**Purpose**

The recommendations of this guideline are for peri-operative antibiotic prophylaxis for patients undergoing a surgical procedure at the Lady Cilento Children’s hospital and who are cared for by Children’s Health Queensland. These guidelines are to be used only before the results of microbiological investigations are available or finalised.

**Scope**

This guideline provides information for all Queensland Health employees (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors, consultants and volunteers).

**Related documents**

**Procedures, Guidelines, Protocols**

- CHQ-PROC-01035 Antimicrobial Restriction Procedure
- CHQ Antimicrobial Restriction list
Guideline

Peri-operative considerations:

Drug administration

- Pre-operative IV antibiotics – should be given within 60 minutes (ideally within 30 minutes) of skin incision.
- Administration after skin incision or > 60 minutes before incision reduces effectiveness.
- One dose is generally sufficient for prophylaxis, when required.
- A second prophylactic dose should be given intra-operatively if the procedure is longer than two half-lives of the agent used:
  - For cephazolin, cefoxitin, benzylpenicillin and piperacillin/tazobactam: give a repeat dose after 4 hours.
  - For gentamicin, only a single dose per 24 hour period should be given. Seek ID/Pharmacy advice about re-dosing and therapeutic drug monitoring.
  - For vancomycin (Loading dose of 25mg/kg (>12 years of age) or 30mg/kg (under 12 years of age), maximum of 1.5g/dose), give a repeat dose of 15mg/kg (maximum 500mg/dose) after 12 hours and seek ID/pharmacy advice on therapeutic drug monitoring.
  - For teicoplanin, only a single dose per 24 hour period should be given. Seek ID/Pharmacy advice about re-dosing.
  - For lincomycin: give a repeat dose after 8 hours.
- Unless specified below, continued dosing will always require ID discussion and approval.

Pre-existing infections (known or suspected) – if patients are on broad spectrum antibiotics, additional surgical antibiotic prophylaxis may not be necessary. Doses should be scheduled to allow for re-dosing just prior to skin incision.

Multi-drug resistance - Colonisation with known Multi-drug resistant organisms may need to be taken into consideration as an alternative regimen could be required. Seek ID advice.

Neonates - Prophylaxis regimens should be individualised by surgeons in consultation with the ID team. Refer to Antibocard or Neofax for neonatal antibiotic dosing advice.

Therapeutic drug monitoring: Seek pharmacist>ID advice on appropriate therapeutic drug monitoring (TDM) and appropriate dosing for patients in renal failure

- Pediatric Tobramycin/Gentamicin Therapeutic drug monitoring
- Pediatric Vancomycin Therapeutic drug monitoring
## Table 1: Surgical Antibiotic Prophylaxis Guidelines

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>PROPHYLAXIS</th>
<th>ALTERNATIVE (Immediate type or severe penicillin or cephalosporin hypersensitivity)</th>
<th>Multi resistant organism colonisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENT</strong> (adenotonsillectomy/ grommet insertion prophylaxis not required)</td>
<td>Cephalozolin 30mg/kg (up to 1g max) IV at induction (2g if &gt;80kg)</td>
<td>Substitute with Lincomycin 15mg/kg (600mg &gt;12yrs) slow IV</td>
<td>For MRSA: Add Vancomycin 30mg/kg (25mg/kg &gt;12yrs) (up to 1.5 g max) slow IV infusion</td>
</tr>
<tr>
<td>Head/Neck/Thoracic Neurosurgery</td>
<td>For Cochlear implantation: Cephalozolin 30mg/kg (up to 1g max) IV at induction (if &gt;80kg, give 2g). Continue Cephalozolin 30mg/kg/dose (max 1g) IV every 8 hours for total of 3 postoperative doses</td>
<td>For cochlear implantation: Substitute with Lincomycin 15mg/kg (600mg &gt;12yrs) slow IV</td>
<td>For VRE: Add Teicoplanin 10mg/kg (up to 400mg max) as an IV bolus over 5minutes and contact ID for further advice Note: Vancomycin not required if concurrently MRSA colonised</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>For Laryngeal reconstruction: Cephalozolin 30mg/kg (up to 1g max) IV at induction (if &gt;80kg, give 2g). Continue Cephalozolin 30mg/kg/dose (max 1g) IV every 8 hours for total of 7 days</td>
<td>For Laryngeal reconstruction: Substitute with Lincomycin 15mg/kg (600mg &gt;12yrs) slow IV</td>
<td>For Pseudomonas aeruginosa: Base antibiotic prophylaxis choice on sensitivities and seek ID advice</td>
</tr>
<tr>
<td>For Cranial vault remodelling or Craniocynosotosis surgery</td>
<td>For Cranial vault remodelling or Craniocynosotosis surgery: Cephalozolin 30mg/kg (up to 1g max) IV at induction (if &gt;80kg, give 2g). Continue Cephalozolin 30mg/kg/dose (max 1g) IV every 8 hours for total of 48hours</td>
<td>Seek ID advice.</td>
<td></td>
</tr>
<tr>
<td>SURGERY</td>
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</table>
| Cardiac Surgery  
Refer to Paediatric Cardiac surgical antibiotic prophylaxis guideline | Cephazolin 50mg/kg (up to 2g max) IV at induction as loading dose, then 30mg/kg/dose (up to 1g) every 8 hours for further 3 doses.  
A second dose to be given at 4 hours 30mg/kg if surgery prolonged | Substitute with Lincomycin 15mg/kg (600mg >12yrs) slow IV  
PLUS Gentamicin 5mg/kg IV (infuse over 30minutes) (1mth to 10yrs: (Max 320mg) >10yrs: (Max 560mg) ) (as a single dose) | For MRSA: Add Vancomycin 30mg/kg (25mg/kg >12yrs) (up to 1.5 g maximum) slow IV infusion.  
For VRE: Add Teicoplanin 10mg/kg (up to 400mg max) as an IV bolus over 5minutes and contact ID for further advice  
Note: Vancomycin not required if concurrently MRSA colonised  
For Pseudomonas aeruginosa:  
Base antibiotic prophylaxis choice on sensitivities and seek ID advice |
| Abdominal Surgery  
(Including colorectal, appendicectomy, upper GIT or biliary including laparoscopic surgery)  
For Endoscopic or colonoscopic procedures: antibiotic prophylaxis not indicated  
For appendicitis, if antibiotics to continue for treatment, see CHQ Antibiocard for recommendations | Cefoxitin 40mg/kg (up to 2g max) IV at induction.  
For Kasai procedure and similar biliary reconstructive surgery:  
Continue Cefoxitin 40mg/kg/dose (max 2g) IV every 8 hours until biliary drain is removed.  
For Gastro-intestinal anastomosis performed, without bowel prep: Continue Cefoxitin 40mg/kg/dose (max 2g) IV every 8 hours for total 3 postoperative doses. | Substitute with single dose of Metronidazole 7.5mg/kg (up to 500mg maximum) slow IV infusion  
PLUS Gentamicin 5mg/kg IV (infuse over 30minutes) (1mth to 10yrs: (Max 320mg) >10yrs: (Max 560mg) )  
Substitute with Metronidazole 7.5mg/kg/dose (up to 500mg maximum) slow IV infusion every 8 houry  
PLUS Gentamicin 5mg/kg IV once daily (infuse over 30minutes) (1mth to 10yrs: (Max 320mg) >10yrs: (Max 560mg) until biliary drain is removed  
Substitute with Metronidazole 7.5mg/kg/dose (up to 500mg maximum) slow IV infusion every 8 hourly for total of 3 post operative doses  
PLUS Gentamicin 5mg/kg IV (infuse over 30minutes) as a single dose (1mth to 10yrs: (Max 320mg) >10yrs: (Max 560mg) ) | For MRSA: Add Vancomycin 30mg/kg (25mg/kg >12yrs) (up to 1.5 g max) slow IV infusion  
For VRE: Add Teicoplanin 10mg/kg (up to 400mg max) as an IV bolus over 5minutes and contact ID for further advice  
Note: Vancomycin not required if concurrently MRSA colonised  
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<tr>
<td>Liver transplantation (For further information, see LCCH Paediatric Post-Liver Transplant Medication Management Guideline)</td>
<td>Piperacillin / Tazobactam IV 100mg/kg/dose (Max 4g Piperacillin component) as a single dose, infused over 30 minutes before procedure. A second dose to be given after 4 hours intra-operatively if surgery prolonged. Prophylaxis should be no greater than 24 hours, with a single dose sufficing in most cases. If abdomen left unsutured or chronic cholangitis present, continue Piperacillin/Tazobactam IV 100mg/kg (Dosed on Piperacillin component. Max 4g) every SIX hourly for 72hours For use in high risk patients per transplant surgeon (e.g. PELD score &gt;22, Cholestasis, Second transplant, previous Kasai surgery) Liposomal Amphotericin IV 1mg/kg (max 50mg/dose) once DAILY and CONTINUE FOR 5 DAYS</td>
<td>For delayed hypersensitivity (e.g. Rash) use: Meropenem IV 20mg/kg/dose (Max 1 gram) every EIGHT hourly intraoperatively For immediate hypersensitivity (e.g. anaphylaxis) use: Aztreonam IV 30mg/kg/dose (Max 2 grams) every SIX hourly intraoperatively PLUS VANCOMYCIN 15mg/kg/dose (Max 500mg) every SIX hourly intraoperatively Prophylaxis should be no greater than 24 hours, with a single dose sufficing in most cases.</td>
<td>For MRSA: Add Vancomycin 30mg/kg (25mg/kg &gt;12yrs) (up to 1.5 g max) slow IV infusion For VRE: Add Teicoplanin 10mg/kg (up to 400mg max) as an IV bolus over 5minutes and contact ID for further advice Note: Vancomycin not required if concurrently MRSA colonised</td>
</tr>
<tr>
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</tr>
<tr>
<td>Percutaneous transhepatic cholangiogram (with or without stent placement) with expected incomplete drainage (e.g. PSC, hilar strictures) or recent ERCP (within 1 week)</td>
<td>Piperacillin / Tazobactam IV 100mg/kg/dose (Max 4g Piperacillin component) as a single dose, infused over 30 minutes before procedure.</td>
<td>Substitute with single dose of Gentamicin IV 5mg/kg, infused over 30 minutes before procedure (1mth to 10yrs: (Max 320mg) &gt;10yrs: (Max 560mg) )</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
<tr>
<td>Interventional radiology (Percutaneous endoscopic gastrostomy (PEG) or jejunostomy (PEJ) or nephrostomy tube placement)</td>
<td>Cephazolin 30mg/kg (up to 1g max) IV at induction (2g if &gt;80kg)</td>
<td>Substitute with single dose of Gentamicin IV 5mg/kg, infused over 30 minutes before procedure (1mth to 10yrs: (Max 320mg) &gt;10yrs: (Max 560mg) )</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
<tr>
<td>Tenckhoff peritoneal dialysis catheter insertion</td>
<td>Cephazolin 30mg/kg (up to 1g max) IV at induction (2g if &gt;80kg)</td>
<td>Seek ID advice</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
<tr>
<td>Urinary tract surgery Prophylaxis indicated only if suspected or confirmed abnormal urinary tract.</td>
<td>Nill if on-going oral prophylaxis, otherwise Gentamicin IV 5 mg/kg (infused over 30 minutes) at induction ((1mth to 10yrs: (Max 320mg) &gt;10yrs: (Max 560mg)). Adjust dose if renal impairment.</td>
<td></td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
<tr>
<td>Micturating cystourethrogram (MCUG)</td>
<td>Trimeprin/Sulfamethoxazole 4mg/kg (Trimethoprim component) as a single dose prior to procedure/imaging. If patient is on existing antibiotic UTI prophylaxis, increase antibiotic to a therapeutic dose for a single dose prior to procedure/imaging.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURGERY</td>
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</tr>
<tr>
<td>Hypospadias surgery</td>
<td>Cephazolin 30mg/kg (up to 1g max) IV at induction (2g if &gt;80kg) Then Oral Trimethoprim/sulfamethoxazole 2mg/kg once daily (Trimethoprim component) until ID C removed.</td>
<td>Substitute cephazolin with single dose of Gentamicin IV 5mg/kg, infused over 30 minutes before procedure (1mth to 10yrs: (Max 320mg) &gt;10yrs: (Max 560mg)</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
<tr>
<td>Amputations (ischaemic limbs and lower limbs)</td>
<td>Benzylpenicillin 30mg/kg (up to 1.2g max) IV at induction, then every six hours for 3 further doses</td>
<td>Substitute Lincomycin 15mg/kg (600mg &gt;12yrs) slow IV</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
<tr>
<td>Burns</td>
<td>Antibiotics based on microbiological results where possible. If no microbiology: Flucl oxacillin IV 50mg/kg/dose (Max 2g). OR If dirt contaminated wound: Piperacillin/Tazobactam IV 100mg/kg/dose (Max 4g Piperacillin component) Antibiotics not continued post procedure in absence of documented infection.</td>
<td>Substitute with a single dose of Lincomycin 15mg/kg (600mg &gt;12yrs) slow IV infusion and single dose of Metronidazole 12.5mg/kg (up to 500mg maximum) as slow IV infusion</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
</tbody>
</table>
Prevention of Endocarditis

Endocarditis in Children with Heart Defects

- Children at risk should establish and maintain the best possible oral health to reduce potential sources of bacteraemia which includes tooth brushing and regular dental review.
- Single dose antibiotic prophylaxis (refer to “Endocarditis” antibiotic prophylaxis – Table 1) is now only recommended for children with the highest risk of adverse outcome of infective endocarditis who are undergoing certain dental or other procedures (see Table 2).
- In certain individual circumstances, medical and dental practitioners may consider giving antibiotics to patients not covered by these revised guidelines including those who have received prophylaxis over their lifetime. Recommendations for individual patients should be discussed with the treating cardiologist.

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>PROPHYLAXIS</th>
<th>ALTERNATIVE</th>
<th>Multi resistant organism colonisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocarditis prophylaxis (for at risk conditions see Table 2 and 3)</td>
<td>Oral amoxycillin 50mg/kg (up to 2g max) (2g for &gt;12 yrs) 1 hour before the procedure OR IV Ampicillin 50mg/kg (up to 2g max)</td>
<td>Substitute with Oral clindamycin 10mg/kg/dose (up to 450mg) 1 hour before the procedure OR substitute with Lincomycin 15mg/kg (600mg &gt;12yrs) slow IV</td>
<td>For MRSA, VRE or Pseudomonas aeruginosa colonisation, seek ID advice</td>
</tr>
</tbody>
</table>

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Table 2: Cardiac Conditions for which endocarditis prophylaxis with dental procedures is recommended (for antibiotic choice, refer to Endocarditis antibiotic prophylaxis section- Table 1)

- Prosthetic cardiac valve or prosthetic valve material used for cardiac valve repair
- Previous episode of infective endocarditis
- Congenital heart disease (CHD) but only if it involves:
  - Unrepaired cyanotic defects, including palliative shunts and conduits
  - Repaired congenital heart defect with prosthetic material or device (surgical or catheter intervention) during the first 6 months after the procedure
  - Repaired defects with residual defect at the site or adjacent to the side of a prosthetic patch or prosthetic device
- Cardiac Transplantation recipients who develop cardiac valvulopathy
- Rheumatic heart disease in indigenous Australians
- If recommended by the QPCS cardiologist in the most recent clinic review letter

Does the patient have any of the conditions listed in Table 2?
- If Yes, Antibiotic prophylaxis for endocarditis MAY BE required. See Table 3.
- If No, Antibiotic prophylaxis for endocarditis NOT required.
### Table 3: Procedures where antibiotic prophylaxis for endocarditis may or may not be required (for antibiotic choice, refer to Endocarditis antibiotic prophylaxis section - Table 1)

<table>
<thead>
<tr>
<th>Prophylaxis ALWAYS REQUIRED</th>
<th>Prophylaxis SHOULD BE CONSIDERED</th>
<th>Prophylaxis IS NOT REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENTAL PROCEDURES:</strong></td>
<td><strong>Consider prophylaxis for the following procedures if multiple procedures are being conducted, the procedure is prolonged, or periodontal disease is present:</strong></td>
<td><strong>DENTAL PROCEDURES:</strong></td>
</tr>
<tr>
<td>Extractions, periodontal procedures including surgery, subgingival scaling, and root planning, replanting avulsed teeth or other surgical procedures (e.g. implant placement, apicoectomy)</td>
<td>• full periodontal probing for patients with periodontitis</td>
<td>• oral examination</td>
</tr>
<tr>
<td><strong>RESPIRATORY PROCEDURES:</strong></td>
<td>• intraligamentary and intraosseous local and anaesthetic injection</td>
<td>• infiltration and block local anaesthetic injection</td>
</tr>
<tr>
<td>Any invasive procedure involving incision or biopsy of respiratory mucosa, for example:</td>
<td>• supragingival calculus</td>
<td>• restorative dentistry</td>
</tr>
<tr>
<td>• tonsillectomy/ adenoidectomy</td>
<td>• removal or cleaning</td>
<td>• supragingival rubber dam clamping and placement of rubber dam</td>
</tr>
<tr>
<td>• rigid or flexible bronchoscopy with incision or biopsy</td>
<td>• rubber dam placement with clamps (where risk of damaging gingiva)</td>
<td>• intracanal endodontic procedures</td>
</tr>
<tr>
<td>• surgery involving bronchial, sinus, nasal or middle ear mucosa, including tympanostomy tube insertion</td>
<td>• restorative matrix band/ strip placement</td>
<td>• removal of sutures</td>
</tr>
<tr>
<td><strong>GENITOURINARY AND GASTROINTESTINAL PROCEDURES:</strong></td>
<td>• endodontics beyond the apical foramen</td>
<td>• impressions and construction of dentures</td>
</tr>
<tr>
<td>Any procedure where antibiotic prophylaxis is indicated for surgical reasons:</td>
<td>• placement of orthodontic bands or interdental wedges</td>
<td>• orthodontic bracket placement and adjustment of fixed appliances</td>
</tr>
<tr>
<td>• lithotripsy</td>
<td>• subgingival placement of retraction cords, antibiotic fibres or antibiotic strips</td>
<td>• application of gels</td>
</tr>
<tr>
<td>• any genitourinary procedure in the presence of a genitourinary infection unless already treating enterococci (for elective cystoscopy or urinary tract manipulations, obtain a urine culture and treat any bacteruria beforehand)</td>
<td></td>
<td>• intraoral radiographs</td>
</tr>
<tr>
<td>• any gastrointestinal procedure in the presence of an intraabdominal infection unless already treating enterococci</td>
<td></td>
<td>• supragingival plaque removal</td>
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<tr>
<td>• sclerotherapy for oesophageal varices</td>
<td></td>
<td><strong>RESPIRATORY PROCEDURES:</strong></td>
</tr>
<tr>
<td><strong>OTHER PROCEDURES:</strong></td>
<td></td>
<td>• endotracheal intubation</td>
</tr>
<tr>
<td>• Incision and drainage of local abscess: brain, boils and carbuncles, dacryocystitis, epidural, lung, orbital, perirectal, pyogenic liver, tooth, surgical procedures through infected skin.</td>
<td></td>
<td>• rigid or flexible bronchoscopy without incision or biopsy</td>
</tr>
<tr>
<td>• Percutaneous endoscopic gastrostomy</td>
<td></td>
<td><strong>GENITOURINARY AND GASTROINTESTINAL PROCEDURES:</strong></td>
</tr>
<tr>
<td></td>
<td>• urethral catheterisation</td>
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<td></td>
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<td>• vaginal delivery</td>
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<td></td>
<td></td>
<td>• transoesophageal echocardiography</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• endoscopy (with or without gastrointestinal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• biopsy including colonoscopy</td>
</tr>
</tbody>
</table>
Consultation

Key stakeholders who reviewed this version:
- Dr Julia Clark, Medical Lead AMS, IMPS (CHQ)
- Dr Clare Nourse, Infection specialist, IMPS (CHQ)
- Nicolette Graham, Antimicrobial Stewardship Pharmacist (CHQ)
- Dr Fiona McFarlane, Director- Anaesthetics (CHQ)
- Dr Anna Miedecke, Deputy Director – Anaesthetics (CHQ)
- Dr Derek Rosen, Anaesthetist (CHQ)
- Dr Cameron Ward, Cardiologist (CHQ)
- Dr Craig McBride, Senior Staff Specialist Paediatric Surgeon (CHQ)
- Dr Bhavesh Patel, Senior Staff Specialist Paediatric Surgeon (CHQ)

Definitions

IgE-mediated (allergic) immediate hypersensitivity is characterised by the development of urticaria, angioedema, bronchospasm or anaphylaxis (with objectively demonstrated hypotension, hypoxia or elevated mast-cell tryptase concentration) within 1 to 2 hours of exposure to a drug. Anaphylaxis is more likely with parenteral rather than oral administration. For penicillin, anaphylaxis occurs at an estimated frequency of 1 to 4 cases per 10 000 courses, with up to 10% of these reactions being fatal. A clear history of an IgE-mediated reaction means the drug should not be administered again without appropriate precautions (eg desensitisation).

IgE-independent (non-allergic) immediate hypersensitivity refers to any acute or immediate reaction that does not involve an IgE-mediated mechanism, usually caused by direct mast-cell degranulation (eg vancomycin infusion–related reactions such as ‘red-man’ syndrome). The reaction may be ameliorated by prophylactic antihistamines and slowing the infusion rate.

Delayed-type (nonimmediate) hypersensitivity reactions are characterised by macular, papular or morbilliform rash, occurring several days after starting treatment. They are more common than immediate reactions, and may be caused by the infection or its treatment. Such reactions are usually T-cell (not IgE) mediated. Delayed-type reactions commonly occur in patients with intercurrent infection, and such reactions may not be reproducible upon a supervised challenge when the patient is well. Delayed rash due to penicillins, especially amoxy/ampicillin, is not strongly predictive of a future reaction, and repeat exposure to beta lactams is not necessarily contraindicated.

Three kinds of delayed-type reaction warrant special mention:
- Serum sickness—characterised by vasculitic rash, arthralgia/arthritis, influenza-like symptoms, and sometimes fever and proteinuria. Serum sickness is triggered more commonly with cefaclor than other cephalosporins, and also by sulfonamides, and commences several days after starting treatment drug rash with eosinophilia and systemic symptoms (DRESS)—characterised by peripheral blood eosinophilia, desquamative dermatitis and liver dysfunction.
- Stevens–Johnson syndrome / toxic epidermal necrolysis (SJS/TEN)—a very rare, acute and potentially fatal skin reaction characterised by sheet-like skin and mucosal loss.
- DRESS and SJS/TEN are contraindications to further drug exposure (including desensitisation) because this can be fatal. Patients with a known severe hypersensitivity should be strongly advised to wear an alert bracelet or necklace.

References and suggested reading

1. Therapeutic Guidelines (eTG 46): Antibiotic 2015 Therapeutic Guidelines Ltd. Melbourne

Guideline revision and approval history

<table>
<thead>
<tr>
<th>Version No.</th>
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<th>Amendments authorised by</th>
<th>Approved by</th>
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<td>4.0</td>
<td>Infectious Diseases Consultants- Antimicrobial Stewardship (Infection Management and Prevention Service (IMPS) and Antimicrobial Stewardship Pharmacist (CHQ))</td>
<td>Medicines Advisory Committee (CHQ) Infectious Diseases Consultant team and Medical Lead - Antimicrobial Stewardship (Infection Management and Prevention Service)</td>
<td>Executive Director of Hospital Services</td>
</tr>
<tr>
<td>5.0</td>
<td>Infectious Diseases Consultants- Antimicrobial Stewardship (IMPS), Anaesthetists, Cardiologist and Antimicrobial Stewardship Pharmacist (CHQ)</td>
<td>Medicines Advisory Committee (CHQ) Infectious Diseases Consultant team and Medical Lead - Antimicrobial Stewardship (Infection Management and Prevention Service)</td>
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<td>Keywords</td>
<td>Paediatric surgical antibiotic prophylaxis, antimicrobial stewardship, cephazolin, vancomycin, lincomycin, teicoplanin, gentamicin, cefoxitin, piperacillin/tazobactam, trimethoprim/sulfamethoxazole, meropenem, aztreonam, liposomal amphotericin, benzylpenicillin, ampicillin, amoxicillin, clindamycin, MRSA colonisation, VRE colonisation, ENT, Head/Neck/Thoracic, Neurosurgery, Orthopaedic Surgery, cochlear implantation, laryngeal reconstruction, cardiac surgery, Abdominal Surgery, colorectal, appendicectomy, upper GIT or biliary including laparoscopic surgery, kasai procedure, reconstructive biliary surgery, Gastro-intestinal anastomosis, Liver transplantation, Percutaneous transhepatic cholangiogram, Interventional radiology, Percutaneous endoscopic gastrostomy (PEG) or jejunostomy (PEJ) or nephrostomy tube placement, Urinary tract surgery, Tenckhoff catheter insertion, Micturating cystourethrogram (MCUG), hypospadias, Dental procedure, Amputations (ischaemic limbs and lower limbs), burns, endocarditis prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accreditation references</td>
<td>EQuIP National Standards (11-15): 3, 4, 1</td>
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