

ASPLENIA/HYPOSPLENIA FEVER ORDERS

(adapted with permission from the IWK Health Centre June 2017)

Patient:				
Age:	Wt:	kg	Date of Wt (dd/mm/yyyy):	
Allergies:				

The following orders will be carried out by a licensed healthcare professional ONLY ON THE AUTHORITY OF AN APPROVED PRESCRIBER. Where choice occurs, check as appropriate.

Refer to APPHON Guidelines for prevention and empiric therapy of bacterial infections for children with asplenia and hyposplenia. For Infants less than 1 month - refer to IWK Dosing Guidelines.

Required Evaluations	CBC with Differential and baseline lactate level within 30 minutes of arrival and then daily CBC with Differential			
	Daily Na, K, Cl, BUN, creatinine, ALT, AST, BILITD venous/cap blood gas, reticulocyte count			
	Blood cultures prior to administration of antibiotics if possible			
	Please check as appropriate			
Optional Evaluations				
	Urine Culture			
	NP (PCR) swab for Influenza, RSV, Adenovirus, Other			
	Throat swab for mycoplasma			
	Chest X-ray			
	LP if suspicion of meningitis and if patient is hemodynamically stable			
	□ Other:			
Vital Signs	Every hour until stable, then q4h and within 30 minutes prior to leaving the hospital			

• Start Antibiotics and call Pediatric Oncologist within 60 minutes of arrival at hospital.

Do NOT wait for CBC results before starting antibiotics. If patient has had a confirmed anaphylactic reaction to beta-lactam antibiotics consult Infectious Diseases. NEVER delay treatment due to an allergy but be prepared to treat a reaction.

Treatment					
Hydration	IV D5W + 0.9% NaCl at 1 ½ x maintenance = mL/hour (up to 150 mL/hour) or oral equivalent				
Infant 1-2 months	Ampicillin mg IV q6h (100-200 mg/kg/24 h, maximum 4 g/24 h) AND				
	cefoTAXime mg IV q8h (100-200 mg/kg/24 h, maximum 2 g/dose and 12 g/24 h)				
Infant 1-2 months with suspicion of meningitis	Ampicillin mg IV q6h (200-400 mg/kg/24 h, maximum 12 g/24 h) AND				
	cefoTAXime mg IV q8h (200 mg/kg/24 h, maximum 2 g/dose and 12 g/24 h)				
	□ If CSF shows positive gram cocci ADD				
	Vancomycin mg IV q6h (50 mg/kg/24 h, maximum 1 g/dose and maximum 4 g/24 h)				
	Drug levels pre 4 th dose (target 5-15 micrograms/mL)				
Infant and child greater than 2 months	In Emergency Department				
	□cefTRIAXonemg IV q24h (100 mg/kg/24h, maximum 2 g/dose)				
	If admitted				
	□cefoTAXimemg IV q8h (100-200 mg/kg/24h, maximum 2 g/dose and 12 g/24 h)				
	If suspected meningitis ADD				
	Vancomycin mg IV q6h (50 mg/kg/24 h, maximum 1 g/dose and maximum 4 g/24 h)				
	Drug levels pre 4 th dose (target 5-15 micrograms/mL)				
□ If patient is suspected to have mycoplasma ADD					
Clarithromycin mg PO q12h (15 mg/kg/24 h, maximum 500 mg/dose)					

DATE (dd/mm/yyyy)	Time (24hr/hh:mm)	Prescriber Signature	

Printed Surname/Registration#

DATE (dd/mm/yyyy)

Time (24hr/hh:mm)

Verified By (Signature)

Printed Surname

Note: Page 2 Clinician Information Only

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Algorithm for the Management of Asplenia Patients with Fever or Acute Illness

(adopted with permission from the IWK Health Centre)

- Immediate assessment to determine if patient has focal point of infection, example meningitis etc.
- Appropriate cultures, including a blood culture before antibiotics if possible.
- Usual organisms include: Streptococcus pneumoniae, Haemophilus influenzae, Neisseria meningitidis, Salmonella and Escherichia coli.
- Early administration of parenteral antibiotics (within 60 minutes of presentation).
- Stop prophylactic penicillin.
- Close observation for 6-12 hours even if a viral etiology is suspected



- When culture & sensitivity results indicate the organism is penicillin susceptible switch to penicillin. If allergic to beta-lactams give clindamycin in place of penicillin.
- If patient greater than 5 years with respiratory symptoms or patient less than 5 years with evidence of mycoplasma or any suspicion of non-compliance with penicillin, add clarithromycin or erythromycin.

* Where intermediate and high penicillin-resistant penumococci are prevalent, use a combination cefoTAXime + Vancomycin. If treated with vancomycin, adjust dosage if abnormal renal function and with levels.

Local infections, example tonsillitis and impetigo, can be treated with penicillin; otitis media with amoxicillin.

Antibiotic treatment should be modified depending on culture results.

Antibiotic dosing:

- 2 month old vancomycin 50 mg/kg/24 h IV q6h (maximum 1 g/dose; 4 g/24 h),cefTRIAXone 100 mg/kg/24 h IV q12-24h (maximum 2 g/dose). cefoTAXime 100-200 mg/kg/24 h IV q8h (maximum 2g/dose and 12 g/24 h).
- Clarithromycin 15 mg/kg/24 h PO q12h (maximum 500 mg/dose).
- Erythromycin 40 mg/kg/24 h IV q6h (maximum 4 g/24 h).
- Clindamycin 40 mg/kg/24 h IV q8h (maximum 4.8 g/24 h).
- If patient has a confirmed anaphylactic penicillin reaction consult ID.
- Possible alternatives include meropenem.

NEVER delay treatment due to an allergy BUT be prepared to treat reaction