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Antimicrobial Stewardship: Molecular Lab Result

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DEMO-03Specimen Type
Nasopharyngeal swabPatient
Jane DoeProvider
Dr. DemoDOB
7/04/1944Resulted
8/26/2026, 6:05:00 PMCollected
8/26/2026, 9:15:00 AMReceived
8/26/2026, 1:40:00 PM

Infection Complexity



Organisms Detected

- Influenza A virus

Resistance Detected

None Detected

Antimicrobial Resistance



Allergies

None reported

Interactions

MAJOR

Vaccines
(representative · scan QR)

1



Full interactions list

Scan or click

Infection Control

Standard, Droplet: Influenza A

#1 RECOMMENDED TREATMENT PLAN

Oseltamivir

Brand: Tamiflu

Antiviral (NAI)

Narrow

Dose: 75 mg PO BID for 5 days

Influenza · per FDA label

DOSE ADJ: RENAL

Est. \$18.54/7d

Current Pricing

Drug Selection Basis

GUIDELINE / FDA

Selected per clinical guidelines
and FDA-approved indications

CLINICAL RATIONALE

Oseltamivir was selected to cover Influenza A virus as a first-line oral agent.

WHEN SHOULD THIS BE TREATED? ‡

Molecular (PCR) detection of a respiratory virus - culture metrics (sputum quality, CAP/HAP/VAP culture-then-de-escalate logic) do not apply to a non-culturable virus. For influenza and COVID-19, start antiviral therapy as early as possible if the patient is hospitalized, severely or progressively ill, or at higher risk (do not withhold in hospitalized/severe illness even beyond 48 h from onset). Other respiratory viruses (RSV, parainfluenza, human metapneumovirus, adenovirus, rhinovirus, seasonal coronaviruses) are supportive care only - no specific antiviral. Antibiotics do not treat viruses; add antibacterials only for evidence of secondary bacterial infection (worsening after initial improvement, new/persistent fever, purulent sputum, a new infiltrate, or rising WBC/procalcitonin).

DISCLAIMER — For clinical decision support only; not a diagnosis, and the patient was not examined. The reporting laboratory assumes no liability for the actions of physicians, facilities, or other users and is not responsible for injury, death, or damage from use, misuse, or interpretation; drug failure is possible, and independent assessment of indications, contraindications, and side effects is required.

Molecular (PCR) assay — detects nucleic acid and only the panel's validated organisms and resistance genes, not phenotypic susceptibility; off-panel organisms, genes, and variants are not detected. Gene detection does not always predict resistance and gene absence does not establish susceptibility, so a negative result does not preclude infection or resistance. Recommendations reflect typical genotype-phenotype relationships and published guidance, not this patient's measured MICs. Confirm the organism and susceptibility with reflex culture and phenotypic AST, correlate clinically, and do not use this report as the sole basis for diagnosis, treatment, or patient management. (IDSA AMR guidance 2026; CDC AR guidance.)

* Printed doses are standard adult regimens, or the weight-based pediatric/neonatal dose when a pediatric age and weight are provided (a per-kg guideline plus a computed absolute for the supplied weight where pediatric/neonatal dosing data exist). All doses assume normal renal and hepatic function — the report flags where renal or hepatic adjustment may be needed but does not calculate that adjustment; resistance varies, so confirm dosing for the individual patient. ‡ Guidance is limited to the detected panel targets for the reported specimen plus any clinical details supplied, and is not a substitute for full clinical assessment. "First-line" and "alternative" denote this report's ranked recommendation for the detected organism and specimen source, not an endorsement by an outside body; the Drug Selection Basis panel states the evidence class behind that ranking. § Pricing is an estimate based on national-average wholesale benchmarks and may differ from actual acquisition cost. Recommendations are derived from freely available, peer-reviewed literature and U.S. government and professional-society guidance. Interpretive recommendations are generated by decision-support software from Open Laboratory Solutions, LLC, validated for clinical use by this laboratory; not FDA cleared/approved; CLIA regulated.

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ALTERNATIVE TREATMENTS

#	Drug (Generic / Brand)	Class	Dose	
#2	Baloxavir / Xofluza	Antiviral (Endo.) Narrow	40-80 mg PO x 1 dose	~\$173/dose Ref.
#3	Peramivir / Rapivab	Antiviral (NAI) Narrow	600 mg IV x 1 dose (infused over 15-30 min)	~\$204/dose Ref.
#4	Zanamivir / Relenza	Antiviral (NAI) Narrow	DOSE ADJ: RENAL 10 mg (2 inhalations) Q12H (via Diskhaler) for 5 days	~\$62.00/5d Ref.

INTERPRETIVE NOTES

DRUG-USE CAUTIONS

peramivir: IV peramivir is used for patients who cannot take oral or inhaled antivirals.

SPECIAL CONSIDERATIONS ‡

Influenza A virus

Oseltamivir most effective within 48h. For >=65, treat regardless of timing. Baloxavir single-dose alternative. Monitor for secondary bacterial pneumonia.

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