

THESE GUIDELINES ARE FOR COMMUNITY ACQUIRED INFECTIONS ONLY

DO NOT USE THESE GUIDELINES (seek senior or microbiology /infectious diseases advice or refer to local antimicrobial guidelines) IF YOUR PATIENT HAS:

1. History of colonization/infection with antibiotic resistant organisms (e.g. MRSA / ESBL / VRE). Review previous laboratory results, IT alerts and/or healthcare record notes to determine evidence of previous colonization/infection with antibiotic resistant organisms.
2. Risk factors for antibiotic resistant organisms (e.g. recent (< 6 weeks) hospital admission, nursing home resident, recent antibiotic use, recent foreign travel (to countries of high risk for antimicrobial resistance), healthcare worker, etc.)
3. Allergy /contraindication to listed antimicrobials below
4. Significant immunocompromising condition e.g. transplant patients
5. Indwelling prosthetic material
6. Sepsis in other specific patient groups not listed below (e.g. infective endocarditis, necrotizing fasciitis, foreign travel-related sepsis, etc.)

Before starting antimicrobials/as soon as possible:

- IDENTIFY likely source of sepsis to ensure early appropriate antimicrobial treatment is commenced
- SEND appropriate microbiological specimens.
- CHECK previous microbiological culture reports as you may need to alter the antimicrobials below

The recommendations presented only apply to initial assessment upon ED presentation and treatment may change as appropriate clinical assessment and investigations are performed. Antimicrobial doses listed below are a guide only - adjust doses as appropriate if evidence of renal/hepatic impairment and/or based on local policy. Subsequent dosing interval and antimicrobial regimen based on clinical decision following further investigations and local policy.

Empiric antimicrobial recommendations according to source of sepsis.

Suspected source of sepsis	Antibiotics
Intraabdominal	Co-amoxiclav 1.2g iv +/-gentamicin* ^δ
Meningitis	Cefotaxime 2g iv (or ceftriaxone 2g iv) + vancomycin ^δ (+/- add dexamethasone as per local policy and aciclovir 10mg/kg iv if evidence or suspicion of viral encephalitis)
Neutropenic	Piperacillin/tazobactam 4.5g iv plus gentamicin ^δ
Respiratory	Community acquired pneumonia: Co-amoxiclav 1.2g iv plus clarithromycin 500mg iv Aspiration pneumonia: Co-amoxiclav 1.2g iv
Skin/soft tissue	Flucloxacillin 2g iv (add clindamycin 900mg iv and benzylpenicillin 2.4 g iv if invasive Group A streptococcus suspected). Infection originating from surgical wound sites following clean-contaminated/contaminated surgery (e.g. surgical procedures performed on gastrointestinal, genitourinary tract) or involving deeper tissues (e.g. necrotizing fasciitis) may have a polymicrobial aetiology (including anaerobic bacteria and gram-negative bacilli) and empiric antimicrobial therapy should be adjusted to reflect this. For these situations consult local guidelines or seek senior or microbiology /infectious diseases advice.
Urinary	Co-amoxiclav 1.2g iv +/- gentamicin* ^δ
Unknown (i.e. source unknown /unidentified following initial clinical assessment)	Without obvious gastrointestinal or genitourinary source Cefotaxime 2g iv (or Ceftriaxone 2g iv) +/- vancomycin* ^δ +/- gentamicin* ^δ

**Consider addition of gentamicin or vancomycin (using appropriate dose calculation) based on clinical judgment (particularly in the case of severe sepsis/septic shock)*

^δCalculate initial dose of gentamicin or vancomycin based on patient's creatinine clearance and local dosing policy