concerns was reported.

CONCLUSION

If the crises of increasing AMR and scanting antibiotic pipeline continue unabated, we must deal with increased mortality rates due to severe infections. Researchers are focusing to reappraise the impact and sustainability of existing antibiotics and exploring their role in patient lives. Amoxicillin+clavulanic acid drug molecule continues to provide opportunities for the future modifications that may provide more efficacious and well tolerated safe compounds. Optimization of ratio and dose of amoxicillin+clavulanic acid based on PK/PD characteristics, it remained a pioneer in tackling a wide range of infections, particularly those of the respiratory tract in both adults and children worldwide. With a heritage of more than 24 years in India, amoxicillin+clavulanic acid is one of the most common antibiotics prescribed, primarily for respiratory tract infections. The combination still preserved its place as first line therapy for outpatient CAP with maintaining high sensitivity among pathogens responsible for the disease. To assure the highest probability of clinical cure and to combat development of resistance, it is imperative for amoxicillin+clavulanic acid to reiterate itself.

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