CLINICAL SCENARIO		DRUGS/DOSES **Standard Protocol** **(Including patients with known or suspected MRSA, immediate[a] or delayed[b] penicillin allergy)**
	Salmonella – non typhoidal	*Salmonella* enteritis is self limiting in many patients. **Consider** antibiotic therapy in infants, immunocompromised children, children with endovascular grafts or if enteritis is severe or prolonged. For uncomplicated enteritis[c] and confirmed to be susceptible use: Oral Amoxycillin 15mg/kg (to a maximum of 500mg) 8 hourly for 7 days. **OR** Oral Cotrimoxazole 4mg/kg of trimethoprim component (to a maximum of 160mg) 12 hourly for 5 days
	Enteric fever – typhoid and paratyphoid	IV Ceftriaxone 50mg/kg/dose (to a maximum of 2grams) 24 hourly For advice about the length of IV therapy, oral step-down therapy and infection control implications, consult Infectious Diseases or Clinical Microbiology services.
	Shigella species	Oral Cotrimoxazole 4mg/kg of trimethoprim component (to a maximum of 160mg) 12 hourly for 5 days **OR** Oral Ciprofloxacin[d] 12.5mg/kg/dose (to a maximum dose of 500mg) 12 hourly for 5 days.
	Campylobacter	*Campylobacter* enteritis is self limiting in many patients. **Consider** antibiotic therapy in infants, immunocompromised children or if enteritis is severe or prolonged. Oral Azithromycin 10mg/kg (to a maximum of 500mg) daily for 3 days
	Giardiasis	Oral Metronidazole 30mg/kg (to a maximum of 2 grams) as a single dose daily for 3 days **OR** Oral Metronidazole 10mg/kg/dose (to a maximum of 400mg) 8 hourly for 5 to 7 days
Clostridium difficile	*Clostridium difficile* (first and second episode)	Colonisation of young infants is common. Treatment of children under 2 years should be discussed with Infectious Diseases or Clinical Microbiology services. Precipitating factors (e.g, broad-spectrum antibiotics such as 3rd generation cephalosporins or carbapenems), should be modified or ceased, where possible. Oral Metronidazole 10mg/kg/dose (to a maximum of 400mg) 8 hourly for 10 days **OR** **IF** unable to tolerate oral therapy, IV Metronidazole 12.5mg/kg/dose (to a maximum of 500mg) 8 hourly for 10 days
	Clostridium difficile – Recurrent	First and second episode should be treated with 10 days of metronidazole (as above) Third episode should be treated with Oral Vancomycin 5-10mg/kg/dose (to a maximum of 125mg) 6 hourly for 7-10 days. If recurrent disease despite this, discuss with Infectious Diseases or Clinical Microbiology services
	Clostridium difficile – Severe	Oral Vancomycin 5-10mg/kg/dose (to a maximum of 125mg) 6 hourly for 7-10 days. Dose may be increased to a maximum of 500mg 6 hourly if required.

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) For disseminated infection (meningitis, septic arthritis) contact Infectious Diseases or Clinical Microbiology Services for advice.

d) Oral Ciprofloxacin should only be used in those patients able to swallow tablets as ciprofloxacin is extremely unpalatable. Doses should be rounded to the nearest portion of a tablet. (Tablet strengths are 250mg and 500mg)

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