



GUIDELINE	
Medical Prophylaxis	
Scope (Staff):	Medical, Nursing, Pharmacy
Scope (Area):	Perth Children’s Hospital (PCH)
Child Safe Organisation Statement of Commitment	
<p>The Child and Adolescent Health Service (CAHS) commits to being a child safe organisation by meeting the National Child Safe Principles and National Child Safe Standards. This is a commitment to a strong culture supported by robust policies and procedures to ensure the safety and wellbeing of children at CAHS.</p>	

This document should be read in conjunction with this [DISCLAIMER](#)

- This guideline should be only be used in consultation with Infectious Diseases and/or Clinical Microbiology. For any staff or family contacts, each prescription should be endorsed with “Contact prophylaxis” and requires a unique medical record number (UMRN) to be included on the prescription. Without a UMRN, PCH Pharmacy is unable to process the prescription.
- Many of the infections covered in the guideline below are vaccine preventable. Please consider immunisation history and offer catch-up vaccination if appropriate. For further information regarding immunisation please refer to the [PCH Immunisation Service site](#).
- For information regarding community exposure to blood and bodily fluids, refer to the ChAMP guideline: [Post exposure prophylaxis following non-occupational exposure to body fluids \(nPEP\)](#)

CLINICAL SCENARIO		DRUGS/DOSES
		Standard Protocol For patients with a beta-lactam allergy, refer to ChAMP Beta-lactam Allergy Guideline ^a
Post exposure prophylaxis	<p><i>Neisseria meningitidis</i> (Meningococcus infections)</p>	<p>Suspected meningococcal cases must be notified urgently to Public Health or to the Communicable Disease Control Directorate (CDCD phone: 08 9388 4999; after hours: 08 9328 0553). Prophylaxis of immediate/household contacts should commence without delay. Refer to: Communicable Diseases Network Australia: Invasive Meningococcal Disease for further information.</p> <p>Oral rifampicin: Neonate < 1 month: 5mg/kg/dose 12 hourly for 2 days Child ≥ 1 month: 10mg/kg/dose (max 600mg) 12 hourly for 2 days OR Oral ciprofloxacin as a single dose Child ≥ 1 month to < 5 years: 125mg as a single dose Child ≥ 5 years to < 12 years: 250mg as a single dose Child ≥ 12 years: 500mg as a single dose OR IM ceftriaxone as a single dose Ceftriaxone not recommended if any history of high risk penicillin allergy. Child ≥ 1 month to < 12 years: 125mg as a single dose Child ≥ 12 years and adults: 250mg as a single dose IM ceftriaxone is the agent of choice for any pregnant contacts.</p> <p>In unimmunised contacts, meningococcal vaccination for serotypes A, C, W and Y (Men ACWY) should be offered.</p> <p>All cases of staff exposure must be discussed with the on-call Clinical Microbiologist who will liaise with the CAHS Staff Health service.</p>
	<p><i>Haemophilus influenzae</i> type B (Hib)</p>	<p><i>Haemophilus influenzae</i> type B (Hib) cases must be notified urgently to Public Health or to the CDCD (phone: 9388 4999; after hours: 9328 0553). Refer to: Communicable Diseases Network Australia: Haemophilus influenza type b invasive infection for further information</p> <p>Oral rifampicin: Neonate < 1 month: 10mg/kg/dose once daily for four days Child ≥ 1 month: 20mg/kg/dose (to a maximum of 600mg) once daily for four days OR IM ceftriaxone Ceftriaxone not recommended if any history of high risk penicillin allergy.</p> <p>Child ≥ 1 month: 50mg/kg/dose (to a maximum of 1 gram) once daily for two days</p>

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		Standard Protocol For patients with a beta-lactam allergy, refer to ChAMP Beta-lactam Allergy Guideline ^a
Post exposure prophylaxis	Pertussis	<p>Refer to the Communicable Diseases Network Australia: Pertussis for further information on specific prophylaxis indications.</p> <p>Oral azithromycin: Child < 6 months old: 10mg/kg/dose (to a maximum of 500mg) once daily for five days Child ≥ 6 months old: 10mg/kg/dose (to a maximum of 500mg) on day one, then 5mg/kg/dose (to a maximum of 250mg) once daily for four days</p>
	Influenza	<p>Consider influenza prophylaxis in those patients at high risk and < 48 hours after exposure including:</p> <ul style="list-style-type: none"> - Patients with heart disease - Patients with Down syndrome - Patients with Obesity - Chronic respiratory patients - Patients with severe neurological conditions - Immunocompromised patients - Patients with chronic illness - Children < 5 years - Aboriginal and Torres Strait Islander people of any age <p>Oral oseltamivir: ≥ 1 month to < 12 months: 3mg/kg/dose once daily for ten days Child ≥ 1 year and 10-15kg: 30mg once daily for ten days Child ≥ 1 year and 15-23kg: 45mg once daily for ten days Child ≥ 1 year and 23-40kg: 60mg once daily for ten days Child ≥ 1 year and ≥ 40kg: 75mg once daily for ten days Child ≥ 13 to 18 years: 75mg once daily for ten days Note: There is limited safety or efficacy data in children < 12 months of age for influenza prophylaxis; it should only be used in high risk infants and in consultation with infectious diseases. Post exposure prophylaxis is NOT a replacement for influenza vaccination.</p>

CLINICAL SCENARIO		DRUGS/DOSES
		Standard Protocol For patients with a beta-lactam allergy, refer to ChAMP Beta-lactam Allergy Guideline ^a
Post exposure prophylaxis	Invasive Group A Streptococcal (iGAS) infection (<i>Streptococcus pyogenes</i>)	<p>Invasive Group A Streptococcal (iGAS) infection is not currently notifiable in WA but it is in some parts of Australia. The risk of secondary cases in household contacts is high. Prophylaxis of immediate/ household contacts should commence without delay.</p> <p>Prophylaxis of immediate and household contacts should be offered in the setting of ALL mother-neonatal pairs and/or iGAS infection, defined as any of the following:</p> <ul style="list-style-type: none"> - Pneumonia - Meningitis - Necrotising fasciitis - Streptococcal toxic shock syndrome - Any presentation leading to PCC admission or death - Bacteraemia - Bone and joint infections - Deep soft tissue infection <p>All age groups: Oral azithromycin: 20mg/kg/dose (to a maximum of 500mg) once daily for three days OR Oral cefalexin: 25 mg/kg/dose (to a maximum of 1g) twice daily for ten days. Oral cefalexin not recommended if history of high risk penicillin allergy. OR Oral clindamycin: 7.5mg/kg/dose (to a maximum of 300mg) twice daily for ten days OR IM Benzathine Benzylpenicillin Benzathine Benzylpenicillin not recommended if history of high or low risk penicillin allergy. Neonate and child ≤ 6kg: 300,000 units (0.6mL) as a single IM dose Child > 6kg to < 12kg: 450,000 units (0.9mL) as a single IM dose Child ≥ 12kg to < 16kg: 600,000 units (1.2mL) as a single IM dose Child ≥ 16kg to < 20kg: 900,000 units (1.7mL) as a single IM dose Child ≥ 20kg: 1,200,000 units (2.3mL) as a single IM dose</p> <p>All cases of staff exposure must be discussed with the on-call Clinical Microbiologist who will liaise with the CAHS Staff Health service..</p>

CLINICAL SCENARIO		DRUGS/DOSES		
		Standard Protocol		
		For patients with a beta-lactam allergy, refer to ChAMP Beta-lactam Allergy Guideline ^a		
Pneumocystis jiroveci (carinii)	Pneumocystis jiroveci (carinii) pneumonia prophylaxis	Oral trimethoprim with sulfamethoxazole (co-trimoxazole) Child ≥ 1 month: 2.5mg/kg/dose of trimethoprim component; equivalent to 0.3mL/kg/dose of suspension (to a maximum of 160mg trimethoprim component) twice daily on three days per week		
		Suggested dose bands:		
		Body Surface Area (m²)	trimethoprim/ sulfamethoxazole tablets (400mg/80mg) given twice daily on three days per week	trimethoprim/ sulfamethoxazole liquid (200mg/40mg per 5mL) given twice daily on three days per week
		< 0.5	N/A	0.3mL/kg/dose
		0.5-0.75	½ tablet	5mL
		0.76-0.99	1 tablet morning and ½ tablet at night	7.5mL
		≥ 1.5	2 tablets	20mL
		OR trimethoprim with sulfamethoxazole (co-trimoxazole) Child ≥ 1 month: 5mg/kg/dose of trimethoprim component (to a maximum of 320mg) once daily on three days per week If oral trimethoprim with sulfamethoxazole (co-trimoxazole) is not tolerated or unsuitable due to interactions IV pentamidine isetionate Child ≥ 1 month: 4mg/kg/dose (to a maximum of 300mg) every four weeks.		
Recurrent VZV/HSV	Recurrent Varicella zoster virus or Herpes Simplex virus prophylaxis (in immunocompromised patients)	Prevention of recurrent Herpes Simplex Virus and prevention of HSV in HSV seropositive patients, Cytomegalovirus and Varicella-Zoster Virus infection post Haematopoietic Stem Cell Transplant or Autologous Stem Cell Rescue		
		IV aciclovir : Child 3 months to < 12 years: 10mg/kg/dose (to a maximum of 750mg) 8 hourly Child ≥ 12 years: 5mg/kg/dose (to a maximum of 750mg) 8 hourly Patients should be converted to oral aciclovir or valaciclovir as soon as oral medications are tolerated Oral valaciclovir : Child ≥ 3 months: 10mg/kg/dose (to a maximum of 500mg) twice daily OR Oral aciclovir : Child ≥ 1 month to 23 months: 100-200mg three times per day Child ≥ 2 years to 17 years: 200-400mg three times per day		

CLINICAL SCENARIO		DRUGS/DOSES			
		Standard Protocol	Known or Suspected MRSA ^b	Low risk penicillin allergy ^a	High risk penicillin allergy ^a
Rheumatic fever	Rheumatic fever – prevention of recurrent ARF/ progressive RHD	IM benzathine benzylpenicillin < 20kg: 600,000 units (1.2mL) OR ≥ 20kg: 1,200,000 units (2.3mL) every 3-4 weeks. or As a second line agent: Oral phenoxymethylpenicillin Child ≥ 1 month to 18 years: 250mg twice daily.	As per standard protocol	erythromycin^c	erythromycin^c
Asplenia/ hyposplenia	Asplenia, sickle cell anaemia, functional hyposplenia, post-splenectomy	Oral amoxicillin 20mg/kg/dose (up to 250mg) once daily OR Oral phenoxymethylpenicillin Child <1 year old: 62.5mg twice daily Child 1-5 years old: 125mg twice daily Child ≥ 5 years: 250mg twice daily	As per standard protocol	roxithromycin ^d OR consider oral challenge in discussion with immunology	roxithromycin ^d
		Refer to Asplenia and Hyposplenia Vaccination and Prophylaxis and the Australian Immunisation Handbook for advice on additional vaccines that are required.			

CLINICAL SCENARIO	DRUGS/DOSES			
	Standard Protocol For patients with a beta-lactam allergy, refer to ChAMP Beta-lactam Allergy Guideline ^a			
Infective endocarditis Prophylaxis against endocarditis is recommended only for children whose cardiac conditions have the highest risk of adverse outcomes from endocarditis, discuss with cardiology if unsure. <ul style="list-style-type: none"> • Previous infective endocarditis • Prosthetic valve or valve repair with prosthetic material • Shunt or conduit <i>in situ</i> • Uncorrected cyanotic heart disease • Recent (< 6 months) closure with prosthetic material or devices (including coils) • Cardiac transplant with valvulopathy • Rheumatic heart disease in high risk patients For children already receiving antibiotic therapy, discuss prophylaxis with infectious diseases or clinical microbiology.				
	Dental and ENT procedures: <ul style="list-style-type: none"> • Dental extraction • Periodontal procedures including surgery, deep subgingival scaling, or root planning • Re-implantation of avulsed permanent teeth • Oral surgical procedures such as apicectomy or implant placement • Tonsillectomy • Adenoidectomy • Invasive procedure to treat established infection 	Oral amoxicillin 50mg/kg/dose (to a maximum of 2 grams) 1 hour before the procedure if not performed under general anaesthetic or IV amoxicillin 50 mg/kg/dose (to a maximum of 2 grams) 15 to 60 minutes before the procedure	As per standard protocol	Oral cefalexin ^e or IV cefazolin ^f
	Also consider prophylaxis for dental procedures if multiple procedures are being conducted, the procedure is prolonged, or periodontal disease is present. Prophylaxis is not routinely recommended for the following dental procedures: <ul style="list-style-type: none"> • anaesthetic injections through non-infected tissue, • routine restorative procedures, • placement of removable prosthodontic or orthodontic appliances, • shedding of deciduous teeth, • bleeding from trauma to the lips and oral mucosa. 			

Infective endocarditis

CLINICAL SCENARIO		DRUGS/DOSES	
		Standard Protocol	
		For patients with a beta-lactam allergy, refer to ChAMP Beta-lactam Allergy Guideline ^a	
Infective endocarditis	<u>Intra-abdominal procedures:</u> appendicitis or peritonitis	As per surgical prophylaxis guideline Amoxicillin/clavulanic acid is routinely indicated for appendicitis or peritonitis surgical prophylaxis. No additional cover for infective endocarditis is required.	Discuss with ID or Microbiology service
	<u>Urological procedures:</u> • Lithotripsy Any procedure in the presence of infection (e.g. drainage of infected hydronephrosis, or cystoscopy with UTI)	As per surgical prophylaxis guideline IF piperacillin/tazobactam is recommended for surgical prophylaxis, no additional cover for infective endocarditis is required. IF cefazolin and gentamicin are recommended for surgical prophylaxis ADD Oral amoxicillin 50mg/kg/dose (to a maximum of 2 grams) 1 hour before the procedure if not performed under general anaesthetic OR IV amoxicillin 50 mg/kg/dose (to a maximum of 2 grams) 15 to 60 minutes before the procedure	Discuss with ID or Microbiology service
	<u>Other surgery or invasive procedures in the presence of infection:</u> e.g. abscess drainage or incision through infected skin/ tissue.	Discuss with ID or Microbiology service	

- a) Refer to the ChAMP Beta-lactam Allergy Guideline:
- Low risk allergy: a delayed rash (>1hr after initial exposure) without mucosal or systemic involvement (without respiratory distress and/or cardiovascular compromise).
 - High risk allergy: an immediate rash (<1hr after exposure); anaphylaxis; severe cutaneous adverse reaction {e.g. Drug Rash with Eosinophilia and Systemic Symptoms (DRESS) and Stevens – Johnson syndrome (SJS) / Toxic Epidermal Necrolysis (TEN)} or other severe systemic reaction

- b) Children known or suspected to be colonised with MRSA may need to have their therapy/prophylaxis modified. Children suspected of having MRSA include:
 - i. Children previously colonised with MRSA
 - ii. Household contacts of MRSA colonised individuals
 - iii. In children who reside in regions with higher MRSA rates (e.g. Kimberley, Pilbara and Goldfields) a lower threshold for suspected MRSA should be given
 - iv. Children with recurrent skin infections or those unresponsive to ≥ 48 of beta-lactam therapy. For further advice, discuss with Microbiology or ID service
- c) Child ≥ 1 month: Oral [erythromycin](#) base **10mg/kg/dose** (to a maximum of 250mg) 12 hourly **or** [erythromycin](#) ethyl succinate **10mg/kg/dose** (to a maximum of **400mg**) 12 hourly.
- d) Child ≥ 1 month: Oral roxithromycin 4mg/kg/dose (to a maximum of 150mg) once daily.
- e) Oral [cefalexin](#) **50mg/kg** (to a maximum of 2 grams) as a single dose given 1 hour before the procedure.
- f) IV [cefazolin](#) **30mg/kg** (to a maximum of 2 grams) as a single dose 15 to 60 minutes prior to the procedure.
- g) IV or oral [clindamycin](#) **20mg/kg** (to a maximum of 600mg) as a single dose. Oral dose given 1 hour before the procedure, IV dose given over at least 20 minutes just before the procedure. Repeat dose if operation > 6 hours.

Related CAHS internal policies, procedures and guidelines

[Asplenia and hyposplenia vaccination and prophylaxis](#)

References and related external legislation, policies, and guidelines

1. Antibiotic Writing Group. eTG complete. West Melbourne: Therapeutic Guidelines Ltd; 2020. Available from: <https://tguidcdp-tg-org-au.pklibresources.health.wa.gov.au/etgAccess>. Rossi S, editor. Australian Medicines Handbook. Adelaide, S. Aust.: Australian Medicines Handbook; 2020. Centre for Disease Control, Department of Health Northern Territory, Public Health Management of invasive group A streptococcal infection, November 2015, Available from: <http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/1187/1/iGAS%20guidelines%20Nov%202015.pdf>
2. UD Allen, DL Moore; Invasive Group A Streptococcal Disease- Management and Chemoprophylaxis, Canadian Paediatric Society, Infectious Diseases and Immunization Committee Paediatr Child Health 2010;15(5):295-302 Posted:Jun 2010 Reaffirmed:Feb 2016
3. Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Recommendations on Public Health Management of Invasive Group A Streptococcal (iGAS) Disease in Ontario. Toronto, ON: Queen's Printer for Ontario; 2014.
4. Health Protection Agency , Group A Streptococcus Working Group, Interim UK Guidelines for management of close community contacts of invasive group A streptococcal disease, Communicable Diseases Public Health, 2004, 7 (4), 354-61
5. The Prevention of Invasive Group A Streptococcal Infections Workshop Participants; Prevention of Invasive Group A Streptococcal Disease among Household Contacts of Case Patients and among Postpartum and Postsurgical Patients: Recommendations from the Centers for Disease Control and Prevention, *Clinical Infectious Diseases*, Volume 35, Issue 8, 15 October 2002, Pages 950–959, <https://doi.org/10.1086/342692>
6. The Department of Health. Series of National Guidelines (SoNGs): Department of Health; 2020 [Available from:

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdnasongs.htm>.

Useful resources (including related forms)

[Series of National Guidelines \(SoNGs\) – Communicable Diseases Network Australia](#)




[Invasive Meningococcal Disease \(IMD\) – National guidelines for public health units](#)

[Haemophilus influenza type b Invasive infection – National guidelines for public health units](#)

[Pertussis – National guidelines for public health units](#)

[Seasonal influenza infection – National guidelines for public health units](#)

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