CLINICAL SCENARIO		DRUGS/DOSES			
		Standard Protocol	**Known or Suspected MRSA**[a]	**Penicillin allergy**[b] **Delayed**	**Penicillin allergy**[b] **Immediate**
Periorbital Cellulitis	Periorbital cellulitis < 3 months	Speak to Clinical Microbiology or Infectious Diseases for advice			
	Mild periorbital cellulitis	Oral Amoxycillin/clavulanic acid 25mg/kg (to a maximum of 875mg amoxycillin component) 12 hourly	**ADD** Cotrimoxazole[c] to standard protocol	Cephalexin[d]	Discuss with ID or Microbiology service
	Moderate Periorbital cellulitis ≥ 3 months	IV Flucloxacillin 50mg/kg (to a maximum of 2grams) 6 hourly **AND** IV Ceftriaxone 50mg/kg (to a maximum of 2grams) daily	Vancomycin[e] **AND** Ceftriaxone[f]	Clindamycin[g] **AND** Ceftriaxone[f]	Discuss with ID or Microbiology service
	Severe periorbital or orbital cellulitis (≥ 3 months)	IV Vancomycin 15mg/kg (to a maximum initial dose of 750mg) 6 hourly **AND** IV Ceftriaxone 50mg/kg (to a maximum of 2grams) daily	As per standard protocol		Discuss with ID or Microbiology service
		Antibiotics alone are not definitive management. Immediate referral to appropriate specialist surgical services is essential			
Eye	Penetrating eye injury	IV Vancomycin 15mg/kg (to a maximum initial dose of 750mg) 6 hourly **AND** IV Ceftazidime 50mg/kg (to a maximum of 2grams) 8 hourly	As per standard protocol		Ciprofloxacin[i] **AND** Vancomycin[e]
		Antibiotics alone are not definitive management. Immediate referral to appropriate specialist surgical services is essential IV treatment around the time of injury and for 1-2 days. Consider changing to oral Ciprofloxacin 10mg/kg 12 hourly for 7 days once surgically stable.			

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

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

e) IV Vancomycin **15mg/kg** (to a maximum initial dose of 750mg) 6 hourly. Therapeutic drug monitoring is required.

f) IV Ceftriaxone **50mg/kg** (to a maximum of 2g) daily

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

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

i) Oral Ciprofloxacin **10mg/kg** (to a maximum of 750mg) 12 hourly

File Name and Path:	W:\Paediatrics\PMH\ChAMP\Guidelines\FINALISED GUIDELINES\ChAMP Recommendations - Eyes - FINAL.doc		
Document Owner:	Children's Antimicrobial Management Program (ChAMP)		
Reviewer / Team:	Children's Antimicrobial Management Program Pharmacist		
Document Sponsor:	PMCCU		
Date First Issued:	December 2013	Version: 1	
Last Revised:	December 2013	Review Date:	December 2015
Endorsed by:	DTC	Date: 16th December 2013	
Standards Applicable:	NSQHS Standards:		
The accuracy of this document is not guaranteed when printed			