CLINICAL SCENARIO		DRUGS/DOSES			
		Standard Protocol	**Known or Suspected MRSA**[a]	**Penicillin allergy**[b] **Delayed**	**Penicillin allergy**[b] **Immediate**
Cellulitis	Cellulitis, erysipelas or soft tissue infection <1 month of age	IV Flucloxacillin **AND** IV Gentamicin (doses as per neonatal guidelines)	Vancomycin[c] **AND** Gentamicin[c]		
	Mild cellulitis or erysipelas ≥ 1 month of age	Oral Cephalexin 12.5mg/kg (to a maximum of 500mg) 6 hourly **OR** Oral Flucloxacillin 12.5mg/kg (to a maximum of 500mg) 6 hourly	Cotrimoxazole[d]	Cephalexin[e]	Cotrimoxazole[d] **OR** Clindamycin[f]
	Moderate cellulitis, erysipelas or soft tissue infection ≥ 1 month of age	IV Flucloxacillin 50mg/kg (to a maximum of 2 grams) 6 hourly	Vancomycin[g]	Cephazolin[h]	Vancomycin[g]
	Severe skin and soft tissue infection (rapidly progressive cellulitis, cellulitis with persisting fever or tachycardia despite 24 hours of therapy) **OR** suspected or proven necrotizing fasciitis	IV Flucloxacillin 50mg/kg (to a maximum of 2 grams) 6 hourly **AND** IV Vancomycin 15mg/kg (to a maximum initial dose of 750mg) 6 hourly **ADD** IV Clindamycin 10mg/kg (to a maximum of 600mg) 6 hourly in suspected/proven necrotizing fasciitis or severe cellulitis with shock.	Vancomycin[g] **AND** Clindamycin[i]		
		Consider a Vancomycin loading dose for patients with severe infection in discussion with Infectious Diseases or Clinical Microbiology services For patients with necrotizing fasciitis or severe cellulitis with shock, discuss with further management with Infectious Diseases or Clinical Microbiology services			

a) Children known or suspected to be colonised with MRSA may need to have their therapy/prophylaxis modified. Children suspected of having MRSA include:
   i) household contacts of MRSA colonised individuals and
   ii) children with recurrent skin infections or those unresponsive to beta-lactam therapy. For further advice, discuss with Microbiology or ID service

b) An immediate (IgE mediated) reaction is characterised by the development of urticaria, angioedema, bronchospasm or anaphylaxis within 1 to 2 hours of drug administration. Delayed reactions including maculopapular or morbilloform rashes, drug fever and cytopenias and are more in keeping with other forms of immunological reactivity. Isolated diarrhoea is not usually immune-mediated and does NOT contraindicate the future use of an antibiotic

c) Doses as per neonatal guidelines

d) Oral Cotrimoxazole **4mg/kg of trimethoprim component 12 hourly; equivalent to 0.5mL/kg of mixture**, (maximum of 160mg trimethoprim component per dose)

e) Oral Cephalexin **12.5mg/kg** (to a maximum of 500mg) 6 hourly

f) Oral Clindamycin **7.5mg/kg** (to a maximum of 600mg) 8 hourly. Use only if the calculated dose is a multiple of 150mg (i.e a full capsule) and patient is capable of swallowing capsules due to the bitter taste of the powder.

g) IV Vancomycin **15mg/kg** (to a maximum initial dose of 750mg) 6 hourly

h) IV Cephazolin **50mg/kg** (to a maximum dose of 2grams) 8 hourly

i) IV Clindamycin **10mg/kg** (to a maximum of 600mg) 6 hourly

∗ Tetanus immunisation history needs to be reviewed. Consider the need for tetanus prophylaxis

¶ Children living in remote Indigenous communities or with previous acute rheumatic fever (ARF) or post-streptococcal glomerulonephritis (PSGN) are at greatest risk. IM Benzathine should be used for impetigo.

CLINICAL SCENARIO		DRUGS/DOSES			
		Standard Protocol	**Known or Suspected MRSA**[a]	**Penicillin allergy**[b] **Delayed**	**Penicillin allergy**[b] **Immediate**
Lymphadenitis	Bacterial lymphadenitis < 3months of age	Discuss with ID or Microbiology service			
	Bacterial lymphadenitis (mild disease)	Oral Cephalexin 12.5mg/kg (to a maximum of 500mg) 6 hourly **OR** Oral Flucloxacillin 12.5mg/kg (to a maximum of 500mg) 6 hourly	Cotrimoxazole[d]	Cephalexin[e]	Cotrimoxazole[d] **OR** Clindamycin[f]
	Bacterial lymphadenitis (moderate disease)	IV Flucloxacillin 50mg/kg (to a maximum of 2 grams) 6 hourly	Vancomycin[g] **AND** Clindamycin[i]	Vancomycin[g] **AND** Clindamycin[i]	Vancomycin[g] **AND** Clindamycin[i]
	Bacterial lymphadenitis (severe disease)	Discuss with ID or Microbiology service			
Impetigo	Impetigo (mild or localised)	Topical 2% mupirocin ointment apply 8 hourly	As per standard protocol		
	Impetigo (widespread or recurrent)	Oral Cephalexin 12.5mg/kg (to a maximum of 500mg) 6 hourly **OR** Oral Flucloxacillin 12.5mg/kg (to a maximum of 500mg) 6 hourly	Cotrimoxazole[d]	Cephalexin[e]	Cotrimoxazole[d]
	Impetigo (high risk of ARF/PSGN¶)	IM Benzathine penicillin. Refer to Therapeutic Guidelines: Antibiotic for dose recommendations. **OR** Oral Cotrimoxazole[d] 4mg/kg (to a maximum of 160mg trimethoprim component) twice daily for 3 days	Cotrimoxazole[d]	Cephalexin[e]	Cotrimoxazole[d]

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   i) household contacts of MRSA colonised individuals and
   ii) children with recurrent skin infections or those unresponsive to beta-lactam therapy. For further advice, discuss with Microbiology or ID service

b) An immediate (IgE mediated) reaction is characterised by the development of urticaria, angioedema, bronchospasm or anaphylaxis within 1 to 2 hours of drug administration. Delayed reactions including maculopapular or morbilloform rashes, drug fever and cytopenias and are more in keeping with other forms of immunological reactivity. Isolated diarrhoea is not usually immune-mediated and does NOT contraindicate the future use of an antibiotic

c) Doses as per neonatal guidelines

d) Oral Cotrimoxazole **4mg/kg of trimethoprim component 12 hourly; equivalent to 0.5mL/kg of mixture**, (maximum of 160mg trimethoprim component per dose)

e) Oral Cephalexin **12.5mg/kg** (to a maximum of 500mg) 6 hourly

f) Oral Clindamycin **7.5mg/kg** (to a maximum of 600mg) 8 hourly. Use only if the calculated dose is a multiple of 150mg (i.e a full capsule) and patient is capable of swallowing capsules due to the bitter taste of the powder.

g) IV Vancomycin **15mg/kg** (to a maximum initial dose of 750mg) 6 hourly

h) IV Cephazolin **50mg/kg** (to a maximum dose of 2grams) 8 hourly

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CLINICAL SCENARIO		DRUGS/DOSES			
		Standard Protocol	**Known or Suspected MRSA[a]**	**Penicillin allergy[b] Delayed**	**Penicillin allergy[b] Immediate**
Animal / Human Bites	*Bites Prophylaxis, or mild to moderate infection	Oral Amoxycillin/clavulanic acid 25mg/kg (to a maximum of 875mg of Amoxycillin component) 12 hourly	Discuss with ID or Microbiology service		
	*Bites Severe infection or injury	IV Piperacillin/tazobactam 100mg/kg (to a maximum of 4 grams piperacillin component) 8 hourly	Discuss with ID or Microbiology service		
Complex wounds including fractures	*Compound fracture <u>without</u> significant contamination or tissue damage/ devitalisation	IV Cephazolin 50mg/kg (to a maximum of 2grams) 6 hourly	Vancomycin[g]	As per standard protocol	Vancomycin[g]
	*Heavily contaminated wounds requiring IV antibiotics	IV Piperacillin/tazobactam 100mg/kg (to a maximum of 4 grams piperacillin component) 8 hourly	Discuss with ID or Microbiology service		
	Polymicrobial necrotising fasciitis including Fournier's gangerene	Discuss with ID or Microbiology service			

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   i) household contacts of MRSA colonised individuals and
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CLINICAL SCENARIO		DRUGS/DOSES			
		Standard Protocol	**Known or Suspected MRSA[a]**	**Penicillin allergy[b] Delayed**	**Penicillin allergy[b] Immediate**
Osteomyelitis and Septic Arthritis	Osteomyelitis or septic arthritis < 3 months of age	Discuss with ID or Microbiology service			
	Uncomplicated Osteomyelitis or septic arthritis ≥3 months of age	IV Flucloxacillin 50mg/kg (to a maximum of 2 grams) 6 hourly	Vancomycin[g]	Cephazolin[h]	Vancomycin[g]
	Osteomyelitis or septic arthritis that is: i) Multifocal **OR** ii) With associated pneumonia or myositis **OR** iii) Requiring ICU admission	IV Flucloxacillin 50mg/kg (to a maximum of 2 grams) 6 hourly **AND** IV Vancomycin 15mg/kg (to a maximum initial dose of 750mg) 6 hourly	Vancomycin[g] **AND** Clindamycin[i]		
		Consider a Vancomycin loading dose for patients with severe infection in discussion with Infectious Diseases or Clinical Microbiology services All patients with sepsis/disseminated infection requiring ICU admission should be discussed with Infectious Diseases or Clinical Microbiology services.			

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