

Guideline

Management of Fever in a Paediatric Oncology Patient

Febrile Neutropenia and Febrile Non-neutropenia

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Author/custodian	Director Paediatric Oncology			Review date	11/06/2022
Supercedes	1.0				
Applicable to	All CHQ staff				
Authorisation	Executive Director Clinical Services QCH				

Purpose

This guideline provides a framework for the treatment of children with cancer and fever from presentation to resolution. Pathways are provided for those with suspected neutropenia and those with known non-neutropenia at presentation.

Scope

This guideline applies to staff caring for children with cancer in CHQ HHS and can be used by the Queensland Paediatric Palliative care Haematology Oncology Network and other State-wide services.

Related documents

Procedures, Guidelines, Protocols

- CHQ Procedure 03450 [Venous Access Device \(VAD\) Insertion and Management of Peripheral and Central Venous Access Devices](#)
- CHQ Procedure 01036 [Antimicrobial: Prescribing and Management](#)
- CHQ Procedure 01000 [Medication](#)
- CHQ Procedure 01001 [CHQ Procedure 01001: Medication - Prescribing](#)
- CHQ Guideline 01075 [Antifungal Prophylaxis and Treatment in Paediatric Oncology Patients and other Immunocompromised Children](#)

- CHQ Guideline 01202 [CHQ Paediatric Antibiocard: Empirical Antibiotic Guidelines](#)
- CHQ Guideline 60010 [Sepsis: Recognition and Early Management in Children](#)
- CHQ Work Instruction [03468 Central Venous Access Device \(CVAD\)-Blood Sampling](#)
- CHQ Work Instruction [03460 Totally Implanted Venous Port Device \(TIVPD\)-Needling](#)
- CHQ Procedure 03455 [Management of Compromised Central Venous Access Device \(CVAD\)](#)
- CHQ Guideline 01069 [Fever in a Child with Central Venous Access Device - Management of Suspected Central Venous Access Device \(CVAD\) Infection in Children](#)
- CHQ Guideline 01065 [Antibiotic Lock Therapy for Catheter Related Blood Stream Infections](#)

Forms and templates

- CHQ Clinical Pathway [Clinical Pathway: Initial Management of Suspected Neutropaenic Sepsis](#)

Guideline

Febrile Neutropenia (FN)

Definition

Fever: $\geq 38.5^{\circ}\text{C}$ on one occasion **or**

$\geq 38.0^{\circ}\text{C}$ on two occasions – at least one hour apart **WITH EITHER**

- **Neutropenia:** a neutrophil count of $<1 \times 10^9/\text{L}$ **OR**
- **Recent Intensive Chemotherapy** (within last 14 days) where neutropenia is expected

Fever in children with cancer is a medical emergency as they are at increased risk of developing severe sepsis and septic shock and may progress from fever to severe sepsis rapidly. Fever may be the only sign of underlying infection and children presenting with fever should be rapidly triaged (minimum Cat 2). Fever in a child with cancer or chemotherapy/treatment induced neutropenia is known as Febrile Neutropenia (FN). Neutropenia must be suspected in any oncology patient that has received chemotherapy within the last 10 - 14 days. Neutropenia in CHQ is defined as a neutrophil count of $\leq 1 \times 10^9/\text{L}$.

Antibiotics given within 60 minutes of presentation improve outcomes and decrease the need for admission to PICU (1, 2). These children can deteriorate rapidly and progress to septic shock if not managed appropriately.

ALERT



DO NOT wait for blood results before initiating treatment.

Antibiotics should be given within 60 minutes of presentation (or fever spike if inpatient)

Antibiotics MUST be commenced after blood cultures but before undertaking other investigations (e.g. CXR, NPA)

Initial Management of Suspected Febrile Neutropenia

Follow the **Febrile Neutropenia antibiotic algorithm** (Page 8) unless neutrophil count is known to be

≥ 1.0 , then follow the **Non Neutropaenic Flow chart** (Page 9).

Complete the [Clinical Pathway: Initial Management of Suspected Neutropaenic Sepsis](#) if available or IEMR Febrile Neutropenia Oncology Paediatric power plan.

Triage (if presentation through Emergency Department):

- Triage as minimum Australasian Triage Scale (ATS) 2

Initial Management:

- Comprehensive patient assessment should be performed within 10 minutes of presentation
- Haemodynamically unstable or critically unwell
 - ABCD management, including fluid bolus (20 mL/kg) and oxygen therapy as required.
 - Refer to [CHQ-GDL-60010-Sepsis: Recognition and Early Management in Children](#)

Intravenous Access:

- Immediately establish intravenous (IV) access - use central venous access device (CVAD) as first option,
 - Insert peripheral line (PIV) if CVAD competent staff unavailable
 - Do not wait for topical anaesthetic
 - Intraosseous access may be required if there are no other options.

Primary Investigations:

- Collect blood samples - Full Blood Count, Blood Cultures from each lumen of CVAD (peripheral blood cultures **NOT** required), and Chem 20 (Collect COAG's only if critically unwell).

Antibiotic Management:



**ALERT: Do not delay antibiotic administration whilst waiting for blood results
If CVAD in-situ and patent, give IV antibiotics through CVAD, not peripherally**

- Commence antibiotics as below and commence intravenous (IV) fluids if clinically indicated
- **Piperacillin/tazobactam** has both gram negative and gram-positive cover and is an effective empiric treatment for most common gram positive infections including *S.aureus* (MSSA). Exceptions include enterococcus, coagulase negative staphylococcus, penicillin resistant *S.mitis*.
 - Dose = 100 mg/kg (of piperacillin component) IV 6-hourly (maximum 4000 mg Piperacillin component per dose).
 - Administer undiluted (200 mg/mL of piperacillin component) as an IV bolus over 3 to 5 minutes via CVAD (can be diluted to 20mg/mL of piperacillin component for infusion over 20 minutes via peripheral IV access).

If septic, critically unwell or haemodynamically unstable (see Febrile Neutropenia Antibiotic Algorithm, Page 10) add Gentamicin and Vancomycin as below.

- **Gentamicin** provides additional gram-negative cover including pseudomonas

Dose:

- 1 month to 10 years: 7.5 mg/kg every 24 hrs (maximum initial dose 320 mg);
- More than 10 years: 6 mg/kg every 24 hrs (maximum initial dose 640 mg)
- If critically ill (septic shock) and more than 10 years of age, use 7 mg/kg every 24 hours (maximum initial dose 640 mg)
- Infuse IV Gentamicin dose in total volume of 30 mL (in sodium chloride 0.9%) over 30 minutes.

Document time of administration and if a syringe driver or burette was used for infusion (as well as if line was primed with sodium chloride 0.9% or gentamicin) – may need levels taken at 2 hours and 6 hours after the dose (timed from start of infusion). Please refer to the [Tobramycin/Gentamicin Therapeutic Drug Monitoring Guideline](#).

- **Vancomycin** provides additional gram positive cover, including MRSA, penicillin resistant *S.mitis* and coagulase negative staphylococcus. Add for patients treated with **high dose** cytarabine (HD ARA C) who have high risk of *S.mitis*, suspected CVAD infection or MRSA.
- Dose = 15 mg/kg (maximum initial dose 750 mg) every 6 hourly (perform therapeutic drug monitoring – Vancomycin trough level 30 minutes before 3rd or 4th dose)
- Administer once flush following Gentamicin is complete
- Dilute Vancomycin dose to 5 mg/mL or less and infuse over at least 120 minutes (2 hours)
- Patients with documented previous Red Man syndrome will require prolonged infusion

Routine addition of vancomycin to the initial empiric regimen within 72 hours does not reduce mortality or time to defervescence and is associated with increased nephrotoxicity.

**ALERT**

All changes to antibiotics need to be discussed with the on-call QCH Paediatric Oncologist

Special considerations:

- **Beta lactam delayed hypersensitivity** – Use Ceftazidime IV (50 mg/kg/dose IV every 8 hourly (maximum 2 grams per dose)) and single dose of Gentamicin (as above)
- **Beta lactam anaphylaxis** – Use Meropenem IV (40 mg/kg/dose IV every 8 hourly (maximum 2 grams per dose)) (see ALERT below)
- Antibiotic approvals are required for restricted antibiotic use outside stated protocol. Please refer to the Medication approval process and the Individual Patient Request form.
https://qheps.health.qld.gov.au/_data/assets/pdf_file/0026/709361/654250.pdf

**ALERT**

Restricted antibiotics e.g. Meropenem, require Infectious Diseases Consultant approval for use > 48 hours

Supplemental Investigations:

- Request other investigations as clinically indicated i.e. \pm CXR, urine/stool M/C/S, Respiratory virus PCR, CRP.
- Note: Antibiotics **MUST** be commenced before undertaking other investigations
- Abnormal CXRs should be discussed with the Paediatric Oncologist at the Oncology Services, QCH

Communication:**ALERT**

For all children presenting to a hospital other than QCH discuss all patients with the Regional Paediatrician and on-call Paediatric Oncologist at Oncology Services Group via Queensland Children's Hospital (QCH) switch: (07) 3068 1111.

- Prescribe blood products if required and other relevant medications e.g. paracetamol; antiemetics; prophylactic antibiotics, antivirals, and antifungals. Not for rectal medications or Ibuprofen.
- Discuss with the Paediatric Oncologist whether children receiving oral chemotherapy should continue to receive this treatment.
- Patients with a fever $\geq 38^{\circ}$ C require observations including temperature, pulse, oximetry, respiration, blood pressure, capillary refill and Children's Early Warning Tool Score (CEWT) hourly until stable and afebrile.
- The decision to reduce the observations are based on the clinical condition of the child. Minimum of 4 hourly observations including temperature, pulse, oximetry, respiration, blood pressure, capillary refill and CEWT score. Daily skin inspection to assess for potential sources of infection including skin, mucous membrane, mouth, perianal area and CVAD should be undertaken.

Ongoing Management of Febrile Neutropenia (Page 11)**Evaluate at 24 hours**

- Consider low risk child for HITH antibiotics (Queensland Children's Hospital only). See Identification and Management of Low-Risk Febrile Neutropenia in Paediatric Oncology Patients Guideline (under development).

Evaluate at 48 hours:

- All culture results should be reviewed, and antibiotics adjusted according to isolates and antibiotic sensitivities (Discuss with Paediatric Oncologist and Infection Management Fellow/Consultant).

Initially stable with suspected Febrile Neutropenia:

Afebrile:

- Evidence of marrow recovery:
- If afebrile for at least 24 hours with all negative cultures - stop empiric antibiotics.
- If afebrile for at least 24 hours with negative blood cultures but evidence of resolving local infection (e.g. UTI, skin, soft tissue, chest) and evidence of marrow recovery - consider intravenous to oral switch to complete 5 to 7 days of appropriate antibiotics.
- No evidence of marrow recovery:
- Continue IV antibiotics and review at 72 hours.

Febrile:

- Continue Piperacillin/Tazobactam. Reassess and re-culture. Repeat blood cultures from all lumens of CVAD no more than once within a 24-hour period.

Initially Unwell or Septic (received Piperacillin/Tazobactam, gentamicin and vancomycin):

- Continue Piperacillin/tazobactam; stop Gentamicin and Vancomycin at 48 hrs if negative cultures and patient is stable.
- Complete a 5 to 7-day course of appropriate intravenous antibiotics, unless specific viral cause identified.
- If afebrile for at least 24 hours at completion of 5 days of appropriate antibiotics stop antibiotics and discharge home
- If remains febrile at 4 to 5 days follow as below.

**ALERT**

Routine addition of vancomycin to the initial empiric regimen within 72 hours does not reduce mortality or time to defervescence

Evaluate at 72 hours:

Afebrile:

- Evidence of marrow recovery:
- If afebrile for at least 24 hours with all negative cultures - stop empiric antibiotics.
- If afebrile for at least 24 hours with negative blood cultures but evidence of resolving local infection (e.g. UTI, skin, soft tissue, chest) and evidence of marrow recovery - consider intravenous to oral switch to complete 5 to 7 days antibiotics.
- No evidence of marrow recovery:
- If afebrile for at least 24 hours, all negative cultures and neutropenia expected to be less than 7 days consider stopping antibiotics and scheduling careful follow up.

- If afebrile for at least 24 hours, all negative cultures and neutropenia expected to be prolonged consider completing a 5 to 7-day course of antibiotics. If stable, these do not need to be intravenous, consider intravenous to oral switch (e.g. oral amoxicillin/clavulanate, cefalexin).

Febrile:

- Continue Piperacillin/tazobactam. Reassess and repeat blood cultures from all lumens of CVAD no more than once within a 24-hour period.
- If there is clinical deterioration, consider change to meropenem or add vancomycin if concern for gram positive infection.
- In children at high risk for invasive fungal disease (IFD) with clinical deterioration consider **Liposomal Amphotericin (AmBisome®)** IV 1 mg/kg once daily and investigate as below.



ALERT

Do not switch initial empiric antibiotics in patients with unresponsive fever unless there is clinical deterioration or a microbiological indication.

Febrile at 4 to 5 days:

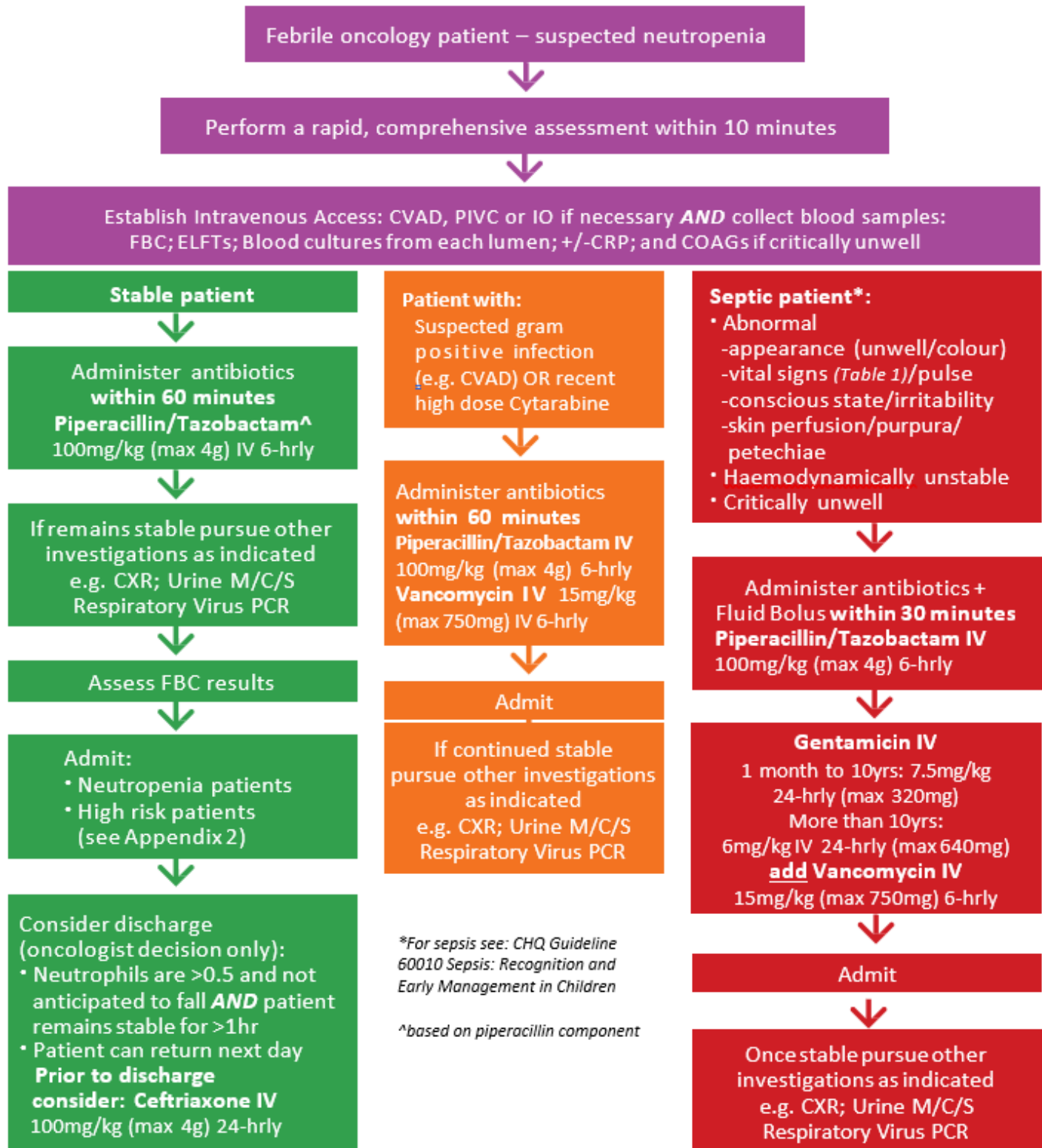
- Reassess and in consultation with the treating team consider:
 - more invasive investigative procedures and imaging
 - transfer to QCH if patient is in a shared-care service
- In high risk children with persistent fever beyond 96 hours perform evaluation for invasive fungal disease (IFD) e.g. CT scan lung, plus abdominal ultrasound (if LFTs deranged) and other clinically suspected areas of infection.
- Add **Liposomal Amphotericin (AmBisome®)** IV 1mg/kg once daily (increase to 3 mg/kg/day if high clinical or radiological suspicion of IFD) – refer to [CHQ GDL 01075 Antifungal Prophylaxis and Treatment in Paediatric Oncology and Immunocompromised Children](#)
- Close monitoring of electrolytes and renal function is essential every 24 hours
- If renal impairment or previous adverse reaction to AmBisome® consider Voriconazole or Caspofungin/Micafungin on Paediatric Infectious Disease (ID) team advice.
- If there is clinical deterioration, consider change to meropenem or add vancomycin if concern for gram positive infection.
- Remember the possibility of viral infection HSV, VZV, CMV, EBV, Adenovirus etc. When indicated, request appropriate viral blood PCRs, swabs, urine, stool or respiratory secretions.
- Daily blood cultures at this stage only when clinically indicated/ requested by senior medical staff.



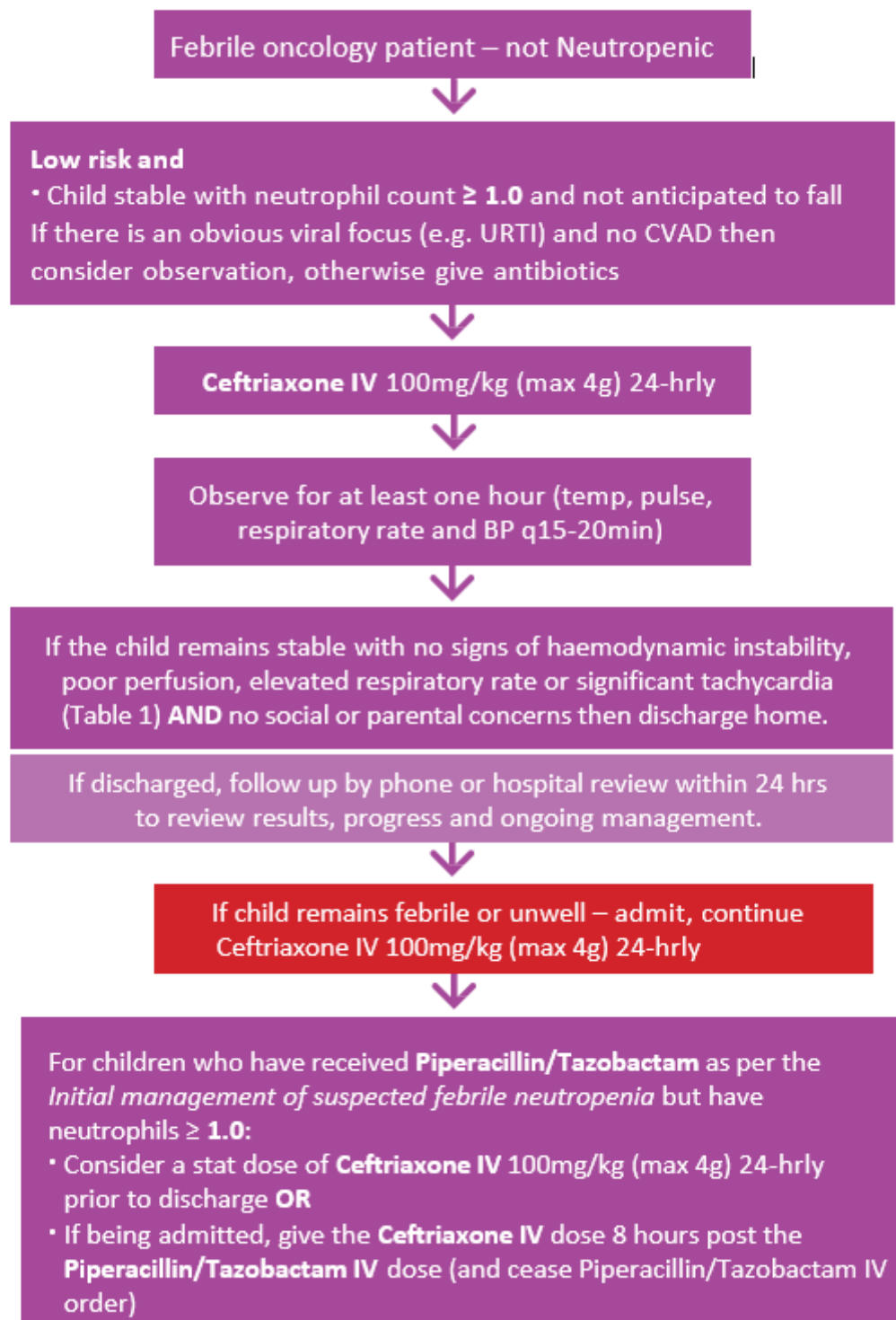
ALERT

Antifungals require Infectious Diseases Consultant approval for use for more than 72 hours for treatment of presumed Invasive Fungal Disease

Febrile neutropenia antibiotic algorithm



Febrile non-neutropenia antibiotic algorithm



ALERT

Exclusion criteria for Febrile non-neutropenia antibiotic algorithm outpatient management:



- **Clinical suspicion of bacteraemia:** hypotension, poor perfusion, rigors, significant tachycardia, tachypnoea, dehydration
- **Impending neutropenia:** IV chemotherapy (other than single agent, Vincristine) within the last 10 to 14 days
- **High risk patients:** AML, ALL undergoing intensification or relapse therapy, High risk solid tumours, Down's Syndrome, infants, Children post HSCT (see [Appendix 2](#))

Admit and follow the Febrile Neutropenia antibiotic algorithm. Discuss all patients with on call oncology consultant.

Febrile neutropenia follow-on management algorithm



Consultation:

Key stakeholders who reviewed this version:

- Director Infection Management
- State-wide Oncology Nursing Educator, QPPHON
- Clinical Nurse, Oncology Services Group, CHQHHS
- Pharmacist Advanced, Antimicrobial Stewardship
- Clinical Pharmacist Lead, Oncology
- Oncology Director and Oncology SMOs

Definition of terms

Term	Definition	Source
CHQHHS	Children's Health Queensland Hospital and Health Service	
CVAD	Central venous access device	
CVL	Central venous line	
IMPS	Infection Management and Prevention Service	
IFD	Invasive fungal disease	
AML	Acute Myeloid Leukaemia	
ALL	Acute Lymphoblastic Leukaemia	
HSCT	Haemopoetic stem cell transplant	
HSV	Herpes Simplex virus	
VZV	Varicella Zoster Virus	
CMV	Cytomegalovirus	
EBV	Epstein barr virus	
GVHD	Graft versus host disease	
UTI	Urinary tract infection	
CXR	Chest Xray	

References and suggested reading

1. Salstrom J et al. Pediatric Patients who receive antibiotics for fever and neutropenia in less than 60 min have decreased intensive care needs. *Pediatr Blood Cancer* 2015; 62:807-815
2. Fletcher M et al. Prompt administration of antibiotics is associated with improved outcomes in febrile neutropenia in children with cancer. *Pediatr Blood Cancer*. 2013 Aug;60(8):1299-306
3. Cometta A et al. Vancomycin versus Placebo for Treating Persistent Fever in Patients with Neutropenic Cancer Receiving Piperacillin-Tazobactam Monotherapy. *CID* 2003; 37:382-9

Guideline revision and approval history

Version No.	Modified by	Amendments authorised by	Approved by
1.0	Surgical Group Director, IMPS	Divisional Director of Medicine	Executive Director Clinical Services QCH
2.0 11/06/2020	Surgical Group Director, IMPS	Divisional Director of Medicine	Executive Director Clinical Services QCH

Keywords	Oncology; Fever; Febrile; Neutropenia; Neutropenic; Non-Neutropenic; Antibiotics; antimicrobial stewardship; sepsis; antifungals, 01249
Accreditation references	NSQHS Standards (1-8): 3; 4; 5; 6 ISO 9001:2015 Quality Management System (4-10)

Appendix 1:

Risk of serious bacterial infection

Low risk patients:

- Age \geq 12 months
- Not on myeloablative treatment or during extremely intensive chemotherapy
- No social or economic conditions that compromise access to care or adherence to treatment
- No other medical conditions requiring hospitalisation
- Evidence of recovering marrow function

Low risk of bacterial infection:

- Not clinically unwell
- No evidence of a significant source of infection (eg pneumonia, soft tissue infection, severe mucositis) requiring IV antibiotics
- No clinically significant positive blood cultures
- Evidence of recovering marrow function (a clinical decision – the consultant should be involved, no evidence for any specific neutrophil cut off to be useful)
- No other clinical features to suggest significant infection (eg CRP $>$ 100 mg/L or rising)

	LOW RISK	HIGH RISK
Absolute neutrophil count	0.1 – 0.5 x 10 ⁹ /L	\leq 0.1 x 10 ⁹ /L
Duration of neutropenia	< 7 DAYS	\geq 7-10 DAYS
Co morbidity	None	<ul style="list-style-type: none"> • Toxic/Shocked • BMT Inpatient • AML patients

Appendix 2:

High risk disease

AML

*ALL: Infant ALL (<1y);
Induction;
Delayed intensification*

Downs syndrome

Lymphoma: Induction therapy

Neuroblastoma stage IV

Allogeneic transplant: Day -14 to Day +180

Autologous transplant: Day -7 to Day +60

Reinduction therapy for any relapse

***If in doubt discuss with Oncology
Consultant on call or treat as high risk***

Table 1

Table 1: Normal range for age specific vital signs

Age	Heart Rate (bpm)	Minimum Systolic BP (mmHg)	Respiratory Rate (bpm)
Term	100-180	60	40-60
6mth	100-180	70	30-50
1yr	100-170	70	20-40
2yr	100-160	70	20-30
4yr	80-130	75	20-30
8yr	70-110	80	16-25
12yr	60-110	90	16-25
16yr +	60-100	90	10-16

As per [CHQ-GDL-60010-Sepsis: Recognition and Early Management in Children](#)