

Sharp Healthcare Treatment Guidelines for Intra-abdominal Infections

Indication	Inpatient Therapy	Transition to Outpatient Therapy	Total Duration
Intra-abdominal abscess	Ceftriaxone 2g IV daily + Metronidazole 500mg IV q8h <i>(Eval risk for resistant organisms)</i>	Augmentin 875/125mg PO BID	4-7 days after full source control <i>Longer course required if source <u>not</u> controlled</i>
		<i>Penicillin allergy:</i> Ceftin 500mg PO BID + Metronidazole 500mg PO TID	
Diverticulitis	<u>Drain abscess if present</u> Ceftriaxone 2g IV daily + Metronidazole 500mg IV q8h	Augmentin 875/125mg PO BID-TID	7-10 days <i>Adjust based on source control</i>
		<i>Penicillin allergy:</i> Ceftin 500mg PO BID + Metronidazole 500mg PO TID	
Cholangitis/Cholecystitis Community-acquired	Ceftriaxone 2g IV daily + Metronidazole 500mg IV q8h	<i>If cholecystectomy, d/c abx day after surgery</i> <i>If no cholecystectomy, 7-10 days of therapy</i> Oral abx for d/c: Augmentin 875mg BID	
Healthcare-acquired or community-acquired with septic shock	Zosyn 4.5g IV q8h <i>(Eval risk for resistant organisms)</i>	Levofloxacin 750mg PO daily + Metronidazole 500mg PO q8h	4-7 days after full source control <i>Longer course required if source <u>not</u> controlled</i>
	<i>Penicillin allergy:</i> Cefepime 2g IV q8h + Metronidazole 500mg IV/PO q8h		
Appendicitis Non-perforated	Initial therapy: Ceftriaxone 2g IV daily + Metronidazole 500mg IV q8h	<i>If appendectomy, d/c abx day after surgery</i> <i>If no appendectomy, 7-10 days of therapy</i> Oral abx for d/c: Augmentin 875/125mg PO BID	
Perforated/abscess	Ceftriaxone 2g IV daily + Metronidazole 500mg IV q8h	Augmentin 875/125mg PO BID	4-7 days after full source control <i>Longer course required if source <u>not</u> controlled</i>
		<i>Penicillin allergy:</i> Ceftin 500mg PO BID + Metronidazole 500mg PO TID	
Spontaneous bacterial peritonitis	Ceftriaxone 1-2g IV daily. Tx 7 days; longer for complicated infection <i>Ceftriaxone allergy:</i> Ciprofloxacin 500mg PO BID <i>Secondary ppx:</i> Bactrim 1 DS tab daily (Alternative: Ciprofloxacin 500mg PO daily)		
Necrotizing pancreatitis (including severe cases)	<u>Antibiotics recommended only for infected necrotizing pancreatitis</u> Most cases are sterile necrosis and antibiotics are NOT needed Antibiotics DO NOT prophylax against subsequent infections. Consider ID review if uncertain about need for antibiotics. <u>Review w/ GI for drainage of any fluid collections</u> Zosyn 4.5g IV q8h <i>Penicillin allergy:</i> Cefepime 2g IV q8h + Metronidazole 500mg IV/PO q8h		Until source control and clinical resolution of infection
	<u>Discontinue all non-essential antibiotics</u> Vancomycin 125mg PO q6h <i>Fidaxomicin can be considered for high-risk patients per ID discretion</i>		
	Vancomycin 500mg PO q6h (consider vanc enema if ileus) + Metronidazole 500mg IV q8h <i>Vancomycin allergy or failure w/ vancomycin:</i> Fidaxomicin 200mg PO BID		
C. difficile infection Mild/moderate infection	Fidaxomicin 200mg PO BID for 10 days or 200 mg PO BID for 5 days followed by QOD for 20 days		10 days
Septic shock, ileus or toxic megacolon	Vancomycin taper: 125mg PO q6h x2 weeks, then 125mg BID x1 week, then 125mg daily x1 week, then 125mg every other day x1 week, then 125mg every 3 rd day for 2 weeks <i>Consider fecal transplant</i>		10 days
≥2 episodes	Fidaxomicin 200mg PO BID for 10 days or 200 mg PO BID for 5 days followed by QOD for 20 days		
Helicobacter pylori	Doxycycline 100mg BID + Metronidazole 250mg QID + Bismuth PO QID + PPI PO BID x14 days		

The above recommendations are based on available literature and national guidelines. They are not intended to replace physician clinical judgment based on patient-specific factors. Last updated 04/2023