# Louth: Antimicrobial Guidelines - Louth Hospitals: Antimicrobial Guidelines: Postnatal

## Obstetrics - Severe Life-Threatening Post-natal Sepsis - Source Unclear

**Indication**

Obstetrics - Severe Life-Threatening Postnatal Sepsis – Source Unclear

Definition of Severe Sepsis: Sepsis plus sepsis-induced organ dysfunction or tissue hypoperfusion.

**First Line Antimicrobials**

**N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. ALWAYS contact clinical microbiologist for advice.**

Meropenem 1g TDS IV

**AND**

Clindamycin 1.2g QDS IV

**N.B.** Use meropenem with great caution and close clinical monitoring if history of immediate-onset or severe penicillin hypersensitivity – approximately 1% risk of immediate-onset hypersensitivity to meropenem in patients with history of immediate-onset penicillin hypersensitivity.

## Obstetrics - Mild Infection - C-section Wound / Endometritis / Perineal / post-ERPC

**Indication**

Obstetrics - Mild Infection - C-section Wound / Endometritis / Perineal / post-ERPC

**First Line Antimicrobials**

Co-amoxiclav 625mg TDS PO

**NON-immediate-onset and NON-severe Penicillin Hypersensitivity**

Cef-AL-exin 500mg TDS PO

**AND**

Metronidazole 400mg TDS PO

**IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity**

Clindamycin 450mg QDS PO

**Comments**

- Send wound swab for C&S and review treatment in conjunction with results when available.

**Duration**

5 - 7 days

## Obstetrics - Moderate to Severe Infection - C-section Wound/ Endometritis/ Perineal/ post-ERPC/ Third or Fourth Degree Tear/ Source Unknown

**Indication**

Obstetrics - Moderate to Severe Infection - C-section Wound/ Endometritis/ Perineal/ post-ERPC/ Third or Fourth Degree Tear/ Source Unknown

**First Line Antimicrobials**

**N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. If present, contact clinical microbiologist for advice.**

Co-amoxiclav 1.2g TDS IV

**AND**

Gentamicin 5mg/kg once daily IV

**NON-immediate-onset and NON-severe Penicillin Hypersensitivity**

**N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. If present, contact clinical microbiologist for advice.**

Cef-UR-oxime 1.5g QDS IV

**AND**

Metronidazole 500mg TDS IV

**AND**

Gentamicin 5mg/kg once daily IV

**IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity**

**N.B. Ask patient about the nature of their penicillin hypersensitivity .**

**N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. If present, contact clinical microbiologist for advice.**

Clindamycin 900mg TDS IV

**AND**

Gentamicin 5mg/kg once daily IV

**Duration**

Minimum 7 days based on C&S results and clinical response.

## Obstetrics - Mastitis – Mild

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| **Indication** |
| Obstetrics - Mastitis – Mild |
| **First Line Antimicrobials** |
| Flucloxacillin 1g QDS PO |
| **NON-immediate-onset and NON-severe Penicillin Hypersensitivity** |
| Cef-AL-exin 1g QDS PO |
| **IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity** |
| Clindamycin 450mg QDS PO |
| **Duration** |
| 7 days |

## Obstetrics - Mastitis/ Breast Abscess – Moderate to Severe

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| **Indication** |
| Obstetrics - Mastitis/ Breast Abscess – Severe |
| **First Line Antimicrobials** |
| Flucloxacillin 2g QDS IV if no history of MRSA<br><br>If history of MRSA colonisation, SUBSTITUTE Vancomycin 25mg/kg loading dose (max 2g), followed by 15mg/kg BD IV<br><br>N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline. |
| **NON-immediate-onset and NON-severe Penicillin Hypersensitivity** |
| Cef-UR-oxime 1.5g QDS IV if no history of MRSA<br><br>If history of MRSA colonisation, SUBSTITUTE Vancomycin 25mg/kg loading dose (max 2g), followed by 15mg/kg BD IV<br><br>N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline. |
| **IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity** |
| Vancomycin 25mg/kg loading dose (max 2g), followed by 15mg/kg BD IV<br><br>**AND**<br><br>Clindamycin 900mg TDS IV (Review clindamycin at 48hrs) |
| **Comments** |
| • **Surgical referral essential if breast abscess confirmed** .<br>• Microbiological Investigations:<br>  • MRSA screen<br>  • Blood cultures<br>  • Breast milk for C&S<br>  • Breast swab (if discharging abscess) for C&S. |

## Obstetrics - Nipple Thrush and Ductal Candidiasis

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| **Indication** |
| Obstetrics - Nipple Thrush and Ductal Candidiasis |
| **First Line Antimicrobials** |
| **Nipple treatment for mother:**<br><br>Miconazole 2% cream applied to nipples and areolae after each feed for 1 to 2 weeks. It is not necessary to wash the cream from the nipples before the next breastfeed - any excess cream should be wiped away.<br><br>**Oral treatment for baby:**<br><br>Miconazole oral gel smeared around inside of mouth four times a day after feeds for 2 weeks. **N.B** . Apply the gel in small amounts with a clean finger and do not use a spoon due to the risk of the baby choking on the viscous fluid.<br><br>**Second line treatment:**<br><br>Fluconazole for ductal candidiasis should only be commenced after senior clinician review.<br><br>If symptoms persist for more than 5 - 7 days, consider oral treatment of mother with fluconazole in addition to topical treatment as above: Loading dose fluconazole 300mg PO, followed by 150mg daily PO for a total of 14 days of treatment. |
| **Duration** |
| Topical treatment for mother and baby should continue until 7 days after symptoms have disappeared.<br><br>Fluconazole PO: 14 days. |
| **Comments** |
| • If a mother reports sore nipples during breastfeeding the first action should always be to re-examine and improve attachment. It is imperative that both mother and baby are treated simultaneously, even when there are no signs in the baby's mouth. Otherwise the baby will re-infect the mother at each feed. Babies frequently show no signs of oral thrush, even though their mothers have the symptoms. |

## Obstetrics - Postnatal Urinary Tract Infection

Urinary Tract Infections