Vancomycin Use Evaluation by Indication

Likely Appropriate

-Culture-documented MRSA infection (susceptible to vancomycin)

-Severe beta-lactam allergy and Gram-positive coverage needed

-Suspected enterococcal infection when resistant to ampicillin but susceptible to vancomycin

-Empiric coverage for septic shock (initial 48 hours)

-Empiric coverage for GPC bacteremia or suspected line-related infection

-Severe, purulent cellulitis or necrotizing fasciitis

-Empiric coverage for osteomyelitis, septic arthritis, or prosthetic joint infection

-Empiric coverage for bacterial meningitis, vertebral osteomyelitis, or epidural abscess

-Empiric coverage for infective endocarditis

-Empiric pneumonia coverage (CAP with risk factors, HAP, VAP, hospital-acquired empyema)

-Empiric coverage for neutropenic fever if MRSA risk factors present

-Orbital/pre-septal cellulitis

Maybe Appropriate

-Non-purulent cellulitis refractory to appropriate doses of beta-lactam therapy

-Fever of unknown origin

-Necrotizing otitis externa

-Community-acquired empyema (review risk factors for MRSA and review pleural fluid cultures)

Likely Inappropriate

-Culture-documented VRE or VRSA infection

-Uncomplicated cystitis, pyelonephritis, or perinephric abscess

-Prostatitis

-Non-purulent cellulitis that is “streaky”

-CAP with less than 2 MRSA risk factors

-Community-acquired aspiration pneumonia

-Uncomplicated intra-abdominal infection (community-onset cholecystitis, diverticulitis, etc.)

-Neutropenic fever without MRSA risk factors (hemodynamic instability, pneumonia, penicillin allergy, severe mucositis, catheter-related infection)

-Immunosuppression as the only reason cited for vancomycin use

Approved by LFH Antimicrobial Stewardship Committee 10/2018

Piperacillin-Tazobactam Use Evaluation by Indication

Likely Appropriate

-Empiric coverage for septic shock (initial 48 hours)

-Complicated UTI (pyelonephritis with sepsis, perinephric abscess)

-Cholangitis following biliary anastomosis

-High risk and/or severe intra-abdominal infection (cholecystitis, peritonitis, perirectal abscess, diverticulitis, necrotizing pancreatitis)

-Necrotizing fasciitis

-Empiric pneumonia coverage (CAP with risk factors, HAP, VAP)

-Severe/limb-threatening DFI

-Infected surgical wound post-op

-Failure of moderately broad-spectrum antibiotics after 48 hours (e.g., ceftriaxone, ampicillin-sulbactam)

-Recent history of documented infection with *Pseudomonas aeruginosa* susceptible to piperacillin-tazobactam

Maybe Appropriate

-Fever of unknown origin

-Necrotizing otitis externa

Likely Inappropriate

-Uncomplicated cystitis or pyelonephritis

-Prostatitis

-CAP with less than 3 risk factors for resistant Gram-negative rods

-Uncomplicated intra-abdominal infection (community-onset cholecystitis, diverticulitis, perirectal abscess, appendectomy with perforation); Cefazolin/flagyl

-Spontaneous bacterial peritonitis (SBP)

-Endometritis (acute postpartum) or salpingitis/PID

-Infective endocarditis

-Septic arthritis/prosthetic joint infection

-Immunosuppression as the only reason cited for piperacillin-tazobactam use

-Bite wound (human or animal)

-Uncomplicated SSTI (furunculosis, cutaneous abscess, cellulitis, mild DFI)

-Neutropenic fever: Cefepime+ AG (Per IDSA guidelines)

Approved by LFH Antimicrobial Stewardship Committee 10/2018