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GUIDANCE ON SWITCHING ANTIBIOTICS FROM IV TO ORAL

Advantages of prompt switch to oral therapy include

- Reduction in hospital acquired bacteraemia caused by infected lines. Peripheral lines should be changed every 72 hours, or earlier if they look infected, and removed as soon as they are no longer required.
- Improved patient comfort and mobility
- Oral doses are more convenient to administer, saving medical and nursing time
- Possibility of earlier discharge from hospital
- Improved use of resources

Considerations for early switch to oral therapy COMH (Review at 24 to 48 hours)

C Clinical improvement observed

O Oral route not compromised

- Suitable oral formulation available
- No vomiting or severe diarrhoea
- No swallowing disorder, patient fully conscious (contact pharmacy for advice on antimicrobials via PEG / NG tube)

M Markers show a trend to normal

- Temperature above 36ºC and below 39ºC, preferably normal for at least 24 hours
- Heart rate less than 90 beats per minute
- Blood pressure stable
- Respiratory rate less than 20 breaths per minute
- White cell count, where available, shows trend to normal

H High risk / deep seated infections and/or a senior clinician or consultant microbiology has specifically advised a longer duration of IV therapy

Certain infections may appear to respond promptly but warrant prolonged IV therapy to optimise response and minimise risk of relapse. Discuss with a consultant microbiologist before switching patients with high risk/deep seated infections	
For deep-seated infections an initial two weeks of therapy may be needed. Examples include • Liver abscess • Osteomyelitis • Septic arthritis • Empyema • Cavitating pneumonia	High risk infections need prolonged IV therapy, such as • Staphylococcus aureus bacteraemia • Necrotising soft tissue infections • Neutropenic sepsis • Infected implants/prosthetics • Meningitis • Intracranial abscess • Mediastinitis • Endocarditis • Exacerbations of cystic fibrosis • Inadequately drained abscesses and empyema

If the patient deteriorates on oral therapy consider return to IV and / or discuss with the Consultant Microbiologist.

Consult Antimicrobial Guideline or contact microbiology for advice on choice of oral therapy.

In general:

IV Agent	Oral
Amoxicillin	Amoxicillin 500mg-1g 8 hourly
Ciprofloxacin	Ciprofloxacin 500mg 12 hourly (750mg 12 hourly if pseudomonas suspected)
Clarithromycin	Clarithromycin 500mg 12 hourly
Clindamycin	Clindamycin 300-450mg 6 hourly
Co-amoxiclav	Co-amoxiclav 375-625mg 8 hourly
Flucloxacillin	Flucloxacillin 500mg-1g 6 hourly
Gentamicin	None equivalent – change as indicated by sensitivities or microbiology advice
Metronidazole	Metronidazole 400mg 8 hourly
Rifampicin	Rifampicin 0.6-1.2g daily in 2-4 divided doses
Teicoplanin/Vancomycin/Meropenem/Tazocin	None equivalent – change as indicated by sensitivities or microbiology advice

***The above table applies only to patients with normal renal function. Doses should be adjusted according to severity of infection. Check for microbiology sensitivity results.**

References:

1. Sevinc F et al. Early switch from intravenous to oral antimicrobials: Guidelines implementation in a large teaching hospital JAC 1999; 43:601-666