Spontaneous Bacterial Peritonitis (SBP) or Spontaneous Bacterial Pleuritis, Cirrhosis Adult Panel

For adults with cirrhosis diagnosed with Spontaneous	Bacterial Peritonitis (ascites PMN greater than	n 250 cells/mm³) or Spontaneous Bacterial Pleuritis (pleura
fluid PMN greater than 500 cells/mm ³ or greater than	250 cells/mm3 with positive culture).	

Recommendations for Plasma Protein Albumin infusions (ordered using the Plasma Protein Albumin 25% panel): Day 1 - Albumin 25% (100ml=25g) IV 1.5 g/kg. Maximum dose is 400ml (100g) per day.

Day 3 - Albumin 25% (100ml-25g) IV 1g/kg on day 3 of SBP treatment. Maximum dose is 400ml (100g) per day.

Blood Culture Panel - Adult x 2

Diagnostic Imaging

Ultrasound guided paracentesis - Consider repeating a diagnostic paracentesis after 48 hours of antibiotic therapy. With non-response (less than 25% reduction in the PMN count), consider broadening antibiotic therapy and ruling out secondary peritonitis: open and merge Gastroenterology Ascites Fluid Analysis panel (diagnostic).

Consider CT Abdomen if polymicrobial culture or signs of secondary peritonitis and no contraindication to CT.

CT Abdomen

Once

Medications

Antibacterial

Select Risk Factor:

Consider the following risk factors when choosing appropriate antibiotics: Hospitalization or antibiotic use within the last 3 months, from long-term care or on hemodialysis, infection starting at or after 72 hours post admission, previous documented colonization or infection with MRSA, VRE or an Extended Spectrum Beta-lactamase producing organism, presentation with sepsis/septic shock. In all patients, it is essential to review and narrow the antibiotic spectrum as soon as possible (72 hours) using culture and susceptibility results. Most patients will need treatment for 7 days.

- Q_IFor patients without risk factors for healthcare associated infection, hospital acquired infection or sepsis/septic shock
 - cefTRIAXone IV (\$4.29)
 - 2 g, intravenous, every 24 hours, scheduled
 - ciproFLOXacin IV or PO
 - ciprofloxacin IV (\$7.20)
 - 400 mg, intravenous, every 12 hours
 - ciprofloxacin tablet (\$0.11) 500 mg, oral, 2 times per day
- Risk factors for healthcare associated infection (hospitalization or antibiotic use within the last 3 months, from long-ter m care, or on hemodialysis)
- Opiperacillin-tazobactam 4.5 g in NaCl 0.9% 100 mL MFG/Premix (\$31)
 - 4.5 g, intravenous, every 8 hours, scheduled, First Dose today at 1615
- Off patient has a known Penicillin Allergy
 - cefTRIAXone 2 g in NaCl 0.9% 100 mL MFG/Premix (\$4.29)
 - 2 g, intravenous, every 24 hours, scheduled, First Dose today at 1615
 - vancomycin IV
 - OVancomycin Loading dose followed by scheduled dose

vancomycin 2,000 mg in NaCl 0.9% 500 mL bag (\$8.71)

2,000 mg (rounded from $2,040 \text{ mg} = 25 \text{ mg/kg/dose} \times 81.6 \text{ kg}$), intravenous, once, today at 1615, For 1 dose Based on actual body weight; maximum maintenance dose is 2 grams. Adjust based on CrCl and dosing tables- reassess at 48-72h with culture results. Vancomycin pre-level 30 minutes or less prior to 4th dose. Do not hold next dose while waiting for results. Consult pharmacist before rescheduling administration times as it may impact drug levels.

□ Followed by

vancomycin 1250 mg in NaCl 0.9% 250 mL mfg (\$8.71)

1,250 mg (rounded from 1,224 mg = 15 mg/kg/dose \times 81.6 kg), intravenous, every 12 hours, First Dose tomorrow at 0415

Based on actual body weight; maximum maintenance dose is 2 grams. Adjust based on CrCl and dosing tables- reassess at 48-72h with culture results. Vancomycin pre-level 30 minutes or less prior to 4th dose. Do not hold next dose while waiting for results. Consult pharmacist before rescheduling administration times as it may impact drug levels.

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linezolid IV or PO
O linezolid injection (\$31)
600 mg, intravenous, every 12 hours, scheduled, use instead of Vancomycin if suspected VRE
○ linezolid tablet (\$33)
600 mg, oral, every 12 hours, scheduled, use instead of Vancomycin if suspected VRE
For any unstable patient with prior colonization/infection with MRSA, add in
vancomycin IV
O Vancomycin Loading dose followed by scheduled dose
vancomycin 2,000 mg in NaCl 0.9% 500 mL bag (\$8.71)
2,000 mg (rounded from 2,040 mg = 25 mg/kg/dose × 81.6 kg), intravenous, once, today at 1615, For 1 dose
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dose while waiting for results. Consult pharmacist before rescheduling administration times as it may impact drug
levels.
For any unstable patient with prior colonization/infection with VRE, add in
linezolid IV or PO
O linezolid injection (\$31)
600 mg, intravenous, every 12 hours, scheduled, use instead of Vancomycin if suspected VRE
O linezolid tablet (\$33)
600 mg, oral, every 12 hours, scheduled, use instead of Vancomycin if suspected VRE
Long Term Prophylaxis After IV antibiotics are complete start accordant prophylaxis with circuffeyagin or on trimayazala. (Cancider switching to Norfleyagin 400 mg PO daily at
After IV antibiotics are complete start secondary prophylaxis with ciprofloxacin or co-trimoxazole. (Consider switching to Norfloxacin 400 mg PO daily at discharge as the first choice for long-term therapy).
Note: These are currently defaulted to start in 7 days from start of order. Change start time as needed.
○ ciprofloxacin tablet (\$0.11)
500 mg, oral, daily, 2 hours after breakfast, Starting H+168 Hours
sulfamethoxazole-trimethoprim 800 mg-160 mg per tablet (\$0.23)

160 mg of trimethoprim, oral, daily, Starting H+168 Hours