1. **PURPOSE:**

1.1. To create awareness on Antibiotic use as misuse is counterproductive

1.2. It restricts the occurrence of antibacterial resistance among the hospital strains and controls spread of infection to susceptible and critically ill patients.

1.3. While cross-infection is a major impediment in control of resistance, careful antibiotic prescribing can curtail the emergence and reduce the prevalence of resistance.

1.4. It is useful in reducing cost of therapy and adverse drug reactions, thus maintaining the quality of care.

1.5. Objectives Of The Antibiotic Policy

1.5.1. Not to use antibiotics casually

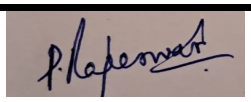
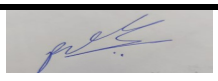
1.5.2. The avoidance of use of powerful antibiotics in the initial treatments

1.5.3. To create awareness that powerful broad spectrum antibiotics are being spared for later treatment

2. **SCOPE:**

Establishment of a rational antibiotic policy is important for better patient care as well as combating anti microbial resistance. In this only common medical and surgical conditions are covered. **Medical profession must realize that our aim is to give the right drug for the right bug.**

3. **RESPONSIBILITY**

Prepared by: 	**Verified by:** 	**Approved by:** 
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3.1. Antibiotic Working Group

3.1.1. Annual action plan and update

3.1.2. Periodic monitoring for compliance

3.1.3. Periodic updating of antibiotic sensitivity patterns to the clinicians

3.1.4. Devise specific plans for certain high risk areas

3.1.5. Devise strategies to improve compliance

3.1.6. Monitor effectiveness of the plan on an annual basis.

3.1.7. The group shall report to the Infection control committee

3.2. Infection Control Committee

3.2.1. Provide relevant surveillance data to the Antibiotic working group

3.2.2. Liaison with the management for implementation of the Antibiotic working group recommendations

3.3. Clinical Staff

3.3.1. Strict adherence to the policy

3.3.2. Discuss with the ICC regarding deviations from the policy

3.3.3. Full cooperation with Antibiotic working group

4. PROCEDURE:

4.1. Appropriate prescribing

4.1.1. This is achieved by

a) Education on appropriate prescribing

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b) Feedback of antibiotic prescribing data

c) Restrictions on antibiotic usage

4.2. Education of staff

4.2.1. Induction training for new staff

4.2.2. Mandatory "on-going" training for existing staff.

4.2.3. Focused training in high risk areas of Hospital Acquired Infection

4.3. Feed back

4.3.1. Monthly feedback of hospital acquired infection to the concerned clinicians

PROCEDURE:

1.1. Recommendations regarding surgical antibiotic prophylaxis:

1.1.1. **Highly recommended:** Prophylaxis unequivocally reduces major morbidity, reduces hospital costs and is likely to decrease overall consumption of antibiotics

1.1.2. **Recommended:** Prophylaxis reduces short-term morbidity but there are no Randomized Critical Trials (RCT) that prove that prophylaxis reduces the risk of mortality or long-term morbidity. However, prophylaxis is highly likely to reduce major morbidity, reduce hospital costs and may decrease overall consumption of antibiotics

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1.1.3. **Recommended with exceptions:** Prophylaxis is recommended for all patients with certain exceptions where Prophylaxis may not reduce hospital costs and could increase consumption of antibiotics, especially if given to patients at low risk of infection.

1.1.4. **Not recommended**: Prophylaxis has not been proven to be clinically effective or consequence of infection is minimal where prophylaxis is likely to increase hospital antibiotic consumption for little clinical benefit.

1.2. Risk Factors for Surgical Site Infection

Factors affecting the incidence of surgical site infection

1.3. Classification of Operation

Operations can be categorized into four classes with an increasing incidence of bacterial contamination and subsequent incidence of postoperative infection.

Refer to the table below:

Class	Definition
Clean	Operations in which no inflammation is encountered and the respiratory, alimentary or genitourinary tracts are not entered. There is no break in aseptic operating theatre technique.
Clean-contaminated	Operations in which the respiratory, alimentary or genitourinary

	tracts are entered but without significant spillage.
Contaminated	Operations where acute inflammation (without pus) is encountered, or where there is visible contamination of the wound. Examples include gross spillage from a hollow viscous during the operation or compound/open injuries operated on within four hours.
Dirty	Operations in the presence of pus, where there is a previously perforated hollow viscous or compound/open injuries more than four hours old.

The guideline applies to all elective operations in the clean, clean-contaminated or contaminated categories. Recommendations for prophylaxis of emergency surgery are limited to clean operations (e.g. emergency repair of abdominal aortic aneurysm or open fixation of a closed fracture) and emergency caesarean section, which is a clean contaminated operation. (AB list attached)

1.4. Insertion of Prosthetic Implants

Insertion of any prosthetic implant increases the risk of infection of the wound and surgical site. The implant has a detrimental effect on the patient's host defenses. As a result, a lower bacterial inoculum is needed to cause infection of a

prosthetic implant than of viable tissue. Thus the chance of infection is increased.

1.5. Duration of Surgery.

Duration of surgery is positively associated with risk of wound infection and this risk is additional to that of the classification of operation.

1.6. Co-Morbidities

The American Society of Anesthesiologists (ASA) has devised a preoperative risk score based on the presence of co-morbidities at the time of surgery (see Table 2). An ASA score >2 is associated with increased risk of wound infection and this risk is additional to that of classification of operation and duration of surgery.

1.7. ASA Classification of Physical Status (Table 2)

ASA score	Physical status
1	A normal healthy patient
2	A patient with a mild systemic disease
3	A patient with a severe systemic disease that limits activity, but is not Incapacitating

4	A patient with an incapacitating systemic disease that is a constant threat to life
5	A moribund patient not expected to survive 24 hours with or without operation

2. REFERENCE:

To Departmental antibiotic protocols

GASTROINTESTINAL & INTRA-ABDOMINAL INFECTIONS

Condition	Likely Causative Organisms	Empiric (Presumptive) Antibiotics/First Line	Alternative Antibiotics/ Second Line	Comments
Acute Gastroenteritis **Food Poisoning**	Viral, Enterotoxigenic & Entero-Pathogenic E. Coli S. aureus, B.cereus, C. botulinum	None	None	Rehydration (Oral/IV) essential

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Cholera	V. Cholerae	Doxycycline 300mg Oral stat	Azithromycin 1gmOral stat (or) Ciprofloxacin 500mg BD for 3 days	Rehydration (Oral/IV) is essential Antibiotics are adjunctive therapy.
Bacterial dysentery	Shigellasp., Campylobacter, Non – typhoidal salmonellosis. Shiga toxin profucing E. coli	Ceftriaxone 2gm IV OD for 5 days Antibiotic Treatment not recommended	Azithromycin 1g OD x 3 days	For Campylobacter the drug of choice is azithromycin
Amoebic dysentery	E. histolytica	Metronidazole 400mg Oral TDS for 7 – 10 days		Add diloxanide furoate 500 mg TDS for 10days
Giiardiasis	Giardia lamblia	Metronidazole 250 – 500mg oral TID x7 to 10 days		
Enteric fever	S. Typhi, S. paratyphi A	**Out patiens:** Cefixime 20mg/kg/day for 14 days or Azithromycin	Cotrimoxazole 960 mg BD for 2 weeks	

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		500mg BD for 7 days. **Inpatients:** Ceftriaxone 2g IV BD for 2 weeks +/- Azithromycin 500mg BD for 7 days		
Biliary tract infections **Acute cholangitis** **Acute Cholescystitis**	Enterobacteriaceae (E.coli, Klebsiellasp.)	Piperacillin-Tazobactam 4.5gm IV + Metronidazole 500mg I.V.TID For 7-10 days Cefoperazone-Sulbactam 3gm IV 12hourlyFor 7-10 days	Imipenem 500mg IV 6hourly	

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Acute Cholescystitis Complicated by Empyema or perforation		Piperacillin- Tazobactam 4.5gm IV For 7-10 days 6 hourly		Carbapenenum, Imipenem 500mg IV 6hourly
Hospital acquired Diarrhea	*C. difficile*	Metronidazole 400 mg oral TDSfor 10days	Severe disease:start Vancomycin 250 mg oral 6h empirically.	
Spontaneous bacterial **Peritonitis**	Enterobacteriaceae (E.coli, Klebsiellasp.)	Cefotaxime 1-2 gm IV TDS +Norfloxacin or Cefoperazone- Sulbactam 3gm IV 12h	Piperacillin- Tazobactam 4.5gm IV 8 hourly	
Helico Bacter Pylori Infections		Amoxicillan - 1grm / Clarithromycian – 500Mg/ Pantaprazole – 40Mg (or) Levofloxacin/Cla		

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		rithromycian – 500Mg/ Pantaprazole 40Mg 10 to 14 days		
Secondary peritonitis, Intra-abdominal abscess/ GI perforation	Enterobacteriaceae (E.coli, Klebsiella sp.), Bacteroides (colonicperforation), Anaerobes	Piperacillin- Tazobactam 4.5gm IV 8 hourly (Or) Cefoperazone- Sulbactam 3gm IV 12hourly in severe Infections In very sick patients, if required, addition of cover for yeast (fluconazole iv	Imipenem 1g IV 8hourly (or) Meropenem 1gm IV 8hourly (or) Doripenem 500mg TDS (or) Ertapenem 1gm IV OD	Source control is important to reduce bacterial load. If excellent source control – for 5-7 days; other wise 2-3 weeks suggested.

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		800 mg loading dose day 1,followed by 400 mg 2nd day onwards) & and for Enterococcus (vancomycin /teicoplanin) may be contemplated		
Acute Pancreatitis (or) Acute Necrotizing Pancreatitis without Infection		No Antibiotics		
Acute necrotizing pancreatitis: infected	Entrobacteriaceae, Enterococci, S.	Imipenem-Cilastatin 500mg IV 6hourly		Duration of treatment is based

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pseudocyst; pancreatic	aureus, S.epidermidis, anaerobes, Candida sp.	Ciprofloxacin 500Mg BD + Metronidazole 500Mg IV TID For 7-10 days	Meropenem 1gm IV 8hourly (or) Doripenem 500mg IV 8h	on source control and clinical improvement
Complicated Intra Abdominal Infections with Post Operative Leaks (Secondary Peritonities)		Imipenem-Cilastatin 500mg IV 6hourly (or) Meropenem 1gm IV 8hourlyFor 7-10 days	Tigecycline Colistin+ Antifungals – Should be started Immidetly incase of Immuno compremised Fluconzole IV 800Mg Loading Dose Day 1 followed by 400 Mg second day onwards	

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Diverticulitis **Mild-OPD treatment**	Gram-Negative Bacteria Anaerobes	Amoxycillin- Clavulanate 625mg TDS for 7 days	Ciprofloxacin + Metronidazole for 7 days	
Diverticulitis moderate	Gram- Negative Bacteria Anaerobes	Ceftriaxone 2gm IV OD +metronidazole 500 mg IV TDS(or) Piperacillin- Tazobactam 4.5 gm IV 8 hourly empirically (Or) Cefoperazoe- Sulbactam 3gm IV 8 Hourly		BL-BLI agents have very good anaerobic cover, so no need to add metronidazole.

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Diverticulitis **Severe**	Gram- Negative Bacteria Anaerobes	Meropenem 1gm IV 8hrly or Imipenem Cilastatin 500mg IV 6 Hourly		Duration based on improvement
Liver Abscess	*Polymicrobial*	Cefoperazone sulbactium 3Grms Iv 8th Hourly + Ofloxacin + Metronidazole 500mg I.V.TID / 800mg oral TID for 2 weeks	Piperacillin-Tazobactam IV	

CENTRAL NERVOUS SYSTEM INFECTIONS

Condition	Likely Causative Organisms	Empiric antibiotics (presumptive antibiotics)	Alternative Antibiotics	Comments

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Acute bacterial Meningitis	S. Pneumoniae, H.Influenzae, Neisseria Meningititidis.	Ceftriaxone 2 g IV 12hourly/ Cefotaxime 2 g IV 4-6hourly + Vancomycin 1gr, IV BD 10-14 days treatment		Antibiotics should be started as soon as the possibility of bacterial meningitis becomes evident, ideally within 30 minutes. Do not wait for CT scan or LP results.
Meningitis-Post-Neurosurgery or Penetrating head trauma	Staphylococcus epidermidis, Staphylococcus aureus, Propionibacteriumacnes, Pseudomonas aeruginosa, Acinetobacter baumanii.	Meropenem 2gm IV 8 Hourly & Vancomycin 15mg/kg IV 8 Hourly For 14 days.		
Meningitis with basilar skull fractures	S.pneumoniae, H. influenzae	Ceftriaxone 2gm IV 12 Hourly + Vancomycin 1gr, IV BD For 14 days		
Brain abscess, Subdural empyema	Streptococci, Bacteroides, Enterobacteria-	Ceftriaxone 2 gm IV 12hourly (Or) Cefotaxime	Meropenem 2gm IV 8hourly	Exclude TB, No cardiac, Aspergillus, Mucor If abscess <2.5cm

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	ceae, S.aureus.	2gm IV 4-6hourly & Metronidazole 1 gm IV 12hourly		& patient neurologically stable, await response to antibiotics. Otherwise, consider aspiration/surgical drainage and modify antibiotics as per sensitivity of aspirated/drained secretions

CARDIOVASCULAR INFECTIONS

Condition	Likely causative Organism	Empiric Antibiotics (presumptive antibiotics)	Alternative Antibiotics	Comments
Infective Endocarditis: Native valve (awaiting cultures) Indolent	Viridians Streptococci, other Streptococci, Enterococci.	Penicillin G 20MU IVdivided doses, 4 Hourly (Or) Ampicillin 2gm iv 4h & Gentamicin	Vancomycin 15mg /kg IV 12 hourly	If patient is stable, ideally wait blood cultures. Antibiotic choice as per

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		1mg/kg IM or IV 8h.Duration: 4-6 Weeks	(maximum 1g 12 hourly)//teicplanin 12mg/kg IV 12 hourly x 3 doses followed by 6 - 12 mg once daily IV depending upon severity + Gentamicin 1mg/kg IM or IV 8 hourly Duration:4-6 Weeks	sensitivity results.
Infective Endocarditic: Native valve (awaiting cultures)In Severe Sepsis	S.aureus, (MSSA or MRSA) Risk for gram-negative bacilli	Vancomycin 25-30 mg/kg loading followed by 15-20 mg/kg IV 12 hourly (maximum 1gm 12 hourly)/teicoplan in 12mg/kg IV 12 hourly x 3 doses followed	Meropenem 1gm IV q8h Duration: 4-6 weeks	Modify antibiotics based on culture results and complete 4-6 weeks of antibiotics

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		by 6 -12 mg once daily IV depending upon severity &Meropenem 1gm IV 8h Duration: 4-6 Weeks		
Infective Endocarditis: Prosthetic Valve awaiting Cultures		Vancomycin 15mg/kg IV 12 Hourly(maximum 1gm 12 hourly)/teicoplan in 12mg/kg IV 12 hourly x 3 doses followed by 6 -12 mg once daily IV depending upon severity + Gentamicin 1mg/kg q12h IV		Antibiotic choice as per sensitivity. .

SKIN & SOFT TISSUE INFECTION

Condition	Likely causative Organism	Empiric Antibiotics (presumptive antibiotics)	Alternative Antibiotics	Comments

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Cellulitis	Streptococcus pyogenes(common), S.aureus	Amoxicillin-Clavulanate 1.2gm IV TDS/625 mg oral TDS Or Ceftriaxone 2gmIV OD	Clindamycin 600-900mg IV TDS	Treat for 5-7 days.
Furunculosis	*S.aureus*	Amoxicillin- Clavulanate 1.2gm IV/Oral 625 TDS (Or) Ceftriaxone 2gm IV OD Duration – 5-7 Days	Clindamycin 600-900mg IV TDS	Get pus cultures before starting antibiotics
Necrotizing fasciitis	Streptococcus pyogenes, S. aureus, anaerobes, Enterobacteriaceae (polymicrobial)	Piperacillin- Tazobactam 4.5gm IV6hourly Or Cefoperazone-Sulbactam 3gm IV 12hourly and Clindamycin 600-900mg IV 8hourly Duration depends on the progress	After Culture and Sensitivity Report	Early surgical intervention crucial

RESPIRATORY TRACT INFECTIONS

Condition	Likely Causative Organisms	Empiric antibiotics (presumptive antibiotics)	Alternative antibiotics	Comments

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Community acquired Pneumonia	S. pneumoniae, H.influenzae, Legionella, E.coli, Klebsiella sp., S.aureus	Mild to moderate Cases: Amoxycillin- 500mg-1 g TDS oral. If IV indicated, amoxycillin- clavulanate1.2 g IV TDS or Ceftriaxone 2g IV OD Severe cases : Amoxycillin- clavulanate 1.2 g IV TDS OrCeftriaxone 2g IV OD Duration 5-8 days	Piperacillin- Tazobactam 4.5gm IV 6 hourly (Or) Imipenem 1g IV 6hourly	If MRSA is a concern, add Linezolid 600mg IV/Oral BD If atypical pneumonia suspected, Doxycycline 100mg bd (Or) Azithromycin 500 mg oral/IV OD

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Hospital Acquired Infections	*S. pneumoniae*, *H.influenzae*, Legionella, *E.coli*, *Klebsiella sp.*, *S.aureus*	Piperacillin-Tazobactam 4.5gm IV 6 hourly or Imipenem 1g IV 6hourly + MRSA Coverage		
Lung abscess, Empyema	S. pneumoniae, E.coli, Klebsiella sp., Pseudomonas aeruginosa, S.aureus, anaerobes	Piperacillin-Tazobactam 4.5gm IV 6hourly	ADD Clindamycin 600-900mg IV 8hourly	3-4 weeks treatment required
Acute bronchitis	Viral	Antibiotics not		
Acute bacterial exacerbation of COPD	S. pneumoniae H. influenzae M. catarrhalis	Amoxicillin-clavulanate 1gm oral BD for 7 days	Azithromycin 500 mg oral OD × 3 days	

URINARY TRACT INFECTIONS

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Asymptomatic bacteriuria NOT to be treated except pregnant women and immunocompromised patients. All cases of dysuria may not be UTI. Refer to Obstetrics and Gynaecology infections for treatment of asymptomatic bacteriuira in pregnant women.

Condition	Likely Causative Organisms	Empiric antibiotics (presumptive antibiotics)	Alternative antibiotics	Comments
Acute uncomplicated Cystitis	E.coli, Staphylococcus Saphrophyticus (insexually active young women), Klebsiella pneumoniae	Nitrofurantoin 100 mg BD for 7 days (or) Cotrimoxazole 960mg BD for 3-5 days (or) Ciprofloxacin 500 mg BD for 3-5 days	Cefuroxime 250 mg BD for 3-5 days	Get urine cultures before antibiotics & modify therapy based on sensitivities.
Acute uncomplicated Pyelonephritis	E.coli, Staphylococcus saphrophyticus (in sexually active young women), Klebsiella pneumoniae, Proteus mirabilis	Amikacin 1 g OD IM/IV (or) Gentamicin 7 mg/kg/day OD (Monitor renal function closely and rationalize according to culture report)	Piperacillin-Tazobactam 4.5g IV 6 hourly (or) Cefoperazone - Sulbactam 3g IV 12 hourly (or) Ertapenem 1 g IV OD	Urine culture and susceptibilities need to be collected before starting antimicrobial treatment to guide treatment.

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		Complete total duration of 14 days		
Complicated Pyelonephritis	Escherichia coli, Klebsiella pneumonia, Proteus mirabilis, Pseudomonas aeruginosa, Enterococcus sp. Frequently multi-drug resistant organisms are present	Piperacillin-Tazobactam 4.5gm IV 6 hourly (or) Amikacin 1 g OD IV (or) Cefoperazone-Sulbactam 3gm IV 12 hourly	Imipenem 1g IV 8 hourly (or) Meropenem 1gm IV 8 hourly	Get urine cultures before antibiotics & switch to a narrow spectrum agent based on sensitivities. Treat for 10-14 days. Monitor renal function if amino glycoside is used.
Acute prostatitis	Enterobacteriaceae (E.coli, Klebsiella sp.)	Doxycline 100 mg BD (or) Co-trimoxazole 960 mg BD.	In severe cases, Piperacillin-Tazobactam - 4.5gm IV 6 hourly(or) Cefoperazone-sulbactam 3gm IV 12 hourly (or) Ertapenem 1 gm IV OD (or) Imipenem 1g IV 8 Hourly (or) Meropenem 1gm IV 8 hourly	

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BONES AND JOINT INFECTIONS

Condition	Likely Causative Organisms	Empiric antibiotics (presumptive antibiotics)	Alternative antibiotics	Comments
Acute osteomyelitis Or Septic arthritis	S.aureus, Streptococcus pyogenes, Enterobacteriaceae	Cefuroxine 1.5gr,s IV BD (or) Piperacillin- tazobactam 4.5gm IV 8hly + Clindamycin 600 to 900 Mg IV 8th Hrly (or) Cefoperazone-Sulbactam 3grms IV 8th Hrly	Ofloxacine – 200M Or Linezolid 600Mg BD	Treat based on culture of blood/synovial fluid/bone Biopsy Duration: 4-6 weeks (From initiation or last major debridement)
Chronic Osteomyelitis Or Chronic synovitis		No empiric therapy		Definitive treatment guided by bone/synovial biopsy culture. Treat for 6 weeks. Minimum Investigate for TB, Nocardia, fungi. Extensive surgical debridement. Total duration of treatment depends on the joint and the organism. Choose antibiotic

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				based on sensitivity.
Compound trauma			Cefuroxine 1.5gr,s IV BD + Amikacin 1grm OD, Metronidazole 500Mg BD (or) Piperacillin-tazobactam 4.5gm IV 8hly	
Prosthetic joint infection	Coagulase negative staphylococci, Staphylococcus aureus, Streptococci Gram-negative bacilli, Enterococcus, Anaerobes	Ceftriaxone 2g IV OD. Add Vancomycin1gm IV BD (or) Teicoplanin 800mg x 3 doses followed by 400mg Once daily, Linozolid 600mg		4 weeks

EAR INFECTIONS:

PATIENT RISK STRATIFICATION		
Patient Type 1 (CAI)	Patient Type 2 (HAI)	Patient Type 3 (NI)
No contact with health care system No prior antibiotic treatment No prior antibiotic treatment Patient young with few co-morbidconditions	Contact with health care system (e.g. recent hospital admission, nursing home, dialysis) Recent antibiotic therapy Patient old with multiple co-morbidities.	Long hospitalization and / or invasive without invasive procedure Recent & multiple antibiotic therapies Cystic fibrosis, structural lung disease, advanced AIDS, neutropenia, other severe immunodeficiency
SEND SAMPLE FOR CULTURE		
PRESUMPTIVE THERAPY	PRESUMPTIVE THERAPY	PRESUMPTIVE THERAPY
Inj. Ciprofloxacin 100ml/iv/BD	Inj. Augmentin 1.2grm/iv/BD	Inj. Levofloxacin 100ml/iv/OD
AFTER CULTURE REPORT		
After Culture /Sensitivity Report Consultant should decide on choice of therapy& Preferably choose the narrowest spectrum antibiotic to which the isolated pathogen is susceptible.		

POST- CARDIOVASCULAR SURGERYINFECTION

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S.No	Infecction / Syndrome	Likely Causative agents	Antibiotics		
			1st Dose	2nd Dose	3rd Dose
1	***Post cardio Vascular Surgery Infections***	Not known	Cifran – 200mg BD + Amikacin 500mg OD (or) Piperacillin- Tazobactam 4.5grm IV 8th Hrly (or) cefipime- tazobactam 2.25grms IV BD	Imilpermem 1grm IV 8th Hrly (or) Meropenem 1grm IV 8th Hrly	Antifungal's – Syscan or Amphoterecin

PAEDIATRIC INFECTIONS

PATIENT RISK STRATIFICATION		
Patient Type 1 (CAI)	Patient Type 2 (HAI)	Patient Type 3 (NI)
No contact with health care system No prior antibiotic treatment No prior antibiotic treatment Patient young with few co-morbid conditions	Contact with health care system (e.g. recent hospital admission, nursing home, dialysis) Recent antibiotic therapy.	Long hospitalization and / or invasive without invasive procedure Recent & multiple antibiotic therapies Cystic fibrosis, structural lung disease, advanced AIDS, neutropenia, other severe immunodeficiency

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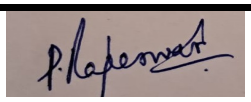
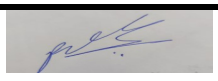
SEND SAMPLE FOR CULTURE	
1st line : Amoxillin Clavulanic acid	
2nd line : Amikacin Ceftriaxone	
Sepsis: Appropriate Antibiotics for pediatric sepsis	
Neonate	Ampicillin plus aminoglycoside or cefotaxime
	Add Vancomycin if nosocomial infection
	Add acyclovir if suspect herpes simplex virus
Child	Cefotaxie or ceftriasxone
	Addvancomycin for meningitis of in areas of high staphylococcal or pneumococcal resistance to methicillinn or cefotaxime respectively
Immunocompromised patient or nosocomial infection	Vancomycin + antipseudomonal antibacterial agent
	Ceftazidime or cefepime
	Aminoglycoside
	Pencillin B-lactomase inhibitor combination (ticarcillin/calvulanic,piperacillin/tazobactam)
	Carbapenem (limipenem or meropenem)
Toxic shock syndrome	Pencillin plus clindamycin

Prepared by: 	Verified by: 	Approved by: 
Dr.P.Rajeswari	Dr.D.N.S.Prakash	Mrs.G.Lakshmi Lavanya
Infection Control Officer	Medical Director	Chief executive Officer

	Vancomycin if methicillin staphylococcus aureus is suspected
Tick – endemic areas	add doxycycline to above regimens
Suspected anaerobic infections	Add clindamycin or metronidazole to above regimens
AFTER CULTURE REPORT	
After Culture /Sensitivity Report Consultant should decide on choice of therapy& Preferably choose the narrowest spectrum antibiotic to which the isolated pathogen is susceptible.	

OBSTETRICS AND GYNAECOLOGY

Condition	Empiric antibiotics	Alternative Antibiotics	Comments
UTI	Nitrofurantoin 100mg, Oral BD for 7 days	Norflox 400mg, oral BD	Incase of Pregnancy Ampicillin 500mg oral TID or Nitrofurantoin 100mg, Oral BD for 7 days. Esclation / De escalation after Culture Sensitivity
Choriamnionitis	Clindamycin 600mg IV TID or Metrogyl 5oomg IV TID + Ceftriaxone 1gm IV BD		
Septic Abortion	Ampicillin 500mg TID + Metrogyl 500mg IV TID		
Endomyometritis	Ceftriaxone 1gm IV BD + Metrogyl 5oomg IV TID	Piperacillin Tazobactum	Esclation / De escalation after Culture Sensitivity

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Candidiasis	Fluconazole oral 5oomg single dose for 3 days. milder cases intravaginal suppositories		
Bacterial Vaginosis	Metronidazole 500mg oral BD for 7 days.		
Trichimonisis	Metronidazole 500mg oral BD for 7 days.		
Cervicitis/ Urethritis	Ceftriaxone 1gm IV BD + Metrogyl 5oomg IV TID		
Pelvic Inflammatory Diseases	Ceftriaxone 1gm IV BD + Metrogyl 5oomg IV TID	Clindamycin + Ceftriaxone	
Mastitis	Amoxycillin Clavulunate / Cephalexine 500mg QID		
Varicella	Aciclovir IV 8th hourly for 1 day 48 to 72 hours shift to oral 800mg		

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