NHS
Tayside

Antimicrobial Treatment and Prophylaxis of Spontaneous Bacterial Peritonitis

Diagnosis

Spontaneous Bacterial Peritonitis (SBP) is a frequent and serious complication of cirrhotic patients with ascites. If your patient has liver cirrhosis, alcohol excess or alcoholic liver disease AND clinical ascites or shifting dullness or a fluid thrill present SBP should be suspected.

Investigations

A diagnostic ascitic tap should be performed and an urgent sample sent to:

- Microbiology for microscopy/gram stain and RCC/WCC cell counts.
- Microbiology (in blood culture bottle) for culture and sensitivities
- Biochemistry for albumin, protein and amylase

SBP is confirmed if:

- Neutrophil count of >250 cells/mm^3

OR

- WCC count >250 cells/ mm^3

AND

- ≥90% polymorphs

Ensure antibiotic treatment (see below) is prescribed, ascites is drained and IV albumin (4%) ordered and prescribed (1 unit for every 3L then continuous for 48 hours).

Antibiotic Treatment

SEVERE DISEASE (i.e. patient has sepsis) Total IV + PO course: 5-7 days

- Co-trimoxazole IV 960mg bd (*If CrCl <30ml/min reduce dose to 480mg BD*)
- Step down to Co-trimoxazole PO 960mg BD to finish course when clinically improved (*If CrCl <30ml/min reduce dose to 480mg BD)*

MILD DISEASE Total course: 5-7 days

- Co-trimoxazole PO 960mg BD
- If CrCl <30ml/min reduce dose to 480mg BD

Antibiotic Prophylaxis

Prophylaxis should be given to patients who do not have SBP but are at risk and those who have finished an SBP treatment course above and are still hospital inpatients. All prophylaxis should be stopped on discharge from hospital unless specific instructions from a consultant are documented in the medical notes.

- Co-trimoxazole PO 960mg OD
- If CrCl <30ml/min reduce dose to 480mg OD

Antibiotic Prophylaxis for Variceal Bleeding in Patients with Liver Cirrhosis

Bacterial infections occur in about 20% of patients with cirrhosis with upper gastrointestinal bleeding within 48 hours of admission, another 50% will have an infection during their hospital stay. Antibiotic prophylaxis reduces the risk of infection and mortality in this patient group.

- Co-trimoxazole 960mg BD for 5 days
- Use IV while NBM and convert to oral when able
- If CrCl <30ml/min reduce dose to 480mg BD

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