# Yukon-Kuskokwim HEALTH CORPORATION

## Clinical Guideline

# Sepsis Antibiotics (Adult)

**Empiric Antibiotic Recommendations by Source of Infection**

If possible, first dose of antibiotics should be administered as a 30 minute infusion to reduce time to therapeutic concentration.

### Unknown Source

**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500 mg.
OR
**Linezolid**[2] 600 mg IV Q12h.

**AND**

**Cefepime** 2 grams IV Q8h.

### Community-Acquired Pneumonia

**Ceftriaxone** 1-2 grams IV Q24h.
**OR**
**Ampicillin-sulbactam** 3 grams IV Q6h.

**AND**

**Azithromycin** 500 mg IV Q24h.
**OR**
**Doxycycline** 100 mg IV Q12h.

**If at risk for aspiration, consider adding:**

**Metronidazole** 500 mg IV Q8h if not on Unasyn.

### Hospital-Acquired Pneumonia or High Risk for Multi-Drug Resistant (MDR) Organisms

**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500 mg.
**OR**
**Linezolid**[2] 600 mg IV Q12h.

**AND**

**Cefepime** 2 grams IV Q8h.

### Meningitis

**Dexamethasone** 10 mg IV prior to antibiotics.

**AND**

**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500mg.

**AND**

**Ceftriaxone** 2 grams IV Q12h.

**If >50 years, ADD**

**Ampicillin** 2 grams IV Q6h.

### Urinary Tract Infection

**Ceftriaxone**
1-2 grams IV Q24h.

**If urological interventions or MDR risk factors, consider adding:**
**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500 mg.
**OR**
**Cefepime** 2 gram IV Q8h.

**If at risk of ESBL, ADD:**
**Meropenem**[3]
500 g IV Q8h.

### Intra-abdominal or Pelvic Infection

**Piperacillin-tazobactam**
4.5 grams IV Q6h.

**OR**

**Cefepime** 2 grams IV Q8h.
**AND**
**Metronidazole** 500 mg IV Q6h.

**OR**

**Ciprofloxacin** 400 mg IV Q12h.
**AND**
**Metronidazole** 500 mg IV Q8h.

### Skin and Soft Tissue or Necrotizing Infections

**IF PURULENT**:
**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500 mg.
**OR**
**Linezolid**[2] 600 mg IV Q12h.

**IF NON-PURULENT**:
**Cefazolin** 2 grams IV Q8h.
**OR**
**Ceftriaxone** 1-2 grams IV Q24h.
**OR**
**Ampicillin-sulbactam** 3 grams IV Q6h.

**IF NECROTIZING:**
**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500mg.
**AND**
**Piperacillin-tazobactam** 4.5 grams IV Q6h.
**AND**
**Clindamycin** 900 mg IV Q8h.

### Neutropenic Cancer Patients (ANC <500)

**Cefepime** 2 grams IV Q8h.
**OR**
**Piperacillin-tazobactam**
4.5 grams IV Q6-8h.

**AND**

**Vancomycin**[1] Load 25 mg/kg using IBW. Max dose 2500 mg.
**OR**
**Linezolid**[2] 600 mg IV Q12h.

**If concerned for HSV or VZV, consider adding:**

**Acyclovir**
10 mg/kg Q8h.
Consult pharmacy for max dosing.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by Clinical Guideline Committee 3/13/23.
**If comments about this guideline, please contact clinical_guidelines@ykhc.org**

[1] Consult pharmacy for subsequent dose/schedule.
[2] Linezolid may be substituted for vancomycin in patients with relative contraindication to vancomycin for high risk for acute kidney injury. Pharmacy consult required.
[3] Pharmacy consult required.

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Clinical Guideline

# Sepsis Vasoactive Medications (Adult)

## Vasopressors

*Central venous access is preferred for administration of vasopressors, but these may be administered through peripheral IV if unable to obtain central access. If in an SRC, pressors may be available. Consult ED physician.*

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| • Norepinephrine 2-80 mcg/min IV initial infusion rate. | First-line vasopressor of choice in sepsis. |
| • Vasopressin 0.03-0.04 units/min. | May be added to norepinephrine to increase MAP or decrease norepinephrine dose. DO NOT use as a single agent. |
| • Epinephrine 1-40 mcg/min initially, titrated to effect. | May be added or used in place of norepinephrine to maintain adequate BP. |
| • Dopamine 2-20 mcg/kg/min. | Second-line option in highly select patients as it causes more tachycardia. |
| • Phenylephrine 40-160 mcg/min IV initial infusion until stabilized. Titrate to usual range of 20-400 mcg/min. | Can be used as salvage therapy for refractive hypotension associated with tachycardia. |
| • Dobutamine 2-20 mcg/kg/min IV infusion. | May be used for inoptropic support in the presence of severe myocardial dysfunction or hypoperfusion with depressed cardiac output. |

## Corticosteroids

*Corticosteroids should NOT be administered for the treatment of sepsis in the absence of shock.*
If considering use of corticosteroids for septic shock refractory to pressors after euvolemia and appropriate antibiotic therapy achieved, consult ICU.
The exception is giving dexamethasone prior to first dose of antibiotics for meningitis.