Dear

Thank you for your Freedom of Information request concerning Antibiotic policy/guidelines.

I would be grateful if you could provide me with an electronic copy of your trust's antibiotic guidelines/policy, in particular relating to orthopaedic procedures. In addition, please could you specify when these guidelines were last updated.

The Trust can provide the following information:

Please see attachments

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk , in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

Yours sincerely

James Cook
Information Governance Administrator

Matthew Hall
Information Governance Manager (Deputy Caldicott Guardian)

Antibiotic Pharmacist: B 209 Microbiologists: B092 Infection Control Nurses B 205

Summary of 6th ed. antibiotic policy - common infections (March 2010)

PRINCIPLES FOR USE OF GUIDELINES:

- ***Infection not covered? Please refer to the complete 6th ed Antibiotic policy (available on intranet and pocket booklet)***
- PRESCRIBE ANTIBIOTICS ONLY WHEN THERE IS LIKELY TO BE A CLEAR CLINICAL BENEFIT
- For clinical advice/ queries, discuss with **Microbiologists on Bleep 092** –out-of-hours 'on-call' Microbiology SpR/Consultant: aircall via switch
- Specimens for Microscopy, Culture & Sensitivity (M,C&S) should always be taken before starting antibiotics
- Check previous microbiology results before prescribing & check for new microbiology results daily and rationalise antibiotic therapy accordingly
- All antibiotics marked MICRO are restricted antibiotics and need to be approved by Microbiology before prescribing
- **TDM** =Therapeutic Drug Monitoring. See Appendix 1 of the 6th ed. antibiotics policy

Infection	1st line	2nd line (true penicillin allergy)
Infective exacerbation COPD At any stage of inpatient stay or other LRTI with no evidence of pneumonia. Collect sputum.	**Doxycycline** 200mg STAT oral then 100mg OD oral for further 4 days **Duration: 5 days (in total)** If IV necessary consult Microbiologists.	If **Doxycycline** contraindicated: **Clarithromycin** 500mg BD oral for 5 days **Duration: 5 days** If IV necessary consult Microbiologists.
Community Acquired Pneumonia Definition of CAP: Acute lower respiratory symptoms; new focal chest signs and, if in hospital, new CXR changes; ≥ 1 systemic feature (fever, shivers, aches and pains or temperature ≥ 38◦C); No other explanation for illness. Clinical findings & severity rating using **CURB-65 score** must be documented. Send sputum, blood cultures (if signs of systemic sepsis). Also send atypical pneumonia serology (acute & convalescent) and/or pneumococcal & legionella urinary antigen if indicated. Seek risk factors for *Legionella* and *Staphylococcus aureus* infection.	**CURB-65 Score 1 or 2:** **Amoxicillin** 1g TDS oral plus **Clarithromycin** 500mg BD oral **CURB-65 Score 3 to 5 (or, if Amox AND Clari in last 7 days):** **Benzylpenicillin** 1.2g QDS IV plus **Clarithromycin** 500mg BD oral/IV **Duration: 5- 7 days usually sufficient** **(7-14 days for atypical pneumonia/severe disease).** Review after 48 hrs & switch to oral if possible. If inpatient in previous 2 months/evidence of clinical deterioration/sickle cell crisis use **Piperacillin/tazobactam** +/- **Gentamicin** regimen as for Hospital Acquired Pneumonia below and discuss case with Microbiologists if necessary.	**CURB-65 Score 1 or 2:** **Clarithromycin** 500mg BD oral **CURB-65 Score 3 to 5:** MICRO-**Teicoplanin** IV 400mg x3 12hrly (loading dose) then 400mg OD IV plus **Clarithromycin** 500mg BD oral/IV **Duration: 5- 7 days usually sufficient** **(7-14 days for atypical pneumonia/severe disease).** Review after 48 hrs & switch to oral if possible If evidence of clinical deterioration, discuss alternative antibiotics with Microbiologists.
Hospital Acquired Pneumonia Infection occurring after ventilation, >3 days hospital stay, inpatient in previous 2 months. Evidence of new consolidation on CXR. Clinical findings must be documented. Collect sputum and (if signs of systemic sepsis) blood cultures.	**Piperacillin/tazobactam** 4.5 g TDS IV If evidence of severe sepsis add in: **Gentamicin** 5mg/kg OD regimen IV (TDM) **Duration: 5- 7 days** Note: **Piperacillin/tazobactam** has excellent anaerobic cover so there is no need to add **Metronidazole** if a patient is on this antibiotic and there is evidence of aspiration.	MICRO-**Teicoplanin** 400mg x3 12hrly IV (loading dose) then 400mg OD IV plus **Gentamicin** 5mg/kg OD regimen IV (TDM) +/- **Metronidazole** 400mg TDS oral/500mg TDS IV (if evidence of aspiration) **Duration: 5- 7 days**

Antibiotic Pharmacist: B 209 Microbiologists: B092 Infection Control Nurses B 205

Infection	1st line	2nd line (true penicillin allergy)
Urinary Tract Infection Urine dipstix Collect MSU/CSU specimen before commencing antibiotic Also blood cultures (if evidence of systemic sepsis) *Then rationalise according to Microbiology culture & sensitivity results.* *All catheters become colonised with bacteria. A positive urine dipstix or the presence of an organism in a catheter specimen of urine is not an indication for treatment in the absence of clinical evidence of infection*	**Lower UTI** **1st line:** Nitrofurantoin 50-100mg QDS oral (if Cr < 150) **2nd line:** Trimethoprim 200mg BD oral **Duration:** 3 days in non-pregnant women. For 7 days in pregnancy & men. If evidence of severe sepsis / indwelling urinary catheter, add Gentamicin 5mg/kg STAT IV If further Gentamicin indicated: 5mg/kg OD regimen IV (TDM) **Pyelonephritis** If younger than 60 years & fit: **Co-amoxiclav** 1.2g TDS IV If older than 60 years/ chronic health issues: **Piperacillin/tazobactam** 4.5 g TDS IV If evidence of severe sepsis, add in: Gentamicin 5mg/kg OD regimen IV (TDM) Review after 48 hrs & switch to oral if possible. If younger than 60 & fit: **Co-amoxiclav** 625mg TDS oral. If older than 60 years/ chronic health issues: Trimethoprim 200mg BD oral (if sensitive) or consult Microbiologists. **Duration: 10-14 days**	**Lower UTI** Oral therapy - no change necessary. Current HPA guidelines (based on National Teratology Information Service review of available evidence) advise that, during pregnancy, short-term use of Trimethoprim (theoretical risk in 1st trimester in patients with poor diet, as folate antagonist; ensure the woman is taking folic acid supplements if recommended in 1st trimester) or Nitrofurantoin (at term, theoretical risk of neonatal haemolysis; if breastfeeding: avoid breastfeeding during treatment if the newborn is glucose-6-phosphate dehydrogonase deficient) is unlikely to cause problems to the foetus. **Pyelonephritis** If younger than 60 & fit: Ciprofloxacin 500mg BD oral. If older than 60 years/ chronic health issues: consult Microbiologists. **Duration: 10-14 days**
Cellulitis Draw demarcation lines to follow progress. Wound swab if broken skin If evidence of MRSA colonisation, discuss appropriate antibiotics with Microbiologists.	**Non-severe** **Amoxicillin** 500mg TDS oral plus **Flucloxacillin** 500mg QDS oral **Severe** **Benzylpenicillin** 1.2g QDS IV plus **Flucloxacillin** 1g QDS IV Conversion to oral antibiotics from IV **Benzylpenicillin** for cellulitis should be to oral **Amoxicillin** (not to Penicillin V). **Duration: 7-14 days**	**Non-severe** Clarithromycin 500mg BD oral **Severe** Clarithromycin 500mg BD IV
Postoperative surgical abdominal sepsis/SBP/ascending cholangitis/ cholecystitis/diverticulitis	**Piperacillin/tazobactam** 4.5 g TDS IV (excellent anaerobic cover, no Metronidazole required).If evidence of severe sepsis, add Gentamicin 5mg/kg OD IV (TDM).	If true penicillin allergy, discuss case with Microbiologists.
***Clostridium difficile* infection (CDI)** ISOLATE IN SIDE ROOM Wash hands with SOAP AND WATER Send stool for *C diff* toxin testing. Stop all non-essential antibiotics. **ALL CASES OF CDI & ANY CHANGES IN TREATMENT REGIMEN MUST BE DISCUSSED WITH THE MICROBIOLOGISTS.**	**Mild & moderate CDI** Metronidazole **400 mg TDS oral or NG tube or PEG** Diarrhoea should resolve in 1-2 weeks. If no improvement in symptoms after one week or symptoms worsening then change to MICRO-R Vancomycin **125mg QDS oral or NG tube or PEG** **Duration: 14 days** **Severe CDI/ Life threatening CDI/ Recurrences** **See 6th ed antibiotics policy & discuss with Microbiologists.**	CDI is a diagnosis in its own right. CDI is most common in over 65 year olds but can occur in adults in all age groups. **Antibiotic use in the preceding 2 months is the major risk factor for CDI.** Correct dehydration & electrolyte abnormalities. Review the nursing records kept in the Bristol Stool Chart in patient's 'end-of-bed' folder daily alongside clinical markers to re-assess severity of CDI and response to treatment.

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CWSH Directorate Obstetrics Empirical Antibiotics policy: FINAL VERSION – MARCH 2011			
Scenario	**Empirical Antibiotics - 1st line**	**Empirical antibiotics - Penicillin allergy**	**Comments**
Group B Strep (GBS): Intrapartum Antibiotic Prophylaxis (IAP)	**Benzyl Penicillin** 3g IV (single dose) then, 1.5g IV every 4 hours until delivery	**Clindamycin** 900mg IV TDS until delivery [If GBS previously isolated & documented as **Erythromycin** resistant: **Teicoplanin** 400mg IV every 12 hours for the 1st 3 doses then 24hrly, or until delivery]	1. GBS IAP should be given as per RCOG guidelines for Prevention of Early Onset Neonatal Group B Streptococcal disease 2. Most GBS that are **erythromycin** resistant will also be **clindamycin** resistant (both macrolide antibiotics) 3. Send Septic screen to Microbiology
Chorioamnionitis or Evidence of Sepsis in labour	**Amoxicillin** 2g IV (single dose) then, 1g IV TDS until delivery + **Metronidazole** 500mg IV (single dose) then, 500g IV TDS until delivery + **Gentamicin** 5mg/kg IV ONCE DAILY until delivery If woman still pyrexial >37[5] by 6 hours post-delivery consider Co-amoxiclav 1.2g IV TDS +/- Gentamicin 5mg/kg IV OD for up to 5/7 (switch to PO Co-amoxiclav once apyrexial for 48 hours)	**Clindamycin** 900mg IV (single dose) then, 900mg IV TDS until delivery + **Gentamicin** 5 mg/kg IV ONCE DAILY until delivery [If GBS previously isolated & documented as **Erythromycin** resistant, replace **Clindamycin** with : **Teicoplanin** 400mg IV every 12 hours for the 1st 3 doses then 24hrly, or until delivery + **Metronidazole** 500mg IV (single dose) then, 500g IV TDS until delivery]	1.**Gentamicin** dosing assumes normal renal function 2. **Gentamicin** dosing should usually be calculated according to the woman's weight at ANC booking appointment. For dosing queries, consult Pharmacy. 3.Maximum **Gentamicin** IV dose = 450 mg/24h 4. If more than 2 doses of once daily **gentamicin** are given, therapeutic drug monitoring (TDM; **Gentamicin** levels) must be taken as per Appendix 1 of Trust antibiotics policy 5. If evidence of systemic sepsis, send septic screen to Microbiology and discuss case with Obstetrics Consultant & Microbiologists
Manual removal of placenta	**Co-amoxiclav** 1.2g IV (single dose)	**Clindamycin** 900mg IV (single dose)	1. If MRSA positive add in: **Teicoplanin** 400mg IV (single dose) to standard surgical prophylactic antibiotic cover. 2. Ideal timing of single dose of antibiotics for Caesarean section controversial - current evidence suggests to give 'at induction' routinely (possible maternal benefit) but consider giving 'at clamping of cord' if premature delivery & neonate likely to need NICU admission (possible decreased neonatal risk of altered normal flora & NEC) 2. ToP - **Azithromycin**, 1 g as a single oral dose may be used as an alternative recommended for patients likely to be non-compliant with **Doxycycline** treatment.
Caesarean section/Hysterectomy	**Co-amoxiclav** 1.2g IV (single dose)	**Clindamycin** 900mg IV (single dose)	
3rd and 4th degree perianal tear	**Co-amoxiclav** 1.2g IV (single dose) then, **Co-amoxiclav** 625mg PO TDS for 5/7	**Clindamycin** 900mg IV (single dose) then **Clindamycin** 300mg PO QDS for 5/7	
Termination of Pregnancy	**Co-amoxiclav** 1.2g IV (single dose) THEN, if high risk of Chlamydia infection: **Doxycycline** 100 mg BD orally for 7 days	**Clindamycin** 900mg IV (single dose) THEN, if high risk of Chlamydia infection: **Doxycycline** 100 mg BD orally for 7 days	
Puerperal infection/infected abortion	**Piperacillin/tazobactam** 4.5g IV TDS + If evidence of severe sepsis, add **Gentamicin** 5mg/kg IV (single dose)	**Clindamycin** 900mg TDS IV + If evidence of severe sepsis, add **Gentamicin** 5mg/kg IV (single dose)	1. See Section 7.3 of Trust antibiotics policy 2. Send Septic screen to Microbiology and discuss case with Obstetrics Consultant and Microbiologists 3. If further **Gentamicin** indicated: 5mg/kg OD IV (TDM)

SURGICAL ANTIBIOTIC PROPHYLAXIS POLICY SUMMARY – ADULTS_fv_Mar 2011

Also available on the intranet Antibiotic Prophylaxis Policy (March 2011 update)
See SIGN (2008) www.sign.ac.uk for background information. See BNF Section 5.1 for guidance on Prevention of endocarditis.
All dosage recommendations are for adults and assume normal renal and hepatic function
Microbiology and Infection Prevention & Control Team – March 2011

Homerton University Hospital NHS
NHS Foundation Trust

There are 2 pages in this guideline
(with thanks to UCLH for sharing their template)

PRESCRIBING

Important reminders:

- For most surgical procedures, if antibiotic prophylaxis is recommended, a **SINGLE DOSE** of antibiotic is adequate. Longer duration has no benefit over a short course.
- Antibiotics should be administered **30 minutes or less before skin incision.**
- An **additional dose** of prophylactic agent is indicated if there is **blood loss >1,500ml** or **procedure > 4h**.

Prescribing in penicillin allergic (PenA) patients:

- **Drugs in RED** are contra-indicated in penicillin allergy.
- **Drugs in ORANGE** should be prescribed with caution.
- **Drugs in GREEN** are considered safe.

Caution = avoid if allergy history suggests anaphylaxis, otherwise benefit usually outweighs risk. Only 5-6.4% (BNF 2009) of patients with a true penicillin allergy are also allergic to cephalosporins.

MRSA POSITIVE

Confirm MRSA status on PRE-OP CHECKLIST before entry into theatre. MRSA positive patients should be identified pre-admission and should receive 5 days topical decolonisation protocol aiming to complete course on the day of surgery.

If patient **is known to be, or at high risk* of being, MRSA positive** add in to the patient's usual surgical antibiotic prophylaxis:

Teicoplanin 400mg (6mg/kg if >85kg) IV single dose ≤ 30 mins pre-incision.

***High risk of being MRSA positive**: Previously MRSA positive; admission to hospital in the last 12 months; admission from a Nursing Home; transfer from another hospital or employment as healthcare worker (including hospital staff, volunteers, staff at residential or nursing home).

Note: If surgical antibiotic prophylaxis is not required for a given surgical procedure then MRSA-covering antibiotic is not indicated.

GASTROINTESTINAL PROCEDURES

Upper GI / small bowel surgery:

1st line: **Cefuroxime** 1.5g IV single dose ≤ 30 mins pre-incision.
PenA: **Gentamicin** 5 mg/kg IV single dose ≤ 30 mins pre-incision.
If Anaerobes suspected (achlorhydric / gastro-oesophageal cancer):
Add **Metronidazole** 500mg IV single dose ≤ 30 mins pre-incision.

Bariatric surgery:

1st line: **Cefuroxime** 1.5g IV **plus** **Metronidazole** 500mg IV ≤ 30 mins pre-incision, then 8-hourly for 2 doses.
PenA: **Clindamycin** 600mg IV ≤ 30 mins pre-incision, then 600 mg IV at 12-hours post-op.

Pancreatic / Biliary tract surgery (cholecystectomy, biliary tree surgery, duct stones present):

For heavy contamination extend to 24 hour dosing.

1st line: **Cefuroxime** 1.5g IV single dose ≤ 30 mins pre-incision.
PenA: **Ciprofloxacin** 400 mg IV single dose ≤ 30 mins pre-incision.
If previous biliary surgery/stents:
Add **Gentamicin** 5mg/kg IV single dose ≤ 30 mins pre-incision.
If Anaerobes suspected (achlorhydric or carcinoma patients):
Add **Metronidazole** 500mg IV single dose ≤ 30 mins pre-incision.

Appendicectomy/Colorectal surgery:

1st line: **Cefuroxime** 1.5g IV single dose ≤ 30 mins pre-incision **plus** **Metronidazole** 500mg IV single dose ≤ 30 mins pre-incision.
PenA: **Gentamicin** 5 mg/kg IV single dose **plus** **Metronidazole** 500mg IV single dose ≤ 30 mins pre-incision.
If appendix acutely inflamed or pus found:
1st line: Start **Piperacillin/tazobactam** 4.5g IV TDS for 5 days.
Pen A: **Ciprofloxacin** 400mg IV (or 500mg PO) BD **plus** **Metronidazole** 500mg IV (or 400mg PO) TDS for 5 days
Heavy faecal contamination and/or peritonitis should be treated with a longer therapeutic course. Please discuss with Microbiologist.

Open or laparoscopic surgery with mesh:

Prophylaxis should be considered in **high risk** patients (Section 3.1 SIGN guidance).

Splenectomy/PEG insertion:

Prophylaxis should be considered in **high risk** patients (immunosupression).

Laparoscopic cholecystectomy:

Prophylaxis should be considered in **high risk** patients (intraoperative cholangiogram, bile spillage, conversion to laparotomy, acute cholecystitis or pancreatitis, jaundice, pregnancy, immunosupression, insertion of prosthetic devices)
If indicated, use prophylaxis as for **Pancreatic / Biliary tract surgery** above.

Hernia repair (with or without mesh)/diagnostic endoscopic procedures:

Surgical antibiotic prophylaxis is not routinely recommended.

IMAGING

ERCP:

See British Society of Gastroenterology guidelines for further information on www.bsg.org.uk.

1st line: **Ciprofloxacin** 750mg PO single dose 60 to 90 minutes prior to procedure.
2nd line: Patients allergic to OR already receiving ciprofloxacin: **Gentamicin** 5 mg/kg IV single dose prior to procedure.
3rd line: Patients unable to take oral medication, **Ciprofloxacin** 400mg IV single dose prior to procedure.

Prophylaxis should be considered in **high risk** patients:
Pancreatic pseudocyst, immunosupression, history of liver transplantation, or risk of incomplete biliary drainage (e.g. PSC, cholangiocarcinoma).
If inadequate decompression of biliary tree continue with:

Piperacillin/tazobactam 4.5g IV tds
OR
PenA: **Ciprofloxacin** 500mg PO bd

until intervention to relieve biliary obstruction.

OTHER SURGICAL PROCEDURES

Oral & maxillofacial:

Surgical antibiotic prophylaxis not routinely recommended for simple extractions/intra-oral soft tissue work.

Breast surgery:

Prophylaxis should be considered for cancer surgery or reshaping procedures & is recommended for surgery with implant.

1st line: **Cefuroxime** 1.5g IV single dose ≤ 30 mins pre-incision.
PenA: **Teicoplanin** 400mg (6mg/kg if >85kg) IV single dose ≤ 30 mins pre-incision.

Other clean contaminated procedures/insertion of a prosthetic device or implant:

Single dose prophylaxis is recommended – discuss site of surgery with Microbiologist.

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ORTHOPAEDIC PROCEDURES

Lacerations/ Drainage of abscess:
Unless spreading cellulitis, systemic antibiotics not indicated.

Arthroplasty (e.g. THR/TKR):
Antibiotic-loaded cement recommended in addition to up to 24 hours surgical antibiotic prophylaxis:

1st line: **Cefuroxime** 1.5g IV≤ 30 mins pre-incision, then **Cefuroxime** 1.5g IV 8-hourly for 3 doses.
PenA: **Teicoplanin** 400mg (6mg/kg if >85kg) IV≤ 30 mins pre-incision, then a 2nd dose of **Teicoplanin** 400mg (6mg/kg if >85kg) IV at 12 hours post-induction.

Revision of infected arthroplasty:
Give dose AFTER taking samples for MC&S

1st line: **Teicoplanin** 400mg (6mg/kg if >85kg) IV **plus** **Gentamicin** 5mg/kg IV single dose ≤ 30 mins pre-incision.

Then continue **Teicoplanin** 400mg (6mg/kg if >85kg) IV BD for 2 doses, then 400mg (6mg/kg if >85kg) IV OD until sensitivity results available – always discuss case with Microbiologist at earliest opportunity.

Second and subsequent revision due to infection:
Discuss with Microbiologist.

Open fractures/open surgery for closed fractures/hip fracture repair/insertion of prosthetic device or implant:

1st line: **Cefuroxime** 1.5g IV single dose ≤ 30 mins pre-incision
PenA: **Teicoplanin** 400mg (6mg/kg if >85kg) IV single dose ≤ 30 mins pre-incision.

Consider addition of **Metronidazole** and extension of prophylaxis to 24 hours (or longer) for complex open fractures with extensive soft tissue damage.

Elective orthopaedic procedures without insertion of prosthetic device or implant (e.g. arthroscopy):
Surgical antibiotic prophylaxis is not routinely recommended.

Soft tissue surgery of the hand:
Surgical antibiotic prophylaxis should be considered.

Lower limb amputation (risk of gas gangrene):

1st line: **Benzylpenicillin** 1.2g IV≤ 30 mins pre-incision, then 1.2g IV QDS for 5 days.
PenA: **Metronidazole** 500mg IV ≤ 30 mins pre-incision, then 500mg IV TDS for 5 days.

OBSTETRICS & GYNAECOLOGY

Termination of pregnancy/ Evacuation of retained products of conception (ERPC):

1st line: **Co-amoxiclav** 1.2g IV single dose ≤ 30 mins prior to procedure.
PenA: **Clindamycin** 900mg IV single dose.
THEN, if high risk of Chlamydia: **Doxycycline** 100mg BD orally for 7 days **OR** **Azithromycin** 1g single oral dose if patient likely to be non-compliant with **Doxycycline** treatment.

Caesarean section / Manual removal of placenta: Consider giving antibiotics at cord clamping if premature delivery & neonate likely to need NICU admission (increased risk of NEC).

1st line: **Co-amoxiclav** 1.2g IV single dose ≤ 30 mins pre-incision.See Obstetric Abx policy for more on dose timing.
PenA: **Clindamycin** 900mg IV single dose.

3rd and 4th degree perineal tear: Timing of abx as per C/S above.

1st line: **Co-amoxiclav** 1.2g IV single dose ≤ 30 mins pre-incision, then 625mg TDS for 5/7.
PenA: **Clindamycin** 900mg IV single dose ≤ 30 mins pre-incision, then 300mg QDS for 5/7.

Group B Strep (GBS) Intrapartum Antibiotic Prophylaxis:

1st line: **Benzylpenicillin** 3g IV single dose, then 1.5g IV 4hrly until delivery.
PenA: **Clindamycin** 900mg IV single dose, then 900mg IV TDS until delivery. If known GBS erythromycin resistant see Obstetrics Abx policy.

Chorioamnionitis or Sepsis in labour:

1st line: **Amoxicillin** 2g IV single dose **plus** **Metronidazole** 500mg IV single dose **plus** **Gentamicin** IV 5mg/kg single dose. See Obstetrics Abx policy for further doses until delivery or still pyrexial by 6 hours post delivery.
PenA: **Clindamycin** 900mg IV single dose plus **Gentamicin** IV 5mg/kg single dose. If known GBS erythromycin resistant see Obstetrics Abx policy.

Hysterectomy and all other gynaecological procedures, including all vaginal surgery (especially where a tape or mesh is inserted), laparoscopy where hydrotubation* is performed, hysteroscopy* and hysteroscopic surgery*:

1st line: **Cefuroxime** 1.5g IV single dose **plus** **Metronidazole** 500mg IV single dose ≤ 30 mins pre-incision.
PenA: **Clindamycin** 600mg IV single dose≤ 30 mins pre-incision.
*THEN, if high risk of Chlamydia **Doxycycline** 100mg BD orally for 7 days **OR** **Azithromycin** 1g single oral dose if patient likely to be non-compliant with **Doxycycline** treatment.

Sacrocolpopexy (in view of mesh implantation):
Add **Gentamicin** 5mg/kg IV single dose ≤ 30 mins pre-incision

UROLOGY PROCEDURES

MSU culture should always be checked before surgery and results discussed with Microbiologist if multi-resistant organisms present/any other queries.

Minor interventions under local anaesthetic: (e.g. urodynamics, catheterisation where infection present or high risk)

1st line: **Gentamicin** 5mg/kg IV as single dose≤ 30 mins prior to procedure.

Transrectal prostatic biopsy/TRUS:
Administered by Uro-oncology nurse practitioner/ Urology SpR as per PGD.

Inguino-scrotal surgery/ radical cystectomy/nephrectomy:

1st line: **Cefuroxime** 1.5g IV single dose **plus** **Metronidazole** 500mg IV single dose ≤ 30 mins pre-incision.
PenA: **Clindamycin** 600mg IV single dose ≤ 30 mins pre-incision.

Endoscopic urology e.g. TURP, PCNL:
Nephrolithotomy may require longer courses of prophylaxis if significant bacteraemia is likely following the procedure.

1st line: **Gentamicin** 5 mg/kg IV as a single dose ≤ 30 mins pre-incision.
If infective stones removed:
Continue **Gentamicin** 80mg IV 8 hourly for 48 hours or until culture results available.

For Percutaneous nephrolithotomy (stone ≥ 20mm or with pelvicocalyceal dilatation), an oral quinolone for one week preoperatively is also recommended.

Transurethral resection of bladder tumour:
Surgical antibiotic prophylaxis not routinely recommended.