

Louth: Antimicrobial Guidelines - Louth Hospitals: Antimicrobial Guidelines: Postnatal

Obstetrics - Severe Life-Threatening Post-natal Sepsis - Source Unclear

Indication
Obstetrics - Severe Life-Threatening Postnatal Sepsis – Source Unclear
Definition of Severe Sepsis: Sepsis plus sepsis-induced organ dysfunction or tissue hypoperfusion.
First Line Antimicrobials
N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. ALWAYS contact clinical microbiologist for advice.
Meropenem 1g TDS IV
AND
Clindamycin 1.2g QDS IV
N.B. Use meropenem with great caution and close clinical monitoring if history of immediate-onset or severe penicillin hypersensitivity – approximately 1% risk of immediate-onset hypersensitivity to meropenem in patients with history of immediate-onset penicillin hypersensitivity.

Obstetrics - Mild Infection - C-section Wound / Endometritis / Perineal / post-ERPC

Indication
Obstetrics - Mild Infection - C-section Wound / Endometritis / Perineal / post-ERPC
First Line Antimicrobials
Co-amoxiclav 625mg TDS PO
NON-immediate-onset and NON-severe Penicillin Hypersensitivity
Cef-AL-exin 500mg TDS PO
AND
Metronidazole 400mg TDS PO
IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity
Clindamycin 450mg QDS PO
Comments
• Send wound swab for C&S and review treatment in conjunction with results when available.
Duration
5 - 7 days

Obstetrics - Moderate to Severe Infection - C-section Wound/ Endometritis/ Perineal/ post-ERPC/ Third or Fourth Degree Tear/ Source Unknown

Indication
Obstetrics - Moderate to Severe Infection - C-section Wound/ Endometritis/ Perineal/ post-ERPC/ Third or Fourth Degree Tear/ Source Unknown
First Line Antimicrobials
N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. If present, contact clinical microbiologist for advice.
Co-amoxiclav 1.2g TDS IV
AND
Gentamicin 5mg/kg once daily IV
NON-immediate-onset and NON-severe Penicillin Hypersensitivity
N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. If present, contact clinical microbiologist for advice.
Cef-UR-oxime 1.5g QDS IV
AND
Metronidazole 500mg TDS IV
AND
Gentamicin 5mg/kg once daily IV
IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity
N.B. Ask patient about the nature of their penicillin hypersensitivity .
N.B. Check lab results for history of resistant organisms, e.g. MRSA, ESBL. If present, contact clinical microbiologist for advice.
Clindamycin 900mg TDS IV
AND
Gentamicin 5mg/kg once daily IV
Duration
Minimum 7 days based on C&S results and clinical response.

Obstetrics - Mastitis – Mild

Indication
Obstetrics - Mastitis – Mild
First Line Antimicrobials
Flucloxacillin 1g QDS PO
NON-immediate-onset and NON-severe Penicillin Hypersensitivity
Cef-AL-exin 1g QDS PO
IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity
Clindamycin 450mg QDS PO
Duration
7 days

Obstetrics - Mastitis/ Breast Abscess – Moderate to Severe

Indication
Obstetrics - Mastitis/ Breast Abscess – Severe
First Line Antimicrobials
Flucloxacillin 2g QDS IV if no history of MRSA
If history of MRSA colonisation, SUBSTITUTE Vancomycin 25mg/kg loading dose (max 2g), followed by 15mg/kg BD IV
N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline.
NON-immediate-onset and NON-severe Penicillin Hypersensitivity
Cef-UR-oxime 1.5g QDS IV if no history of MRSA
If history of MRSA colonisation, SUBSTITUTE Vancomycin 25mg/kg loading dose (max 2g), followed by 15mg/kg BD IV
N.B. Adjust dose if renal impairment, trough level monitoring required, click on link above for calculator and guideline.
IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity
Vancomycin 25mg/kg loading dose (max 2g), followed by 15mg/kg BD IV
AND
Clindamycin 900mg TDS IV (Review clindamycin at 48hrs)
Comments
<ul style="list-style-type: none"> Surgical referral essential if breast abscess confirmed . Microbiological Investigations: <ul style="list-style-type: none"> MRSA screen Blood cultures Breast milk for C&S Breast swab (if discharging abscess) for C&S.

Obstetrics - Nipple Thrush and Ductal Candidiasis

Indication
Obstetrics - Nipple Thrush and Ductal Candidiasis
First Line Antimicrobials
Nipple treatment for mother:
Miconazole 2% cream applied to nipples and areolae after each feed for 1 to 2 weeks. It is not necessary to wash the cream from the nipples before the next breastfeed - any excess cream should be wiped away.
Oral treatment for baby:
Miconazole oral gel smeared around inside of mouth four times a day after feeds for 2 weeks. N.B. . Apply the gel in small amounts with a clean finger and do not use a spoon due to the risk of the baby choking on the viscous fluid.
Second line treatment:
Fluconazole for ductal candidiasis should only be commenced after senior clinician review.
If symptoms persist for more than 5 - 7 days, consider oral treatment of mother with fluconazole in addition to topical treatment as above: Loading dose fluconazole 300mg PO, followed by 150mg daily PO for a total of 14 days of treatment.
Duration
Topical treatment for mother and baby should continue until 7 days after symptoms have disappeared.
Fluconazole PO: 14 days.
Comments
<ul style="list-style-type: none"> If a mother reports sore nipples during breastfeeding the first action should always be to re-examine and improve attachment. It is imperative that both mother and baby are treated simultaneously, even when there are no signs in the baby's mouth. Otherwise the baby will re-infect the mother at each feed. Babies frequently show no signs of oral thrush, even though their mothers have the symptoms.

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Obstetrics - Postnatal Urinary Tract Infection

[Urinary Tract Infections](#)