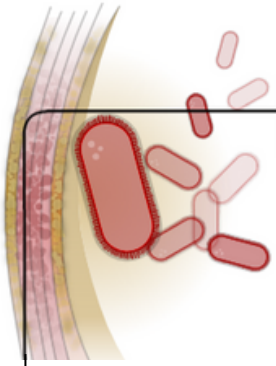

Spontaneous bacterial peritonitis and pleuritis

Specific management

Provide appropriate and timely antibiotics

***As needed, adjust all antibiotic doses based on creatinine clearance.**
***Continue antibiotics for 5-7 days (duration for bacteremia may differ by local guidelines)**
***Streamline antibiotic spectrum to culture susceptibility results**
***Repeat paracentesis at 48 hour with clinical non-response, particularly at centers with high rates of resistance (the PMN count should decrease by ≥25% from baseline; if not broaden antibiotics and investigate for secondary peritonitis)**
***The algorithm may need to be adjusted for local antibiotic resistance patterns**

Sepsis/septic shock? → **REFER TO LOCAL SEPSIS MANAGEMENT GUIDELINES Suggest Meropenem AND Vancomycin OR Linezoid (if history of Vancomycin Resistant Enteroccus)**

Hospital acquired? (≥72 hours post admission) OR KNOWN PREVIOUS RESISTANT ORGANISM previous documented colonization/infection with ESBL or ampC producing organism → **Suggest Meropenem**

Risk factors for Healthcare Acquired Infection
- Hospitalization, antibiotic use within last 3 months, from long term care or on hemodialysis

→ **Suggest Piperacillin-tazobactam**

None of the described risk factors? → **Suggest Ceftriaxone**

In addition, for any unstable patient who has

Previous colonization/infection with MRSA → **Suggest adding Vancomycin**

Previous colonization/infection with VRE → **Suggest adding Linezolid**

Example doses for normal renal function

Active treatment

- Cefriaxone 2grams IV every 24 hours
- Ciprofloxacin 400mg IV (or 500 mg PO) every 12 hours
- Linezolid 600mg IV/PO every 12 hours
- Meropenem 500mg IV every 6 hours
- Piperacillin-tazobactam 4.5 grams IV every 8 hours
- Vancomycin 25 mg/kg IV once. *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*

THEN

- *Vancomycin 15mg/kg IV every 12 hours. 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.*

Secondary Prophylaxis (preventing recurrent infection)

- Start prophylaxis once antibiotic course completed
- Continue indefinitely (unless complete resolution of ascites & pleural fluid)
- **Preferred:** Norflaxicin 400mg PO QD (not on hospital formulary in Alberta, but can be prescribed at discharge)
- **Alternatives (one of)**:
  - Ciprofloxacin 500mg PO QD
  - Levofloxacin 250mg PO QD
  - TMP-SMX 1 double strength tab PO QD (patients who develop quinolone-resistant organisms may also have resistance to TMP-SMX)