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 q12h *(Eval risk for resistant organisms)*	Augmentin 875/125mg PO BID *Penicillin allergy:* Ceftin 500mg PO BID + Metronidazole 500mg PO bID	4-7 days after full source control *Longer course required if source <u>not</u> controlled*
Diverticulitis	<u>Drain abscess if present</u> Ceftriaxone 2g IV daily + Metronidazole 500mg IV q12h	Augmentin 875/125mg PO BID-TID *Penicillin allergy:* Ceftin 500mg PO BID + Metronidazole 500mg PO BID	7-10 days *Adjust based on source control*
Cholangitis/Cholecystitis Community-acquired	Ceftriaxone 2g IV daily + Metronidazole 500mg IV q12h	<u>If cholecystectomy</u>, d/c abx day after surgery <u>If no cholecystectomy</u>, 7-10 days of therapy Oral abx for d/c: Augmentin 875mg BID	
Healthcare-acquired or community-acquired with septic shock	Zosyn 4.5g IV q8h *(Eval risk for resistant organisms)* *Penicillin allergy:* Cefepime 2g IV q8h + Metronidazole 500mg IV/PO q12h	Levofloxacin 750mg PO daily + Metronidazole 500mg PO q12h	4-7 days after full source control *Longer course required if source <u>not</u> controlled*
Appendicitis Non-perforated	Initial therapy: Ceftriaxone 2g IV daily + Metronidazole 500mg IV q12h	<u>If appendectomy</u>, d/c abx day after surgery <u>If no appendectomy</u>, 7-10 days of therapy Oral abx for d/c: Augmentin 875/125mg PO BID	
Perforated/abscess	Ceftriaxone 2g IV daily + Metronidazole 500mg IV q12h	Augmentin 875/125mg PO BID *Penicillin allergy:* Ceftin 500mg PO BID + Metronidazole 500mg PO BID	4-7 days after full source control *Longer course required if source <u>not</u> controlled*
Spontaneous bacterial peritonitis	Ceftriaxone 1-2g IV daily. Tx 7 days; longer for complicated infection *Ceftriaxone allergy:* Ciprofloxacin 500mg PO BID *Secondary ppx:* 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 *Penicillin allergy:* Cefepime 2g IV q8h + Metronidazole 500mg IV/PO q12h		Until source control and clinical resolution of infection
C. difficile infection Mild/moderate infection	**<u>Discontinue all non-essential antibiotics</u>** Vancomycin 125mg PO q6h *Fidaxomicin can be considered for high-risk patients per ID discretion*		10 days
Septic shock, ileus or toxic megacolon	Vancomycin 500mg PO q6h (consider vanc enema if ileus) **+** Metronidazole 500mg IV q8h *Vancomycin allergy or failure w/ vancomycin:* Fidaxomicin 200mg PO BID		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 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 3rd day for 2 weeks *Consider fecal transplant*		
Helicobacter pylori	Doxycycline 100mg BID + Metronidazole 500mg 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 10/2024