Adult IV to Oral Antibiotic Switch Therapy Guidelines

NHS Dumfries & Galloway

Patients receiving IV antibiotics may be considered suitable for a switch to oral WITHIN THE FIRST 48hrs and every 24hrs thereafter IF the following inclusion criteria are MET and NONE of the specific exclusion criteria apply.
The need for IV therapy should be reviewed after 24hrs however 48hrs will usually be required to observe a pattern of improvement assuming the use of IV antibiotic has been appropriate initially.
The rationale to continue IV therapy must be clearly documented in medical notes.
Be guided by culture and sensitivities. If in doubt, contact Consultant Microbiologist

General Inclusion Criteria

- Able to swallow and tolerate oral fluids
- Clinical improvement
- Temperature 36ºC - 38ºC for at least 48hrs
- Heart rate <90bpm for previous 12hrs
- White cell count (WCC) between 4 and 12x10^9L
- Oral formulation or alternative available

make the switch
FROM IV TO ORAL ANTIBIOTICS

Specific Exclusion Criteria

- Oral route compromised:
  - Vomiting/nil by mouth
  - Unconscious without enteral feed tubes
  - Mechanical swallowing disorder
  - Oral fluids not tolerated
- Absorption problem- diarrhoea/steatorrhoea
- Continuing severe sepsis - 2 or more from
  - Temp >38ºC or <36ºC
  - Heart beat >90bpm
  - Respiratory rate >20/min
  - Worsening WCC and/or CRP
- Febrile with neutropenia - neutrophils <1
- Specific indications
  - Meningitis/encephalitis
  - Endocarditis
  - Immunosuppression
  - Osteomyelitis
  - Septic arthritis
  - Deep abscess
  - Cystic fibrosis
  - severe soft tissue infections such as group A streptococcal infections
  - Hickman (central) line infection
- No oral formulation of the drug or specified alternative available

SUITABLE FOR SWITCH?

YES

Make the switch to oral therapy
Switch to oral therapy (usually for 5 - 7 days)
- Check contra-indications, ADRs and potential drug interactions in BNF
- Change on medicine chart
- Remove IV cannula if not required

NO

Continue IV
- Continue to review the need for IV antibiotics every 24hrs.
- Monitor venflon site daily every time vital sign observations are made.

Switch to Oral Therapy - Check empirical guidelines first for recommended switch. If no oral switch given, the following is a guide or alternatively, contact microbiology or pharmacy.

IV Agent	Oral agent with dose suggestions	Liquid & rectal formulations available
Amoxicillin	Amoxicillin 500mg 8 hourly	Amoxicillin suspension 125mg/5ml & 250mg/5ml
Benzylpenicillin	Phenoxymethylpenicillin[1] 500mg-1g, 6 hourly OR Amoxicillin[1] 500mg tds	Phenoxymethylpenicillin oral solution 125mg/5ml & 250mg/5ml Amoxicillin suspension 125mg/5ml & 250mg/5ml
Cefotaxime	Discuss with Consultant Microbiologist	Discuss with Consultant Microbiologist
Ciprofloxacin	Ciprofloxacin[2] 500-750mg 12 hourly (if pseudomonas suspected increase to Ciprofloxacin 750mg 12 hourly)	Ciprofloxacin suspension 250mg/5ml
Clarithromycin	Clarithromycin 500mg 12 hourly	Clarithromycin suspension 125mg/5ml & 250mg/5ml
Clindamycin	Clindamycin <60kg 300mg 6 hourly, >60kg 450mg 6 hourly	No liquid formulation available.
Co-Amoxiclav	Co-Amoxiclav 375-625mg 8 hourly.	Co-Amoxiclav suspension 250/62. If dose is 625mg prescribe 250/62 x 10ml
Flucloxacillin	Flucloxacillin 500mg - 1g 6 hourly	Flucloxacillin oral solution 125mg/5ml & 250mg/5ml
Gentamicin	Ciprofloxacin 500mg bd or 750mg bd if pseudomonas suspected[2]	Ciprofloxacin suspension 250mg/5ml
Metronidazole	Metronidazole 400mg 8 hourly	Metronidazole suspension 200mg/5ml and 500mg suppositories
Rifampicin	Rifampicin 0.6 - 1.2g daily in 2-4 divided doses	Rifampicin syrup 100mg/5ml
Tazocin	Co-Amoxiclav 375-625mg 8 hourly.	Co-Amoxiclav suspension 250/62. If dose is 625mg prescribe 250/62 x 10ml
Vancomycin	Discuss with Consultant Microbiologist	Discuss with Consultant Microbiologist

1. Amoxicillin has slightly better tissue penetration than Phenoxymethylpenicillin and is better for deep seated infections
2. Oral ciprofloxacin has excellent bioavailability, good tissue and pus penetration and is active against pseudomonas

The table above applies only to patients with normal renal function. Doses should be adjusted according to severity of infection.

FOR MORE INFORMATION OR ADVICE, CONTACT CONSULTANT MICROBIOLOGIST

Developed by Antibiotic Management Team July 2009 This version April 2012