## Waterford: Antimicrobial Guidelines - Antimicrobial Guideline: Sepsis in Pregnancy

	Sepsis in Pregnancy
General points See Sepsis and National Clinical G	Suideline No26 Sepsis management for adults including maternity 2021
See below for antimicrobial recom	
1. Sepsis in pregnancy	
	eptic shock) in pregnancy.
	blogy test results for antimicrobial resistance.
<ul> <li>Note Group B Streptococci (C 20-30% of GBS isolates both lo cannot be recommended.</li> </ul>	BSB) are universally susceptible to penicillins and most cephalosporins including cefuroxime and ceftriaxone. Between ocally and nationally are resistant to clindamycin therefore for empiric use (where susceptibility is unknown) clindamycin to repatients with known or suspected MDROs such as ESBL, CPE. Discuss these cases with Clinical Microbiologist.
Ensure appropriate microbiolog     Identify source of sepsis as s     The empirical antimicrobial regi	into account when prescribing as recent exposure to a particular agent is a risk factor for resistance to same. gical specimens (blood, urine, swabs) sent before starting treatment where possible. soon as possible to ensure timely source control. ime should be rationalised as soon as microbiology test results available.
<ul> <li>Review need for Gentamicin/Ar</li> </ul>	Sepsis in Pregnancy (no identifiable source)
First Line (Empiric Therapy) Co-amoxiclay 1.25g TDS IV + Ge	entamicin 5mg/kg OD IV (booking weight, max 480mg) (please see Gentamicin dosing schedule).
	Illin-tazobactam 4.5g IV QDS + Gentamicin 5mg/kg OD IV (booking weight, max 480mg) may be warranted depending ology test results or recent co-amoxiclav use.
	infection consider adding Vancomycin 15mg/kg IV 12 hourly (booking weight, max 2g/dose), <u>(please see Vancomycin</u> /kg (max 2g) loading dose if severe infection or septic shock.
	BMI ≥30kg/m <sup>2</sup> use Obese Dosing Weight/Adjusted Body Weight ( <u>Please see formulae for weight calculations</u> ) and not entamicin dose. <u>(Please see Gentamicin dosing schedule</u> ). BNY
NOT IgE-mediated /anaphylaxis/	
CefUROXime 1.5g IV C	JDS.
+ Metronidazole 500m	g IV TDS.
+ Gentamicin 5mg/kg (	OD IV (booking weight, max 480mg). (Please see Gentamicin dosing schedule)
	infection consider adding Vancomycin 15mg/kg IV 12 hourly (booking weight, max 2g/dose). Consider 25mg/kg (max n or septic shock. <u>(Please see Vancomycin dosing schedule).</u>
gE-mediated /anaphylaxis/sever	re penicillin reaction:
Vancomycin 15mg/kg l (Please see Vancomyci	IV 12 hourly (booking weight, max 2g/dose). Consider 25mg/kg (max 2g) loading dose if severe infection or septic shock in dosing schedule).
+ Gentamicin 5mg /kg	once daily (use booking weight) (Please see Gentamicin dosing schedule)
+ Metronidazole 500m	g IV TDS
Add clindamycin if invas	sive Group A Strep Infection suspected.
	BMI ≥30kg/m <sup>2</sup> use Obese Dosing Weight/Adjusted Body Weight <u>(See formulae for weight calculations)</u> and not Actual in dose. ( <u>Please see Gentamicin dosing schedule</u> )
	micin can cause nephrotoxicity as an adverse effect. This risk is increased when both agents are used together and is oncomitant piperacillin-tazobactam and other nephrotoxic medications. Review use of these medications daily, monitor
	Sepsis (severe) in Pregnancy e.g. septic shock tot IgE-mediated/anaphylaxis or non-severe penicillin allergy) Empiric Therapy
Meropenem 1-2g TDS + Clindamycin 1.2g QE	
	OD IV (booking weight, max 480mg) (Please see Gentamicin dosing schedule)
In patients with a history (Please see Amikacin d	
history of an sick factors for MDC	
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If there is a strong suspicion clinically that the septic shock may be relating to Group A Streptococcus, then IV immunoglobulin could be considered.

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