

Original Research Article

Clinician perspectives on cefpodoxime use in respiratory tract infections in India: results from a nationwide survey

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ABSTRACT

Background: Despite several clinical studies regarding the effectiveness of cefpodoxime in various infections, there is a dearth of studies among clinicians. So, this study aims to assess the perspectives of clinicians on the clinical use and perceived outcomes of cefpodoxime in respiratory tract infections (RTIs) in India.

Methods: A cross-sectional study was conducted among clinicians practicing in routine clinical settings across India. A 22-question structured questionnaire was used to assess respiratory infection management, with a focus on cefpodoxime use, etiology, diagnostic approaches and clinical outcomes. Descriptive statistics were used to summarize responses as frequencies and percentages using Microsoft Excel.

Results: Among 818 clinicians, 51% reported that lower RTIs (LRTIs) are the most commonly encountered infections in their clinical practice. More than half (58.92%) indicated prescribing cefpodoxime primarily for LRTIs. About 59% of respondents stated that both bacterial and viral etiologies contribute to upper RTIs (URTIs) in their practice. Around 53% identified chest X-ray as the most preferred diagnostic modality for *Mycoplasma pneumoniae* infection in adults. The majority (75.67%) reported cefpodoxime as the most commonly used antimicrobial agent for URTIs. A large proportion (85.82%) indicated cefpodoxime as the preferred oral drug for acute otitis media. Approximately 51% rated cefpodoxime as providing marked improvement on a 5-point global improvement scale.

Conclusions: LRTIs are most prevalent in clinical practice, with cefpodoxime widely used across respiratory indications. Clinicians recognize mixed etiologies in URTIs and prefer chest X-ray for diagnosis. Cefpodoxime demonstrates high usage, favorable outcomes and marked clinical improvement, supporting its effectiveness and utility in routine RTI management.

Keywords: Antibiotic therapy, Clinical practice, Cefpodoxime, LRTI, RTIs, URTI

INTRODUCTION

RTIs are a leading cause of global morbidity and a major driver of outpatient visits and antibiotic prescriptions, particularly in developing countries such as India.¹ Both URTIs and LRTIs contribute substantially to the disease burden.^{2,3} Overlapping clinical features and diagnostic uncertainty often result in empirical antibiotic use in routine practice. RTIs accounted for approximately 336.5 million cases and 2.4 million deaths globally in 2016, rising to nearly 2.6 million deaths by 2019 and ranking as the fourth leading cause of mortality worldwide.^{4,6} URTIs

alone contributed an estimated 17.2 billion cases in 2019, representing 42.83% of all reported infections, while LRTIs remain the third leading cause of death worldwide.⁷⁻⁹ RTIs also represent one of the most frequent reasons for healthcare utilization, contributing substantially to outpatient visits, emergency consultations and antimicrobial use.¹⁰ In developed countries, acute respiratory infections account for nearly 20% of all medical consultations and constitute a major indication for antibiotic use.¹¹ The burden of RTIs has been further amplified by the COVID-19 pandemic. In India, severe acute respiratory infections (SARI) contribute

significantly to mortality, particularly in children, accounting for nearly 18% of the global burden.¹² Additionally, otitis media, a common complication of URTIs, has a high global incidence (61 cases per 100 children annually) and is a leading cause of hearing impairment, affecting approximately 42 million individuals worldwide.¹³ Cefpodoxime, a third-generation cephalosporin, is widely utilized in the empirical management of RTIs due to its broad-spectrum antibacterial activity and favorable pharmacokinetic profile.^{14,15} Cefpodoxime proxetil demonstrates enhanced activity against major respiratory pathogens compared to earlier-generation, oral cephalosporins and amoxicillin and remains stable against plasmid-mediated β -lactamases commonly produced by resistant bacteria.¹⁶ Furthermore, cefpodoxime is stable against many β -lactamase enzymes, making it effective against several organisms resistant to penicillins and earlier cephalosporins, although it may be inactivated by extended-spectrum β -lactamases. Its bactericidal action results from inhibition of bacterial cell wall synthesis through binding to penicillin-binding protein 3, thereby blocking peptidoglycan formation.¹⁷

Though several clinical studies have been conducted regarding the effectiveness of cefpodoxime in various infections, there is a dearth of studies among clinicians. Therefore, the present survey aimed to assess clinicians' perspectives on the clinical use and perceived outcomes of cefpodoxime in the management of RTIs across India.

METHODS

Study settings

A cross-sectional study was carried out among clinicians involved in the management of a wide range of RTIs in the major Indian cities from June 2025 to December 2025. The study was performed in accordance with Bangalore Ethics, an Independent Ethics Committee (ECR/355/Indt/KA/2022), which was recognized by the Indian Regulatory Authority, the Drug Controller General of India.

Study participants

An invitation was sent to leading clinicians in managing a wide range of RTIs in the month of March 2025 for participation in this Indian survey. About 818 clinicians from major cities of all Indian states, representing the geographical distribution, shared their willingness to participate and provide necessary data.

Study procedure

The questionnaire booklet titled the SCRIPT (study on cefpodoxime and combinations in respiratory infections in Indian patients) study was sent to the clinicians who were interested in participating in the survey. The study questionnaire comprised 22 questions that assessed clinician-reported treatment preferences, disease burden and management approaches for RTIs, with a specific

focus on the use of cefpodoxime in routine clinical practice. It assessed treatment trends across LRTIs, URTIs, urinary tract infections and skin and soft tissue infections. The questionnaire further explored clinicians' perspectives on etiological agents, diagnostic approaches (including investigations for infections such as *Mycoplasma pneumoniae*) and complications associated with respiratory infections, including influenza. Additionally, the survey assessed the need for combination therapy, switching of antibiotics and duration of cefpodoxime therapy in conditions such as URTIs and acute otitis media. Reliability, as determined by a split-half test (coefficient alpha), was adequate but should be improved in future versions of the questionnaire. A study of criterion validity was undertaken to test the validity of measures of Physicians' Perspectives. However, the extraneous variables in this include the clinician's experience, usage of the newer drugs, etc. The two criteria used were the doctors' perspectives from the clinical practice and the assessment of an external assessor and statistician. Clinicians had the option to skip questions as desired and were instructed to complete the survey independently, without peer consultation. Before participating in the survey, all respondents provided written informed consent.

Statistical analysis

Survey responses were analyzed using descriptive statistical methods. Categorical variables were summarized as frequencies and percentages. Data were presented in the form of tables and charts prepared using Microsoft Excel (version 2409, build 16.0.18025.20030).

RESULTS

A total of 818 clinicians participated in the survey. Around 51% of the respondents reported that LRTIs are the most commonly encountered infections in their clinical practice (Table 1). Nearly 35% of the respondents reported treating 25–50 patients with RTIs per month. More than half (58.92%) of the participants reported preferring cefpodoxime primarily for LRTIs (Table 2). Around 38% of the clinicians reported sinusitis as the most common URTI in clinical practice. According to 59% of the respondents, both bacterial and viral etiologies are responsible for URTIs in their practice (Table 3). Around 46% of the clinicians stated that 11–30% of their patients require more than one antibiotic for RTIs. More than half (53.3%) of the clinicians reported that about 10% of patients require a change or shift of antibiotics during treatment. Nearly 39% of respondents indicated *Streptococcus pneumoniae* as the most common causative organism in RTIs in adults. According to 53%, chest X-ray is the most preferred diagnostic method for *Mycoplasma pneumoniae* in adults (Figure 1). Approximately 43% of practitioners reported primary viral pneumonia as the most common complication of influenza infection in adults. Around 30% of clinicians stated that patients aged above

60 years are the most commonly affected group with complicated RTIs. Approximately 47% of respondents reported recommending antibiotics to 50–75% of patients with RTIs. Most clinicians (75.67%) preferred cefpodoxime as the most commonly used antimicrobial agent for URTIs (Figure 2).

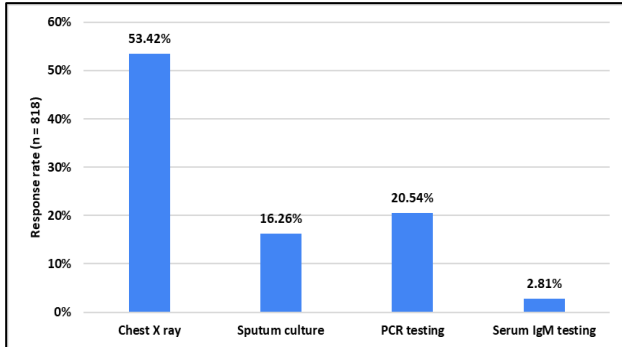


Figure 1: Distribution of responses on preferred diagnostic methods for *Mycoplasma pneumoniae* in adults.

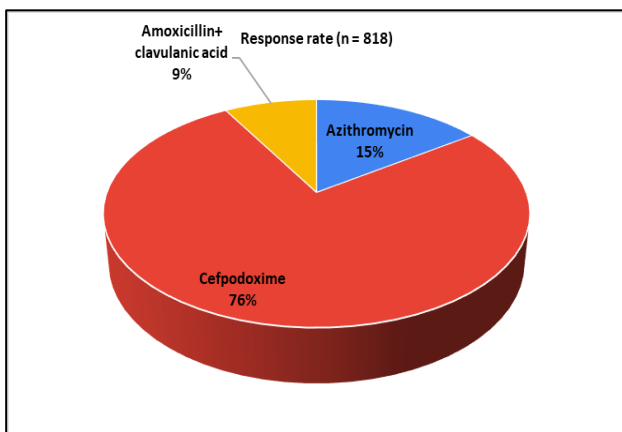


Figure 2: Distribution of responses on the most commonly used antimicrobial agents for URTIs in clinical practice.

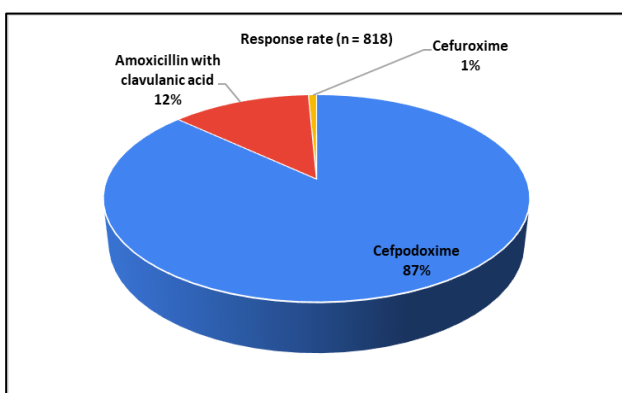


Figure 3: Distribution of responses on the most preferred oral drug for acute otitis media in clinical practice.

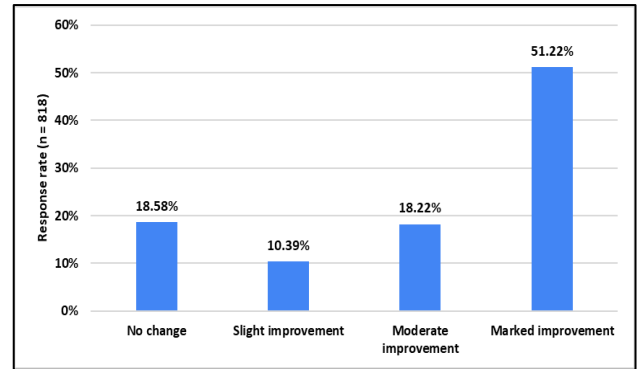


Figure 4: Distribution of responses on rating the efficacy with cefpodoxime on a 5-point scale [global improvement scale].

Around 36% of participants reported that children aged 1–5 years and 5–10 years are the most common age groups presenting with acute otitis media. The majority of respondents (85.82%) stated cefpodoxime as the most preferred oral drug for acute otitis media (Figure 3). About 70% of clinicians reported prescribing cefpodoxime for 5–7 days in URTIs (Table 4). Half (51.59%) of the respondents recommended cefpodoxime for 5–7 days in acute otitis media. Approximately 52% indicated a bacterial cure rate of more than 80% with cefpodoxime. Most respondents (79.58%) stated that cefpodoxime offers multiple advantages, including a broad spectrum of activity, favorable pharmacokinetics and good efficacy. Around 42% noted that 61–90% of patients complete the prescribed antibiotic course. The majority (89%) observed no adverse drug reactions with cefpodoxime in their patients. Approximately 51% of clinicians rated cefpodoxime as providing marked improvement on a 5-point global improvement scale (Figure 4).

Table 1: Distribution of responses on the most commonly seen infections among patients reporting to the clinic in clinical practice (n=818).

Infections	Response rate (%)
Lower respiratory tract infections	50.73
Upper respiratory tract infections	43.03
Urinary tract infections	2.81
Skin and soft tissue infections	0.61
All of the above	2.81

Table 2: Distribution of responses on indications for prescribing cefpodoxime (n=818).

Indications	Response rate (%)
Lower respiratory tract infections	58.92
Upper respiratory tract infections	34.72
Urinary tract infections	2.81
Skin and soft tissue infections	0.98
All of the above	2.57

Table 3: Distribution of responses on the most common etiology of URTIs in clinical practice (n=818).

Etiology	Response rate (%)
Bacterial	26.65
Viral	14.06
Both	59.17

Table 4: Distribution of responses on the duration of cefpodoxime use for URTIs in clinical practice (n=818).

Number (days)	Response rate (%)
<5	4.65
05-July	69.68
07-October	24.08
>10	1.22

DISCUSSION

The survey demonstrates that LRTIs are the most commonly encountered infections ($\approx 51\%$), underscoring their substantial clinical burden in routine practice. This finding is consistent with global epidemiological evidence indicating that RTIs remain a major contributor to morbidity, healthcare utilization and mortality worldwide. Charles Feldman and Erica Shaddock have described LRTIs as “exceedingly common,” emphasizing their persistent global clinical burden. LRTIs are recognized as the leading infectious cause of mortality worldwide, further highlighting their clinical significance.¹⁸ Similarly, Peter and Jennings noted that respiratory infections, including LRTIs, are among the most frequently encountered conditions in clinical medicine.¹⁹ In addition, Jasmin Biscevic-Tokic and colleagues have reported that pneumonia, a major subset of LRTIs, remains one of the most common infectious diseases encountered in routine clinical settings.²⁰

Most of the participants in the present survey reported prescribing cefpodoxime primarily for LRTIs. This observation is supported by existing evidence. A classic review by Geddes demonstrated that cefpodoxime proxetil has potent activity against key bacterial pathogens responsible for LRTIs, including *Streptococcus pneumoniae*, *Haemophilus influenzae* and *Moraxella catarrhalis*.²¹ Furthermore, a multicenter randomized clinical trial by Klein reinforced this practice by showing high clinical success rates (over 95%) with cefpodoxime in children with acute LRTIs, such as pneumonia and bronchitis.²²

In addition, a review by Aggarwal et al reported that cefpodoxime is widely used as empirical therapy for RTIs, particularly in regions with increasing resistance to penicillins and macrolides. The drug is also recommended as a step-down or switch therapy in more severe infections, further supporting its preferential use in LRTIs in routine

clinical practice.²³ More recent real-world evidence from India by Deepak Talwar et al, identifies cefpodoxime as an empiric drug of choice for LRTIs, including acute exacerbations of chronic obstructive pulmonary disease, reflecting contemporary management trends.²⁴

In the present survey, most of the participants indicated that URTIs arise from both bacterial and viral causes. This observation is consistent with existing evidence showing that, although URTIs are predominantly viral, bacterial pathogens may contribute either as primary agents in specific conditions or as secondary infections. Tobin et al described URTIs as being caused by a broad spectrum of pathogens, with viral predominance but notable bacterial involvement, particularly in pharyngitis and sinusitis.²⁵

Similarly, George et al emphasized that, despite the primarily viral nature of URTIs (e.g., rhinovirus, influenza, RSV), the upper respiratory tract often harbors bacterial organisms such as *Streptococcus pneumoniae* and *Haemophilus influenzae*, supporting overlapping etiologies.²⁶ Moreover, MacIntyre et al demonstrated in a prospective study that coexisting bacterial colonization and viral infections are common, indicating that URTIs frequently involve concurrent pathogens rather than a single causative agent.²⁷

A substantial proportion of the respondents identified chest radiography as the preferred initial diagnostic modality for *Mycoplasma pneumoniae* infection in adults. This observation is consistent with existing literature, which underscores the importance of radiological assessment in the diagnostic work-up of atypical pneumonia. Kishaba highlighted the role of chest X-ray as a key component in evaluating *Mycoplasma pneumoniae*.²⁸

Similarly, Abdulhadi et al reported that imaging is routinely employed alongside clinical assessment, with chest radiographs commonly demonstrating reticulonodular opacities or patchy consolidation, despite their non-specific nature.²⁹ Further supporting this, Miyashita et al, demonstrated that chest radiography is routinely utilized to detect pulmonary involvement and aid in the differential diagnosis of atypical pneumonia.³⁰ In addition, Kono et al observed that radiographic abnormalities, including consolidation in a significant proportion of adult patients, are frequently encountered and clinically relevant.³¹ More recent evidence from Sui et al, also indicates that chest radiography remains the first-line imaging modality in the initial evaluation of pneumonia, with computed tomography reserved for further characterization.³² Collectively, these findings support the widespread clinical reliance on chest X-ray for the assessment of *Mycoplasma pneumoniae* infection in adults. Most clinicians in the current survey identified cefpodoxime as the most commonly used antimicrobial agent for URTIs and the most preferred oral agent for the treatment of acute otitis media. This finding is consistent with the PERCEPT survey conducted by Jain et al which

demonstrated that cefpodoxime, either as monotherapy or in combination with clavulanic acid, is among the most preferred antibiotics for the management of RTIs in India, reflecting its widespread clinical acceptance.³³ Furthermore, in a previous study conducted by the present authors, cefpodoxime was similarly identified as the most frequently preferred antimicrobial agent for URTIs, with clinicians favoring it due to its broad-spectrum activity, clinical efficacy and favorable tolerability profile.³⁴

This observation is further supported by evidence from El-Shabrawi et al who reported that cefpodoxime is an effective, safe and well-tolerated antimicrobial for managing acute otitis media in children, making it a suitable option for empirical therapy.³⁵ Similarly, Fulton and Perry concluded that cefpodoxime demonstrates good bacteriological and clinical efficacy in pediatric patients with acute otitis media.³⁶ Furthermore, a comparative study by Mendelman et al highlighted the clinical effectiveness of twice-daily cefpodoxime in the treatment of acute otitis media.³⁷ Notably, a short 5-day course of cefpodoxime has been approved for this indication and has shown efficacy comparable to or greater than commonly used agents such as amoxicillin-clavulanate, cefixime and cefaclor.³⁸

Another key observation from the present survey is the prescription of cefpodoxime for a duration of 5–7 days in the management of URTIs. This practice aligns with evidence reported by Chugh and Shruti, who demonstrated that a 5-day course of cefpodoxime is effective in treating URTIs and is well tolerated, even when administered for a shorter duration compared to the conventional 10-day regimen. The drug is associated with a low incidence of adverse effects and a convenient twice-daily dosing schedule, which may enhance patient adherence.³⁹ Furthermore, findings by Hamid et al demonstrated significant improvement in URTI-related signs and symptoms within 5–6 days of initiating cefpodoxime therapy, further supporting the clinical utility of shorter treatment durations.¹⁴

More than half of the present survey respondents rated cefpodoxime as providing marked improvement on a 5-point global improvement scale in RTIs. In line with this finding, Bergogne-Berezin reported high clinical response rates in RTIs, with the majority of patients categorized as having excellent or good outcomes, reflecting significant clinical improvement.⁴⁰ Similarly, Akiyama et al demonstrated approximately 80% overall efficacy, with responses graded as excellent or good, corresponding to meaningful improvement on global assessment measures.⁴¹ In addition, findings from Hamid et al showed high cure rates (around 83%) along with additional improvement in a substantial proportion of patients, further supporting the effectiveness of cefpodoxime in achieving significant symptomatic relief in URTIs.¹⁴

The strengths of the current survey include its large sample size (n=818), which provides robust clinical insights into

RTIs management. It comprehensively covers trends in epidemiology, diagnostic approaches, antibiotic treatment patterns, treatment duration and outcomes, while incorporating both adult and pediatric perspectives, thereby enhancing its clinical relevance and generalizability. However, the findings are subject to certain limitations. As the data are self-reported, the survey may be affected by recall and reporting bias. The absence of patient-level and microbiological data limit's objective validation of the findings. Additionally, the lack of clearly defined geographic distribution and practice settings may reduce representativeness and the cross-sectional design precludes the establishment of causal relationships.

CONCLUSION

LRTIs are the most commonly encountered infections in clinical practice, with cefpodoxime widely prescribed, particularly for LRTIs and URTIs. Most clinicians recognize mixed bacterial and viral etiology for URTIs and prefer chest X-ray for diagnosing *Mycoplasma pneumoniae*. Cefpodoxime is commonly used for acute otitis media and URTIs, typically for 5–7 days, demonstrating high efficacy, favorable safety and good patient compliance. The findings underscore cefpodoxime's broad clinical utility, effectiveness and tolerability in managing RTIs across diverse patient populations.

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Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

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