NHS Grampian Acute Sector Antimicrobial Therapy
Prescribing Guidance For Obstetric Patients

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Executive Sign-Off
This document has been endorsed by the Director of Pharmacy and Medicines Management

Signature: ___________________________
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Lead Author/Coordinator: Fiona McDonald/Gillian Macartney, Specialist Antibiotic Pharmacist

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Policy, Protocol, Procedure or Process Document: Guideline

Antimicrobial Prescribing Guideline for Acute Obstetrics

Document application: NHS Grampian – Aberdeen Maternity Hospital and Dr Gray’s Hospital – Obstetric Ward

Purpose/description: To provide guidance for prescribers working in obstetric wards in NHS Grampian on the antibiotic therapy or antibiotic prophylaxis choice(s) for obstetric patients.

Responsibility: Responsibility for the effective management of the Acute Sector’s policy, protocol, procedure and process documentation ultimately lies with the General Manager for the Acute Sector. Delegation for formulating, disseminating and controlling these documents falls to either a named individual or a working group.

Policy statement: It is the responsibility of all staff to ensure that they are working to the most up to date and relevant policies, protocols, procedures.
Responsibilities for ensuring registration of this document on the NHS Grampian
Lead Author/Co-ordinator: Specialist Pharmacists – Antibiotics

Physical location of the original of this document: Pharmacy and Medicines Directorate, Westholme
Job title of creator of this document: Specialist Pharmacists - Antibiotics
Job/group title of those who have control over this document: Specialist Pharmacists - Antibiotics

Responsibilities for disseminating document as per distribution list:
Lead Author/Co-ordinator: Specialist Pharmacists - Antibiotics

Responsibilities for implementation:
Organisational: Operational Management Team and Chief Executive
Sector: General Managers, Medical Leads and Nursing Leads
Departmental: Clinical Leads
Area: Line Manager

Review frequency and date of next review: Review every 2 years (or sooner if required)

Responsibilities for review of this document:
Lead Author/Co-ordinator: Specialist Antibiotic Pharmacists

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Previous Revision Date</th>
<th>Summary of Changes (Descriptive summary of the changes made)</th>
<th>Changes Marked* (Identify page numbers and section heading )</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2016</td>
<td>n/a</td>
<td>Refer to Appendix 1</td>
<td>Whole document</td>
</tr>
</tbody>
</table>

* Changes marked should detail the section(s) of the document that have been amended, i.e. page number and section heading.
NHS Grampian Acute Sector Antimicrobial Therapy Prescribing Guidance For Obstetric Patients

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Introduction
This guidance should be used to determine the choice of antibiotic therapy for obstetric patients in acute hospitals in NHS Grampian. This guidance does not cover the choice of antibiotic therapy for all infections (refer to main acute sector empirical antibiotic guidelines (http://www.nhsgrampian.com/grampianfoi/files/NHSGEmpA.pdf) for infections not covered in this guideline) and does not replace the need for taking samples to determine the specific causative organism to further direct therapy. Specialist advice will be required for some infections.

The document should not be used to guide therapy if the organism is known and there are specific microbiological sensitivities or if there are other reasons that determine specific antimicrobial therapy, e.g. previous sensitivity testing. The document does not cover the treatment of infections in patients with some chronic disorders such as cystic fibrosis or apply in all cases, for example, patients who are immunosuppressed.

Doses quoted are for patients without renal or hepatic impairment therefore adjustments may be required depending on patient circumstances. Drug interactions should also be considered, for example with macrolides – refer to BNF/BNFC.

Adolescents ≥12 years to <18 years
For adolescents aged between 12 and 18 years, please refer to the dosing recommendations in the BNF for Children. Extra caution should be taken when deciding on doses for younger girls or those who are underweight.

IV to oral switch therapy (IVOST)
Recommendations for IV to oral switches are included in the guidance and reference should be made to the IVOST policy for more information on suitable criteria and patient assessment (http://intranet.grampian.scot.nhs.uk/foi/files/NHSGIVOST.pdf).

Penicillin allergy
Options for patients with penicillin allergy are included in the guidance – for further information refer to the penicillin allergy policy (http://intranet.grampian.scot.nhs.uk/foi/files/NHSGPenA.pdf).

Gentamicin and Vancomycin Guidelines
There are separate policies for gentamicin and vancomycin based on age. For girls less than 16 years the paediatric policies should be used. There are links to the appropriate policies within the document. For gentamicin a single dose is recommended and therapy should only be continued based on senior medical advice.

Labour Ward Management Guidelines
For further details about the management of specific infections please refer to the Labour Ward Management Guidelines available on the Department of Obstetrics and Gynaecology page on the NHS Grampian intranet.
Urinary Tract

- Samples should be taken prior to starting treatment
- Send blood for culture if pyrexial
- Refer to SIGN 88 algorithm “Management of suspected LUTI in pregnant women”

<table>
<thead>
<tr>
<th>INFECTION</th>
<th>Likely organisms</th>
<th>1st Choice Antibiotics</th>
<th>2nd Choice Antibiotics</th>
<th>Comments/changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic bacteriuria in pregnancy</td>
<td>Enterobacteriaceae spp.</td>
<td>See comments</td>
<td></td>
<td>Start treatment once microbiology results known. Take urine culture 7 days after completion of therapy as test of cure.</td>
</tr>
<tr>
<td>UTI in pregnancy</td>
<td>Staphylococcus saprophyticus</td>
<td>*Nitrofurantoin 50mg oral 6 hourly for SEVEN (7) days</td>
<td>**Trimethoprim 200mg oral 12 hourly for SEVEN (7) days</td>
<td>Start treatment while awaiting sample results and review in light of results. *Nitrofurantoin should be avoided in third trimester and in renal impairment. **Trimethoprim should be avoided in the first trimester for all pregnant women. Trimethoprim should be avoided in all trimesters by pregnant women with established folate deficiency, low dietary folate intake or women taking other folate antagonists. Take urine culture 7 days after completion of therapy as test of cure.</td>
</tr>
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### Urinary Tract

- Samples should be taken prior to starting treatment
- Send blood for culture if pyrexial
- Refer to [SIGN 88 algorithm “Management of suspected LUTI in pregnant women”](#)

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</thead>
<tbody>
<tr>
<td>Upper UTI without sepsis</td>
<td><em>Gram-negative bacteria</em>&lt;br&gt;Occasionally <em>staphylococci</em> and <em>streptococci</em></td>
<td>Co-amoxiclav oral 625mg 8 hourly&lt;br&gt;Total duration: 14 days</td>
<td>In penicillin allergy,&lt;br&gt;<strong>Trimethoprim oral 200mg 12 hourly&lt;br&gt;Total duration: 14 days</strong>&lt;br&gt;If penicillin allergic and in first trimester OR if patient not responding see ‘Pyelonephritis/Upper UTI with sepsis’</td>
<td>Start treatment while awaiting sample results and review in light of results.&lt;br&gt;<strong>Trimethoprim should be avoided in the first trimester for all pregnant women. Trimethoprim should be avoided in all trimesters by pregnant women with established folate deficiency, low dietary folate intake or women taking other folate antagonists.</strong>&lt;br&gt;<strong>Trimethoprim should be avoided in all trimesters by pregnant women with established folate deficiency, low dietary folate intake or women taking other folate antagonists.</strong></td>
</tr>
<tr>
<td>Pyelonephritis/Upper UTI with sepsis</td>
<td><em>Gram-negative bacteria</em>&lt;br&gt;Occasionally <em>staphylococci</em> and <em>streptococci</em></td>
<td>Gentamicin 7mg/kg IV single dose (see guidance for calculating dose - use booking weight)&lt;br&gt;Amoxicillin 1g IV 8 hourly&lt;br&gt;Switch to oral option guided by microbiology sensitivities. If empirical switch required, co-amoxiclav oral 625mg 8 hourly.&lt;br&gt;Total duration: 7-14 days</td>
<td>In penicillin allergy,&lt;br&gt;Gentamicin 7mg/kg IV single dose (see guidance for calculating dose – use booking weight)&lt;br&gt;Switch to oral option guided by microbiology sensitivities. If empirical switch required,&lt;br&gt;<strong>Trimethoprim oral 200mg 12 hourly&lt;br&gt;Total duration: 14 days</strong></td>
<td>Take urine culture 7 days after completion of therapy as test of cure.</td>
</tr>
</tbody>
</table>
### Genital system

- For full guidelines see British Association of Sexual Health and HIV - [www.bashh.org/guidelines](http://www.bashh.org/guidelines)
- If STD is suspected patients should be referred to GUM Clinic (Sexual Health Service) tel 0345 337 9900
- Send blood for culture if pyrexial

#### INFECTION | Likely organisms | 1st Choice Antibiotics | 2nd Choice Antibiotics | Comments/changes
---|---|---|---|---
Pelvic Inflammatory Disease | *Chlamydia trachomatis, Neisseria gonorrhoeae, intestinal aerobes and anaerobes* | Ceftriaxone* 2g IV stat, then Clarithromycin 500mg oral 12 hourly *If severe add* Metronidazole 400mg oral 8 hourly Total duration: 14 days Or if IV required Ceftriaxone* 2g IV stat then Clarithromycin 500mg IV 12 hourly *If severe add* Metronidazole 500mg IV 8 hourly Total duration: 14 days | Seek specialist advice | Management of PID 2011 – BASHH Guideline

*12 – 18 years
Ceftriaxone – usual dose is 250mg stat but can increase to 2g if severe

Endometritis | *Polymicrobial* | *Chlamydia negative:* Co-amoxiclav 625mg oral 8 hourly If sepsis, Co-amoxiclav 1.2g IV 8 hourly +/- Gentamicin 7mg/kg IV *single dose* (see guidance for calculating dose - use booking weight) | *In penicillin allergy and/or chlamydia positive:* Clarithromycin 500mg oral twice daily AND Metronidazole 400mg oral three times daily If sepsis, Clindamycin 600mg IV 6 hourly +/- Gentamicin 7mg/kg IV *single dose* (see guidance for calculating dose - use booking weight) | If sepsis and chlamydia positive, seek advice from Medical Microbiology or Infection Unit.
**Genital system**

- For full guidelines see British Association of Sexual Health and HIV - [www.bashh.org/guidelines](http://www.bashh.org/guidelines)
- If STD is suspected patients should be referred to GUM Clinic (Sexual Health Service) tel 0345 337 9900
- Send blood for culture if pyrexial

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<th>2&lt;sup&gt;nd&lt;/sup&gt; Choice Antibiotics</th>
<th>Comments/changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trichomoniasis</td>
<td>Trichomoniasis vaginalis</td>
<td>Metronidazole 400mg oral 12 hourly for 5 - 7 days</td>
<td>For treatment failure: Seek specialist advice</td>
<td>Management of Trichomonas vaginalis – BASHH Guideline 2014</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>Herpes simplex virus 1 or 2</td>
<td>All ages: Aciclovir 200mg oral 5 times daily or ≥18 years only: Aciclovir 400mg oral 8 hourly Duration: 5 days</td>
<td>All ages: Valaciclovir 500mg oral 12 hourly Duration: 5 days</td>
<td>Samples: remove exudates or pus and swab lesions or cervix directly and put swab in viral transport medium. Send aspirate of vesicle or tissue in a dry sterile container. Management of Genital Herpes in Pregnancy RCOG &amp; BASHH Guideline Oct 2014</td>
</tr>
<tr>
<td>Vaginal Candidiasis</td>
<td>Candida albicans</td>
<td>Clotrimazole vaginal pessary 100mg at night for 6 days. During pregnancy the pessary should be inserted without using the applicator.</td>
<td></td>
<td>In pregnancy avoid oral fluconazole. Longer courses are more effective than shorter courses. For persistent or recurrent infections refer to BASHH 2007</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>Gardnerella vaginalis</td>
<td>Metronidazole 400mg oral 12 hourly for 5 - 7 days</td>
<td>Metronidazole* 0.75% vaginal gel 5g PV at night for 5 nights If metronidazole not suitable: Clindamycin* 2% cream 5g PV at night for 7 days (Caution in the 1&lt;sup&gt;st&lt;/sup&gt; trimester)</td>
<td>Send vaginal swabs, pus or exudates. Bacterial Vaginosis 2012 - BASHH Guideline</td>
</tr>
</tbody>
</table>
**Blood**
- Take blood (2 sets - 20mL per set) and urine cultures before starting treatment, plus swabs from any other focus of infection, e.g. sputum, wound swabs, etc.

<table>
<thead>
<tr>
<th>INFECTION</th>
<th>1st Choice Antibiotics</th>
<th>2nd Choice Antibiotics</th>
<th>Comments/changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pyrexia in labour</strong></td>
<td>Co-amoxiclav 1.2g IV 8 hourly</td>
<td>In penicillin allergy, Clarithromycin 500mg IV 12 hourly</td>
<td>Labour Ward Management Guidelines</td>
</tr>
<tr>
<td>(defined as 38°C once or 37.5°C on two occasions 2 hours apart)</td>
<td>Review after delivery. Considering stopping if mother well and inflammatory markers normal. If empirical antibiotics need to continue switch to oral co-amoxiclav 625mg 8 hourly. Total duration: up to 5 days</td>
<td>Review after delivery. Consider stopping if mother well and inflammatory markers normal. If empirical antibiotics need to continue switch to oral clarithromycin 500mg 12 hourly Total duration: up to 5 days</td>
<td></td>
</tr>
<tr>
<td><strong>Postnatal pyrexia – no obvious source</strong></td>
<td>Treat as probable endometritis (see Genital System section) until source confirmed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NHS Grampian Acute Sector Antimicrobial Therapy Prescribing Guidance For Obstetric Patients

### Blood

- Take blood (2 sets - 20mL per set) and urine cultures before starting treatment, plus swabs from any other focus of infection, e.g. sputum, wound swabs, etc.

<table>
<thead>
<tr>
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<th>1st Choice Antibiotics</th>
<th>2nd Choice Antibiotics</th>
<th>Comments/changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis (Pre or Postnatal) no obvious source</td>
<td>Co-amoxiclav 1.2g IV 8 hourly +/- Gentamicin 7mg/kg IV <strong>single dose</strong> (see guidance for calculating dose - use booking weight)</td>
<td>Clindamycin IV 600mg 6 hourly +/- Gentamicin 7mg/kg IV <strong>single dose</strong> (see guidance for calculating dose - use booking weight)</td>
<td>Seek advice from Medical Microbiology or Infection Unit.</td>
</tr>
<tr>
<td>Give antibiotics within 1 hour of diagnosis of sepsis</td>
<td>Piperacillin/tazobactam IV 4.5g 8 hourly + Gentamicin 7mg/kg IV <strong>single dose</strong> (see guidance for calculating dose - use booking weight)</td>
<td>Clindamycin IV 1.2g 6 hourly + Gentamicin 7mg/kg IV <strong>single dose</strong> (see guidance for calculating dose - use booking weight)</td>
<td>Prompt diagnosis is vital to allow early targeting and rationalisation of treatment.</td>
</tr>
<tr>
<td>Severe Sepsis (Pre or Postnatal) (evidence of organ dysfunction)</td>
<td>If suspected Streptococcal Group A infection <strong>add</strong> Clindamycin 600mg (can increase to 1.2g IV 6 hourly if life-threatening)</td>
<td>If MRSA, add Vancomycin IV see guidance</td>
<td>Avoid prescribing NSAIDs in patients with sepsis as they impede the ability of polymorphs to fight GAS infection.</td>
</tr>
<tr>
<td></td>
<td>If MRSA, add Vancomycin IV see guidance. Switch to oral co-amoxiclav 625mg 8 hourly Total duration: 7 – 14 days</td>
<td></td>
<td><strong>Bacterial Sepsis in Pregnancy - RCOG Green-top Guideline 64a 2012</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Sepsis following Pregnancy - RCOG Green-top Guideline 64b 2012</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Labour Ward Management Guidelines - Sepsis</strong></td>
</tr>
<tr>
<td>INFECTION</td>
<td>Likely organisms</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; Choice Antibiotics</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; Choice Antibiotics</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mastitis</td>
<td><em>Staphylococcus aureus</em></td>
<td>Flucloxacillin 500mg oral 6 hourly for 14 days</td>
<td>In penicillin allergy, Clarithromycin 500mg oral 12 hourly for 14 days</td>
</tr>
<tr>
<td>Post natal wound infection – with no evidence of systemic illness</td>
<td><em>Staphylococcus aureus</em>  <em>Anaerobes</em></td>
<td>Flucloxacillin 500mg oral 6 hourly</td>
<td>In penicillin allergy, Clarithromycin 500mg oral 12 hourly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If anaerobes suspected, add metronidazole 400mg oral 8 hourly</td>
<td>If anaerobes suspected, add metronidazole 400mg oral 8 hourly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duration: 10–14 days</td>
<td>Duration: 10–14 days</td>
</tr>
<tr>
<td>Varicella Zoster (chicken pox)</td>
<td></td>
<td>If &gt;20 weeks gestation and within 24 hours of rash developing, Aciclovir oral 800mg 5 times daily for 5 days</td>
<td>If &lt;20 weeks pregnant, aciclovir should also be considered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If severe, Aciclovir IV 5mg/kg 5 times daily for 5 days</td>
<td></td>
</tr>
</tbody>
</table>

Varicella Zoster (chicken pox)

If >20 weeks gestation and within 24 hours of rash developing, Aciclovir oral 800mg 5 times daily for 5 days

If severe, Aciclovir IV 5mg/kg 5 times daily for 5 days

If <20 weeks pregnant, aciclovir should also be considered.

[Chickenpox in Pregnancy RCOG Greentop Guideline 13](http://cks.nice.org.uk/mastitis-and-breast-abscess#scenariorecommendation)
## Skin

<table>
<thead>
<tr>
<th>INFECTION</th>
<th>Likely organisms</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Choice Antibiotics</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Choice Antibiotics</th>
<th>Comments/changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post natal wound</td>
<td><em>Staphylococcus aureus</em> <em>Anaerobes</em></td>
<td>Flucloxacillin 1g IV 6 hourly</td>
<td>In penicillin allergy, Clarithromycin 500mg IV 12 hourly</td>
<td></td>
</tr>
<tr>
<td>infection – systemically unwell</td>
<td></td>
<td>If not responding or BMI&gt;30, consider increasing to Flucloxacillin 2g IV 6 hourly</td>
<td>If anaerobes suspected, add Metronidazole 500mg IV 8 hourly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If anaerobes suspected, add Metronidazole 500mg IV 8 hourly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If severe sepsis consider adding Gentamicin 7mg/kg IV single dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(see guidance for calculating dose - use booking weight)</td>
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</tbody>
</table>
## Antibiotic Prophylaxis

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>1st Choice Antibiotics</th>
<th>2nd Choice Antibiotics</th>
<th>Comments/changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-term pre-labour rupture of membranes</td>
<td>Erythromycin 250mg oral 6 hourly for 10 days</td>
<td>Clindamycin 150mg oral 6 hourly for 10 days</td>
<td>Preterm Prelabour Rupture of Membranes – RCOG Green-top Guideline 44 2010</td>
</tr>
<tr>
<td>Group B Streptococcus (GBS) prophylaxis</td>
<td></td>
<td></td>
<td>Labour Ward Management Guidelines</td>
</tr>
<tr>
<td>o Antibiotics if GBS detected vaginally or rectally during the current pregnancy OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o GBS detected in urine during the current pregnancy OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o History of a previous baby who was affected by GBS infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Uterine Inversion</td>
<td>Co-amoxiclav 1.2g IV single dose</td>
<td>In penicillin allergy, Clindamycin 900mg IV single dose</td>
<td>Labour Ward Management Guidelines</td>
</tr>
</tbody>
</table>

Group B Streptococcus (GBS) prophylaxis:
- If GBS isolate sensitive to clindamycin:
  - Clindamycin IV 900mg at start of labour and every 8 hours until birth
- If GBS isolate shows clindamycin resistance, Vancomycin IV – see guidance, Give loading dose then maintenance dosing until birth.

GBS antibiotic prophylaxis is not required for caesarean section with intact membranes.

Refer to Labour Ward Management Guidelines 2012 for further details on administration.

Vancomycin – refer to the paediatric policy for children <16 years

References

8. SPC for Zovirax (GlaxoSmithKline UK) last updated on eMC on 1/04/15 – accessed at www.medicines.org.uk (Accessed 29/6/16)
11. SPC for Dalacin Cream 2% (Pharmacia Ltd) last updated on eMC on 10/09/14 – accessed at www.medicines.org.uk (Accessed 29/6/16)


Consultation List

This policy has been sent to the following for comment via email:

- All obstetric consultants – June 2016

Comments received from:

Dr Manisha Kumar, Consultant Anaesthetist
Dr Tara Fairley, Consultant Obstetrician
Dr C Hemming, Consultant Gynaecologist

This policy has been reviewed and agreed by:

- NHS Grampian Antimicrobial Management Team – June 2016
Appendix 1: Version Control
Statements Changes from Version 1 (August 2013)

All sections
References and hyperlinks updated where appropriate

Introduction
p2
‘The antibiotics and doses recommended in this policy are appropriate for adolescents aged between 12 and 18 years, except where additional comments have been added to give alternative recommendations.’ changed to ‘For adolescents aged between 12 and 18 years, please refer to the dosing recommendations in the BNF for Children. Extra caution should be taken when deciding on doses for younger girls or those who are underweight.’

Changed advice on how to access Labour Ward guidelines.

Urinary Tract
p3
UTI in pregnancy
Nitrofurantoin listed as first line option

New indications added for Upper UTI and Upper UTI/Pylonephritis with sepsis.

Genital Tract
p5
GUM telephone number changed to 0345 3379900
Information on reducing dose in adolescents removed

Endometritis – new recommendations for if patient has sepsis added

Vaginal Candidiasis
Clotrimazole pessary dosing changed from 500mg stat dose to 100mg at night for 6 days to correspond with primary care guidance and PHE guideline.

New comments: For persistent or recurrent infections refer to BASSH 2007 Longer courses are more effective than shorter courses.

Blood
p8
Pyrexia in labour:
‘Review after 24 hours changed to ‘Review after delivery. Considering stopping if mother well and inflammatory markers normal. If empirical antibiotics need to continue switch to oral.’

Sepsis
p9
First line for sepsis changed from piperacillin/tazobactam to co-amoxiclav +/- gentamicin. Severe sepsis will remain piperacillin/tazobactam + gentamicin.

Penicillin allergy – remove ceftriaxone + metronidazole option and leave clindamycin + gentamicin as only option to simplify

New comment: Avoid prescribing NSAIDs in patients with sepsis as they impede the ability of polymorphs to fight GAS infection.

Increase of clindamycin dosing and recommendation of 1.2g qds for severe sepsis.

Skin
p10
Mastitis
Clarithromycin dosing range changed from 250 – 500mg to 500mg 12 hourly.

New recommendations for mastitis + sepsis

Post natal wound infection
Dose for flucloxacillin changed from 500mg to 1g and comment added that if not responding or BMI>30 can consider increasing to 2g 6 hourly.

Varicella Zoster
New indication – as per Labour Ward Guidelines

Prophylaxis
p11
Streptococcus B
Mild penicillin allergy option removed to simplify treatment options. Vancomycin dosing changed from 1g 12 hourly to use standard local protocol.