Antibiotic Pathway for Vascular Surgery Clinical Network

For guidance on any other infection not covered by this policy see 'Hospital Antibiotic Adult for more information
Separate dosing guidelines are available for 'Vancomycin' and 'Gentamicin'. See ward pharmacist for more information
Always document indication and duration/review date in medical notes and administration chart
Separate guidance is available for 'Antibiotic Prophylaxis in Vascular Surgery'

NHS Tayside

TREATMENT

Before starting antibacterial treatment take blood cultures and appropriate samples. Assess severity and MRSA risk (see HPS Decolonisation Policy for treatment)

	Mild Patient has no sign of systemic infection i.e. SIRS < 2. Infection is confined to the skin or subcutaneous tissue.	**Moderate** Either: (a) lymphatic streaking, deep tissue infection (involving subcutaneous tissue, fascia, tendon, bone) or abscess, or (b) cellulitis >2 cm.	**Severe** Any infection accompanied by severe systemic toxicity (fever, chills, shock, vomiting, confusion, metabolic instability).	**MRSA positive or high risk of MRSA based on risk factor assessment** Confirm sensitivities
Chronic Limb Ischaemia (CLI) +/- areas of necrosis	Treat as per Cellulitis guidelines Flucloxacillin 1g qds If pen allergy Doxycycline100mg bd	Flucloxacillin 2g IV qds + Metronidazole 500mg IV tds + Gentamicin* IV If pen allergy Vancomycin IV + Gentamicin* IV + Metronidazole 500mg IV tds **Review** all antibiotics at **72 hours** and rationalise where possible *(esp. the need for continuing IV gram negative therapy)* Step down to Co-amoxiclav 625mg tds or if pen allergy Doxycycline100mg bd + Metronidazole 400mg tds		Vancomycin IV instead of Flucloxacillin IV if appropriate for moderate and severe regimens opposite. If patient cannot tolerate Vancomycin then use Linezolid 600mg bd as an alternative (second line). Seek ID/micro advice. See guidance
Infected Prosthetic Graft	Flucloxacillin 2g IV qds + Gentamicin* IV. If penicillin allergy Vancomycin IV + Gentamicin* IV [NB. In situations where Prosthetic graft infection is suspected and no cultures back or culture negative – risk/benefit assessment needs to be made by surgical team. May need long term oral antibiotic therapy e.g. co-trimoxazole 960mg od or doxycycline 100mg od +/- rifampicin following a period of IV treatment therapy. Check for rifampicin sensitivity. Rifampicin should be prescribed after consideration of co-morbidities, potential hypersensitivity and drug interactions. If cultures then come back positive or if patient worsens seek ID/Micro advice]. Must be reviewed every 3-6 months by vascular specialists. Step down to Co-trimoxazole 960mg bd			Vancomycin IV instead of Flucloxacillin IV to regimen opposite. Check sensitivities for IVOST options e.g. Doxycycline 100mg od + Rifampicin Or Co-trimoxazole 960mg bd + Rifampicin Or Linezolid 600mg bd
Diabetic Foot Infection	See NHS Tayside Diabetic Foot Ulcer Treatment Guidelines Antibiotic therapy is to treat infection NOT heal ulcers Samples for microbiology should be obtained from all ulcers prior to initiation of antibiotic therapy Infection Specialist advice should be sought if any uncertainty			Vancomycin IV instead of Flucloxacillin IV to regimen opposite
OHPAT Discuss with ID team: Tay.id@nhs.scot and OHPAT team Tay.immohpat@nhs.scot	Assess suitability for patients requiring OHPAT. Contact ID and OHPAT team for advice at least 3 working days prior to discharge. May require Daptomycin therapy. See guidance			

* If patient is receiving dialysis or other renal risk factors, has an eGFR <30ml/min, is on concurrent nephrotoxic drugs, cannot tolerate Gentamicin, or if IV therapy is still indicated after 96 hours check sensitivities and consider using Aztreonam See guidance

Updated by Vascular Team/AMG
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