

## Louth: Antimicrobial Guidelines - Louth Hospitals: Antimicrobial Guidelines: Vascular Catheter Infections

<b>Indication</b>	
Peripheral Vascular Catheter (PVC) Infection	
<b>First Line Antimicrobials</b>	
Flucloxacillin 2g QDS IV	
If history of MRSA colonisation, <b>SUBSTITUTE</b> <a href="#">Vancomycin</a> 25mg/kg loading dose (max 3g), followed by 15mg/kg BD IV	
N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline.	
<b>NON-immediate-onset and NON-severe Penicillin Hypersensitivity</b>	
Cef-AZ-olin 2g TDS IV	
If history of MRSA colonisation, <b>SUBSTITUTE</b> <a href="#">Vancomycin</a> 25mg/kg loading dose (max 3g), followed by 15mg/kg BD IV	
N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline.	
<b>IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity</b>	
Clindamycin 450mg QDS PO or 600mg QDS IV (excellent oral bioavailability)	
If history of MRSA colonisation, <b>SUBSTITUTE</b> <a href="#">Vancomycin</a> 25mg/kg loading dose (max 3g), followed by 15mg/kg BD IV	
N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline.	
<b>Comments</b>	
<b>REMOVE THE INFECTED PVC IMMEDIATELY.</b>	
PVCs are a portal of entry for <i>Staph. aureus</i> . PVC infections can manifest as local phlebitis or bloodstream infections. The risk of PVC infection may be reduced by:	
<ul style="list-style-type: none"> <li>• Insertion with care and strict attention to standard precautions</li> <li>• Daily review of ongoing need for PVC and removal as soon as no longer required.</li> </ul>	
<b>Microbiological Investigations:</b>	
<ul style="list-style-type: none"> <li>• Blood cultures if systemically unwell</li> <li>• Swab pus or exudate from PVC exit site</li> <li>• <b>N.B. Check for history of MRSA infection or colonisation – this may influence choice of empiric agent.</b></li> </ul>	
<b>Duration of Treatment</b>	
<b>If blood cultures positive for <i>S. aureus</i> :</b>	
<ul style="list-style-type: none"> <li>• <b>14 DAYS MINIMUM IV COURSE</b> from the date of first negative set of blood cultures and absence of deep-seated infection (e.g. endocarditis) on further investigation. Always discuss with Clinical Microbiology team.</li> </ul>	
<b>If phlebitis with sterile blood cultures:</b>	
<ul style="list-style-type: none"> <li>• Review at 5 days</li> <li>• Review empiric antimicrobial therapy in conjunction with C&amp;S after 48 hours &amp; consider IV to PO switch</li> </ul>	
<b>Indication</b>	
Central Vascular Catheter (CVC) Infection	
<b>First Line Antimicrobials</b>	
<b>Local CVC exit site infection in systemically well patient:</b>	
Line removal and topical antiseptic care may be sufficient.	
If antimicrobials indicated, please contact Clinical Microbiologist to discuss.	
<b>Systemically unwell patient with suspected CVC infection (please note CVC exit site may appear normal):</b>	
<a href="#">Vancomycin</a> 25mg/kg loading dose (max 3g), followed by 15mg/kg BD IV	
N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline.	
<b>Comments</b>	
<b>CAN THE CVC BE REMOVED?</b> Always discuss with senior clinician.	
<b>Microbiological Investigations:</b>	
<ul style="list-style-type: none"> <li>• Take <b>two sets of blood cultures</b> from CVC lumen and from peripheral vein or if peripheral blood cultures cannot be obtained, take second set from a different lumen of CVC</li> <li>• Swab pus or exudate from CVC exit site if evidence of local infection</li> <li>• If CVC is removed for suspected infection, send <b>CVC tip</b> in sterile container.</li> </ul>	
<b>Duration of Treatment</b>	
Duration depends on blood culture results, pathogens isolated, clinical response and absence of deep-seated focus of infection (e.g. endocarditis) on further investigation.	