CLINICAL GUIDELINE

IV to Oral Antibiotic Switch Therapy (IVOST) Adult

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Adult IV→ Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics DAILY

Can antibiotic therapy be stopped (e.g. alternative diagnosis)?

If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to Oral when:

✓**CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9ºC, reduction in the NEWS score, improving SEPSIS

✓**ORAL ROUTE** **is available reliably** (eating/drinking and no concerns regarding absorption)

✓**UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST:

Infection requiring specialist advice includes CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or Bone/Joint infection, Undrainable deep abscess

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness

Record the **stop date** on HEPMA

If IVOST criteria met → SWITCH TO ORAL

Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures

IF NO positive MICROBIOLOGY switch to oral as outlined below

DIAGNOSIS	EMPIRIC ORAL SWITCH■		TOTAL duration (IV + PO)
	1ST LINE	2nd LINE/PENICILLIN ALLERGY	
Neutropenic sepsis	**Co-amoxiclav** 625mg 8 hrly **& Discuss with micro/ID**	**Levofloxacin** 500mg 12 hrly **& Discuss with micro/ID**	7 days
Resolving sepsis and source unknown	**Co-amoxiclav** 625mg 8 hrly	**Co-trimoxazole** 960mg 12 hrly	5-7 days
Community-acquired pneumonia OR Infective exacerbation of COPD	**Amoxicillin** 500mg 8 hrly	**Doxycycline** 200mg as a one-off single dose then 100mg daily	5 days
Hospital-acquired pneumonia	**Co-amoxiclav** 625mg 8 hrly	**Co-trimoxazole** 960mg 12 hrly **OR Doxycycline** 100mg 12 hrly **OR Levofloxacin** 500mg 12 hrly	5 days
Aspiration pneumonia	**Amoxicillin** 500mg 8 hrly	**Clarithromycin** 500mg 12 hrly **PLUS Metronidazole** 400mg 8 hrly	5 days
Cellulitis	**Flucloxacillin** 1000mg 6 hrly	**Co-trimoxazole** 960mg 12 hrly **OR Doxycycline** 100mg 12 hrly	7-10 days
Infected human/ Animal bite	**Co-amoxiclav** 625mg 8 hrly	**Doxycycline** 100mg 12 hrly **PLUS Metronidazole** 400mg 8 hourly	7 days
Intra-abdominal/ Biliary tract infection	**Co-amoxiclav** 625mg 8 hrly	**Co-trimoxazole** 960mg 12hrly (or Ciprofloxacin 500mg 12 hrly) **PLUS Metronidazole*** 400mg 8 hrly	5 days (assuming source control) **Metronidazole is NOT required **for biliary tract infection,** unless severe*
Spontaneous bacterial peritonitis	if prior co-trimoxazole prophylaxis: **Co-amoxiclav** 625mg 8 hrly	If NO prior co-trimoxazole prophylaxis: **Co-trimoxazole** 960mg 12 hrly Or if prior co-trimoxazole prophylaxis: **Levofloxacin** 500mg 12 hrly	7 days
Urinary Sepsis/ Pyelonephritis	**Co-trimoxazole** 960mg 12 hrly	**Ciprofloxacin** 500mg 12 hrly	7 days
Tonsillitis	**Phenoxymethylpenicillin** 500mg 6 hrly	**Clarithromycin** 500mg 12 hrly	Phenoxymethylpenicillin- 10 days Clarithromcyin- 5 days

■Consult the product literature or pharmacy for doses in renal/hepatic dysfunction. Serious drug interactions/QT prolongation with clarithromycin & quinolones. Reduced absorption of doxycycline & quinolones with calcium, iron & magnesium. See the BNF or consult pharmacy.

Consider OPAT

If ongoing IV therapy anticipated but patient is otherwise fit for discharge- refer to OPAT via TrakCare

If unsure, contact the OPAT Service at QEUH on 0141 452 3107 (internal: 83107) Weekend: 0141 452 3105

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