Standing Orders for the Treatment of Outpatient Peritonitis

1. **Definition of Peritonitis:**
   a. Cloudy effluent.
   b. WBC > 100 cells/mm³ with >50% polymorphonuclear (PMN) cells with minimum 2 hour dwell.
   c. Abdominal pain, tenderness, nausea, diarrhea or vomiting may be present.
   d. Bacteria or other microorganism may be seen on gram stain.
      Absence of organisms does not rule out peritonitis.
   e. Presence of two of the above four is clinically indicative of peritonitis.

2. **Nurse will instruct patient to:**
   a. Save the cloudy bag (refrigerated or on ice if delayed).
   b. Record temperature, note any other symptoms.
   c. Notify NKC Peritoneal staff for further instructions.
   d. Patient may be directed to come into unit or go to ER.

3. **Lab Sampling and Requisitions**
   a. Cell Count and Differential (ICD10 = K65.9)
      i. Send 3 ml lavender topped tube filled with effluent.
   b. Bacterial Culture and Sensitivity with Gram Stain (ICD10 = K65.9)
      i. Send 50 ml of cloudy effluent in a 100 ml sterile specimen container.
      ii. Send 10 ml sterile red-topped tube filled with effluent.
   c. Fungal Culture (ICD10 = K65.9)
      i. Send 50 ml effluent in 100 ml sterile specimen container for culture.

4. **Antibiotic Therapy**
   a. **Antibiotics should have a minimum dwell time of six hours.**
   b. CAPD patients will add the antibiotics to the overnight exchange.
   c. APD patients will add the antibiotics to the day exchange. If a day exchange is not usually done, one will be added for the duration of the antibiotic therapy.

5. **Initial Treatment – Empiric Antibiotics**
   a. Notify MD.
b. Check for antibiotic allergies.
c. Look for evidence of exit site or tunnel infection.
d. Drug dose may depend on the presence of residual kidney function (RKF).
   i. If urine output > 100 ml/day = RKF is present.
   ii. If urine output is ≤ 100 ml/day = no RKF.
e. Antibiotics are administered by the intraperitoneal (IP) route as a single daily dose with the exception of Vancomycin, which is administered every 5-7 days.
f. Empiric antibiotics will be given until culture results become available.
   i. **Give combination of Vancomycin and Ceftazidime (Use Tobramycin for cephalosporin allergy)**
      1. Vancomycin is given IP q 5-7 days (based on vancomycin random levels).
         a. Standard dose: 15-30 mg/kg (See Dosing Chart).
         b. Vancomycin random level before second and all subsequent doses (target greater than 15 mcg/ml and less than 20 mcg/ml).
         c. Adjust dose and subsequent dosing interval per specific MD order based on vancomycin random level.

**AND**

2. Ceftazidime 1000 mg IP for weight <50 kg and 1500 mg IP for weight ≥50 kg.

3. **For Cephalosporin Allergy Use**
   a. Tobramycin 0.75 mg/kg/day IP with **RKF present**.
   b. Tobramycin 0.6 mg/kg/day IP with **no RKF**. (See Dosing Chart)
      i. Prolonged aminoglycoside use should be avoided if an alternative agent is available. When used, levels should be closely monitored to avoid nephrotoxicity in patients with residual kidney function.

4. If treatment started on a weekend or holiday levofloxacin can be used for gram negative coverage until NKC pharmacy is available to provide IP medication.
   a. Levofloxacin dose 500 mg PO first dose then 250mg PO every other day.

5. For vancomycin allergy use Cefazolin.

**g.** Refer to Appendix A to adjust antibiotics based on culture and sensitivities. Cefazolin should not be used unless sensitivities known.

**h.** Refer to Appendix B tables for antibiotics.

i. Consider adding Heparin 500 u/L IP to each bag of dialysate per protocol. (Always use heparin 1:1000 u/ml.)
j. Consider fungal prophylaxis: fluconazole 200 mg po for first dose then 100 mg po every other day for up to one week after the antibiotic therapy is completed.
k. Notify physician if patient develops diarrhea during antibiotic therapy due to risk of Clostridium Difficile colitis.

6. **Treatment Follow-Up**
   a. Cell count with differential 2 weeks post completion of antibiotics.
   b. If patient is on vancomycin, cell count with differential 19 days post completion of vancomycin.

7. **Retraining and Prevention of Future Infections**
   a. All patients who develop peritonitis must be evaluated in clinic for technique problems and scheduled for retraining and a home visit as needed per nursing evaluation.
   b. Review of aseptic technique and infection-related education topics is mandatory for all patients who develop peritonitis.
   c. Staff should ensure that Gentamicin 0.1% cream is being used to prevent exit site infections in all patients. If patient has a gentamycin allergy Mupirocin cream may be used.
   d. Patients with suspected relapsing or recurrent peritonitis should be evaluated as per peritonitis standing orders.

8. **Technique Break (ICD10 = Z41.8)**
   a. To prevent a peritonitis following a break in sterile technique, a single dose of Vancomycin 1 gm IP should be administered as soon as possible after the incident. If unable to receive antibiotics at PD unit, the patient should be directed to the Emergency Room for management. If allergic to vancomycin may use cefazolin.
   b. Each patient must come to PD clinic following a technique break to review aseptic technique and infection-related education topics. Retraining and home visit as needed per nursing evaluation.

9. **References**

_________________________ ________________________
Physician Name (Please Print) RN Name (Please Print)

_________________________ ________________________  _________
Physician signature     RN signature      Date
(see referral sheet)

Patient Name  NKC#  _________  
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APPENDIX A: ANTIBIOTIC ADJUSTMENT ALGORITHMS

1. **Culture Negative**

Continue Initial Treatment

If culture remains negative at 72 hours, repeat cell count with differential and gram stain.

**Infection resolving**

Stop Ceftazidime/Tobramycin, Continue Vancomycin IP

Continue treatment for 14 days

**Infection not resolving**

Confer with physician and consider adjustment of antibiotics. Consider culture for unusual pathogens: mycobacteria, Legionella, etc. Consider fungal infection.

If culture remains negative and patient is not responding to treatment by 5 days, consider catheter removal.

Continue treatment for at least 14 days after catheter is removed
Northwest Kidney Centers
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2.

Staphylococcus aureus on Culture

Methicillin sensitive Staphylococcus aureus (MSSA)
Stop vancomycin, ceftazidime/tobramycin
Start cefazolin IP

Methicillin resistant Staphylococcus aureus (MRSA)
Stop ceftazidime/tobramycin
Continue vancomycin IP
Consider rifampin 600 mg PO daily for 5-7 days

At Day 3-5 of therapy: If no improvement, repeat cell count, differential and gram stain, re-culture and re-evaluate.

If peritonitis is associated with an exit site or tunnel infection, consider catheter removal. Duration of treatment may need to be extended to 21 days depending on clinical course. If failure to respond to treatment by 5 days on appropriate antibiotics, consider prompt catheter removal.

Duration of therapy: at least 21 days
3.

**Enterococcus/Streptococcus on Culture**

Stop vancomycin, ceftazidime/tobramycin
Start continuous ampicillin 125 mg/L each bag: consider adding tobramycin for Enterococcus

If ampicillin resistant, continue IP vancomycin
If vancomycin-resistant enterococcus, consider daptomycin, quinupristin/dalfopristin or linezolid

At Day 3-5 of therapy: If no improvement, repeat cell count, differential and gram stain, re-culture and re-evaluate.

If peritonitis is associated with an exit site or tunnel infection, consider catheter removal. Duration of treatment may need to be extended to 21 days depending on clinical course.
If failure to respond to treatment by 5 days on appropriate antibiotics, consider prompt catheter removal.

**Duration of therapy:**
14 days for Streptococcus
21 days for Enterococcus
4. Other Gram-positive Organisms Including Coagulase-Negative Staphylococcus on Culture

Methicillin sensitive organisms:
Stop vancomycin, ceftazidime/tobramycin
Start cefazolin IP

Methicillin resistant organisms:
Stop ceftazidime/tobramycin
Continue vancomycin IP

At Day 3-5 of therapy: If no improvement, repeat cell count, differential and gram stain, re-culture and re-evaluate.

If peritonitis is associated with an exit site or tunnel infection, consider catheter removal. Duration of treatment may need to be extended to 21 days depending on clinical course. If failure to respond to treatment by 5 days on appropriate antibiotics, consider prompt catheter removal.

Duration of therapy: 14 days
5.

**Single Gram Negative on Culture**

- **Other**
  - E. coli, Proteus, Klebsiella, etc

  Stop vancomycin
  Adjust antibiotics to sensitivity pattern
  Ceftazidime may be indicated

- **Stenotrophomonas**

  Treat with 2 drugs with differing mechanism based on sensitivity pattern
  (oral trimethoprim/sulfamethoxazole is preferred)

  At Day 3-5 of therapy: If no improvement, repeat cell count, differential and gram stain, re-culture and re-evaluate.

If peritonitis is associated with an exit site or tunnel infection, consider catheter removal. Duration of treatment may need to be extended to 21 days depending on clinical course.

If failure to respond to treatment by 5 days on appropriate antibiotics, consider prompt catheter removal.

**Duration of therapy:**
- **14-21 days per MD orders**
- **21-28 days per MD orders**
6. **Pseudomonas Species on Culture**

**Without exit site/tunnel infection:**
Give 2 different antibiotics acting in different ways that organism sensitive to e.g. levofloxacin, ceftazidime, tobramycin, piperacillin

**At Day 3-5 of therapy:** If no improvement, repeat cell count, differential and gram stain, re-culture and re-evaluate.

If peritonitis is associated with an exit site or tunnel infection, consider catheter removal. Duration of treatment may need to be extended to 21 days depending on clinical course. If failure to respond to treatment by 5 days on appropriate antibiotics, consider prompt catheter removal.

**Duration of therapy: 21 days**

**With exit site/tunnel infection current or prior to peritonitis:**
Give 2 different antibiotics acting in different ways that organism sensitive to e.g. levofloxacin, ceftazidime, tobramycin, piperacillin

Remove catheter and continue oral and/or systemic antibiotics for at least 2 weeks.
7. Polymicrobial Peritonitis on Culture

**Multiple gram-negative organisms or mixed gram negative/gram positive:**
- Consider GI problem
- Change therapy to metronidazole in conjunction with ampicillin, ceftazidime or aminoglycoside
- Obtain urgent surgical assessment
- Treatment and catheter removal depending on findings
  - Duration of Therapy: 14 days or as clinically indicated

**Multiple gram-positive organisms:**
- Consider touch contamination or catheter infection
- Therapy based on sensitivities
- Consider catheter removal if exit site or tunnel infection present
- Duration of Therapy: 21 days based on clinical response
APPENDIX B: DOSING ALGORITHM FOR COMMONLY USED IP ANTIBIOTICS

1. Vancomycin Dosing (same for RKF present or No RKF)

   IMPORTANT: Vancomycin is dosed every 5-7 days depending on vancomycin trough levels NOT DAILY. Add the entire dose in one bag of the dialysate.

<table>
<thead>
<tr>
<th>Actual Weight (Kg)</th>
<th>Vancomycin Dose IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;60</td>
<td>1000 mg</td>
</tr>
<tr>
<td>60-90</td>
<td>1500 mg</td>
</tr>
<tr>
<td>&gt;90</td>
<td>2000 mg</td>
</tr>
</tbody>
</table>

   - Vancomycin dose and interval will be affected by presence or absence of residual renal function. Shorter dosing intervals should be anticipated with residual renal function while longer dosing intervals should be anticipated in the absence of residual kidney function, guided by trough levels.
   - Consult with physician for individual dosing parameters based on trough levels (target greater than 15 mcg/ml and less than 20 mcg/ml).

2. Ceftazidime Dosing: 1000 mg IP if < 50 kgs., 1500 mg IP if ≥ 50 kgs

<table>
<thead>
<tr>
<th>Cefazolin dose IP</th>
<th>Actual Weight Urine output ≤100 ml/day Based on 15 mg/kg</th>
<th>Actual Weight Urine output &gt;100 ml/day. Based on 18.75 mg/kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 mg</td>
<td>≤66</td>
<td>≤53</td>
</tr>
<tr>
<td>1500 mg</td>
<td>67-100</td>
<td>54-80</td>
</tr>
<tr>
<td>2000 mg</td>
<td>101-133</td>
<td>81-106</td>
</tr>
<tr>
<td>2500 mg</td>
<td>&gt;133</td>
<td>&gt;106</td>
</tr>
</tbody>
</table>
3. Tobramycin Dosing

<table>
<thead>
<tr>
<th>Actual Weight (Kg)</th>
<th>&lt;100 ml/day urine output: Tobramycin Dose IP Based on 0.6 mg/kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;34</td>
<td>20 mg</td>
</tr>
<tr>
<td>34-41</td>
<td>25 mg</td>
</tr>
<tr>
<td>42-50</td>
<td>30 mg</td>
</tr>
<tr>
<td>51-58</td>
<td>35 mg</td>
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<td>67-75</td>
<td>45 mg</td>
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<td>76-83</td>
<td>50 mg</td>
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<td>84-91</td>
<td>55 mg</td>
</tr>
<tr>
<td>92-100</td>
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<tr>
<td>117-125</td>
<td>75 mg</td>
</tr>
<tr>
<td>126-133</td>
<td>80 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual Weight (Kg)</th>
<th>&gt;100 ml/day urine output: Tobramycin Dose IP Based on 0.75 mg/kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;27</td>
<td>20 mg</td>
</tr>
<tr>
<td>28-33</td>
<td>25 mg</td>
</tr>
<tr>
<td>34-40</td>
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<tr>
<td>41-46</td>
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<td>121-126</td>
<td>95 mg</td>
</tr>
<tr>
<td>127-133</td>
<td>100 mg</td>
</tr>
</tbody>
</table>

- Tobramycin dose will be affected by presence or absence of residual renal function.
- Consult with physician for individual dosing parameters based on trough levels (target less than 1mcg/L).