SHARP Infectious Diseases & Antimicrobial Stewardship Newsletter

The Steward

April 2026

NEW SHC Sepsis Guidelines

Sepsis guidelines have been updated to delineate between sepsis and septic shock/higher risk factors

- Antibiotic recommendations differ and are broader in presence of shock or specific risk factors for MDROs
- Presence of sepsis or severe sepsis alone does not always warrant use of antipseudomonal or anti-MRSA agents
  - Refer to suspected source of infection for guidance
- Total duration of therapy does NOT need to be extended in septic patients that are clinically responding
  - Use standard infection-specific treatment durations
- Empirical broad-spectrum antibiotics can be de-escalated if no specific organisms are recovered and patients are stable
  - Anti-MRSA agents or anti-pseudomonal agents can be de-escalated if no MRSA or pseudomonas in cultures
  - Carbapenems can be de-escalated if no ESBL in cultures
  - Fluoroquinolones can be de-escalated based on susceptibilities
- Consider discontinuing antibiotics if cultures are negative and if subsequently there is low suspicion of infection
- Refer to page 2 and the link above for details on the guidance and specific recommendations per suspected source

Provider Tip

- Positive MRSA nares alone is not an indication for anti-MRSA therapy in CAP - prior MRSA isolation from a clinical site in past year is required
- Pseudomonas does NOT routinely need to be covered in diabetic foot infections
  - Only if: moist appearance +/- pus, hx of from deep cultures, significant water or warm tropical exposure

Nursing Tip

- Refer to the Y-site compatibility chart for most updated recommendations
- Refrain from referring to an organism as "MDRO" as it is too broad. Read the susceptibilities to the provider to ensure appropriate antibiotic selection

Pharmacist Tip

- Meropenem is the preferred ESBL agent for ICU patients w/ shock or albumin <2.5
  - Can narrow to ertapenem once shock and/or hypoalbuminemia resolves

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Suspected Source	Sepsis/Severe Sepsis	Septic Shock or Other Specific Risk Factors
Community acquired pneumonia (CAP)	Ceftriaxone 2g IV q24h + Azithromycin 500mg IV q24h	• *Pseudomonas risk*[1]: Cefepime 2g IV q8h + Azithromycin 500mg IV q24h +/- Tobramycin 7mg/kg IV x1 if septic shock • *MRSA risk*[2]: add Vancomycin[3,4] IV or Linezolid 600mg IV q12h
Nosocomial Pneumonia HAP/VAP	Cefepime 2g IV q8h + [Vancomycin[3,4] IV or Linezolid 600mg IV q12h]	• *If septic shock:* Cefepime 2g IV q8h + [Vancomycin[3,4] IV or Linezolid 600mg IV q12h] +/- Tobramycin IV 7mg/kg x1 • *ESBL hx*: Meropenem 500mg IV q6h + [Vancomycin[3,4] IV or Linezolid 600mg IV q12h]
Urinary tract	Ceftriaxone 2g IV q24h	• *ESBL hx (w/in 6 mo):* Ertapenem 1g IV q24h • *ESBL hx (w/in 6 mo) and septic shock*: Meropenem 500mg IV q6h
Intra-abdominal	Ceftriaxone 2g IV q24h + Metronidazole 500mg IV q8h	• *Septic shock*: Zosyn 4.5g IV q8h • *Septic shock and PCN allergy*: Cefepime 2g IV q8h + Metronidazole 500mg IV q8h • *ESBL hx*: Meropenem 500mg IV q6h
Cellulitis	Cefazolin 2g IV q8h	• *Septic shock:* Zosyn 4.5 g IV q8h + Linezolid 600mg IV q12h • *Septic Shock and PCN allergy*: Cefepime 2g IV q8h + Linezolid 600mg IV q12h
Abscess	Vancomycin[2,3] IV or Linezolid[3] 600mg IV q12h	
Necrotizing Skin and Soft Tissue including fasciitis, Gas Gangrene	Zosyn 4.5g IV q8h + Linezolid 600mg IV q12h	
Diabetic Foot/Wound/Ulcer	Unasyn 3g IV q6h OR Ceftriaxone 2g IV q24h + Metronidazole 500mg IV q8h	• *Pseudomonas and MRSA risk factors*[5]: Zosyn 4.5g IV q8h + [Vancomycin[3] IV or Linezolid 600mg IV q12h] • *Pseudomonas and MRSA risk factors and PCN allergy:* Cefepime 2g IV q8h+ Metronidazole 500mg IV q8h+ [Vancomycin[3] IV or Linezolid 600mg IV q12h] • *ESBL hx*: Meropenem 500mg IV q6h + [Vancomycin[3] IV or Linezolid 600mg IV q12h]
Unknown Source	Zosyn 4.5g IV q8h + Vancomycin[3] IV	• *PCN allergy*: Cefepime 2g IV q8h + Vancomycin[3] IV +/- Metronidazole 500mg IV q8h • *ESBL hx*: Meropenem 500mg IV q6h + Vancomycin[3] IV
OB/GYN	Zosyn 4.5g IV q8h +/- [Clindamycin 900mg IV q8h or Linezolid 600mg IV q12h][6,7]	• *PCN allergy*: Cefepime 2g IV q8h + Metronidazole 500mg IV q8h +/- [Clindamycin 900mg IV q8h or Linezolid 600mg IV q12h][6,7] • *ESBL hx*: Meropenem 500mg IV q6h +/- [Clindamycin 900mg IV q8h or Linezolid 600mg IV q12h][6,7]

1 Prior respiratory isolation of Pseudomonas, IV ABX in last 90 days, structural lung disease

2 if MRSA isolated from clinical site (not just from nares) the last year; consider for post-influenza pneumonia, cavitary pneumonia, empyema

3 For patients with allergic reactions (excluding vancomycin infusion reaction) to vancomycin or a history of vancomycin resistant enterococcus (VRE), substitutewith Daptomycin 6mg/kg IV q24h for non-respiratory infections. For respiratory infections, substitute with Linezolid 600mg IV Q12H. For patients with red man syndrome to vancomycin, please re-challenge with vancomycin slow infusion +/- premedication.

4 Consider de-escalating if no MRSA identified

5 Pseudomonas risk factors: moist appearance +/- pus, significant water or warm tropical exposure, hx from deep cultures. MRSA risk factors: known colonization or prior hx, IVDU, recent healthcare exposure, environmental exposure (incarcerated, military, child care centers, contact sports, sharing sharp objects), IV abx in past 6 months

6 Add linezolid or clindamycin for anti-toxin effect if suspected severe streptococcal infection or presence of toxic shock syndrome. Treatment of anti-toxin effect is for a duration of 48-72 hours of clinical hemodynamic stability.

7 Consider adding doxycycline 100 mg IV/PO q 12h for septic abortion or retained products of conception. Doxycycline may be considered when there is a need for coverage of atypical pathogens (i.e. Mycoplasma or Ureaplasma) in the following clinical settings (1) early (< 22 weeks gestational age) spontaneous abortion who undergo surgical uterine aspiration, (2) induced surgical abortion at any gestational age, or (3) lack of clinical improvement while on appropriate antibiotics.