Not all aspiration events need to be treated with antibiotics. If the patient is stable without signs of hypoxia, hypotension, or serious sequalae from the event, supportive care can be appropriate.

Patients that are hypoxic and concerning for development of secondary pneumonia can be treated with empiric antibiotics while further testing is pending. Abx with anaerobic coverage is usually the best choice: Augmentin, doxycycline.

Prophylactic Antimicrobial Therapy for Acute Aspiration Pneumonitis – PubMed (nih.gov)

Background: Prophylactic antimicrobial therapy is frequently prescribed for acute aspiration pneumonitis, with the intent of preventing the development of aspiration pneumonia. However, few clinical studies have examined the benefits and harms of this practice.

Methods: A retrospective cohort study design was used to compare outcomes of patients with aspiration pneumonitis who received prophylactic antimicrobial therapy with those managed with supportive care only during the initial 2 days following macroaspiration. The primary outcome was in-hospital mortality within 30 days. Secondary outcomes included transfer to critical care and antimicrobial therapy received between days 3 and 14 following macroaspiration including escalation of therapy and antibiotic-free days.

Results: Among 1483 patients reviewed, 200 met the case definition for acute aspiration pneumonitis, including 76 (38%) who received prophylactic antimicrobial therapy and 124 (62%) who received supportive management only. After adjusting for patient-level predictors, antimicrobial prophylaxis was not associated with any improvement in mortality (odds ratio, 0.9; 95% confidence interval [CI], 0.4-1.7; P = .7). Patients receiving

prophylactic antimicrobial therapy were no less likely to require transfer to critical care (5% vs 6%; P = .7) and subsequently received more frequent escalation of antibiotic therapy (8% vs 1%; P = .002) and fewer antibiotic-free days (7.5 vs 10.9; P < .0001).

Conclusions: Prophylactic antimicrobial therapy for patients with acute aspiration pneumonitis does not offer clinical benefit and may generate antibiotic selective pressures that results in the need for escalation of antibiotic therapy among those who develop aspiration pneumonia.

A comparison between time to clinical stability in community-acquired aspiration pneumonia and community-acquired pneumonia – PubMed (nih.gov)

Antimicrobial therapy has been the main stay of therapy of community-acquired aspiration pneumonia (CAAP), but the duration of treatment has not been established. The objective of this study was to describe the time to reach clinical stability in patients with aspiration pneumonia compared to community-acquired pneumonia (CAP). A retrospective case control study at two university affiliated centers encompassing 329 consecutive patients admitted with CAAP and 329 consecutive patients with CAP was conducted between 2007 and 2011. While the median time to stability for patients with CAP was distributed around a median of 4 days, there was a bimodal distribution for time to clinical stability in patients with CAAP with dual peaks at days 2 and 5, respectively. CAAP patients who required more than 2 days to achieve clinical stability had a higher mortality rate compared to those with 2 days or less [odds ratio (OR) 5.95, 95% CI 2.85-12.4], and a longer hospital stay (6.6 ± 5.8 vs. 3.9 ± 1.2 days; p < 0.001). None of the CAAP patients who achieved clinical stability in 2 days or less was transferred to a higher level of care. In a multivariate analysis, time to clinical stability was found to be an independent predictor of outcome in patients with CAAP (OR 2.59, 95% CI 2.02-3.32). Normalization of vital signs in aspiration pneumonia follows a distinct pattern from that of patients with CAP. Time to achieve clinical stability may assist in identifying

CAAP patients who are likely to require a shorter hospital stay and a shorter course of antimicrobial therapy.