<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>Usual Duration</th>
<th>Drugs/Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salmonella – non typhoidal enteritis</strong></td>
<td>5 to 7 days</td>
<td><em>Salmonella</em> enteritis is self-limiting in many patients. <strong>Consider</strong> antibiotic therapy in children &lt; 3 months old, children 3-12 months who are febrile or toxic, immunocompromised children, children with endovascular grafts or if enteritis is severe or prolonged. For uncomplicated enteritis use: Oral <strong>co-trimoxazole</strong> 4mg/kg/dose of trimethoprim component (to a maximum of 160mg) 12 hourly. Or, if confirmed resistance to co-trimoxazole: Oral <strong>azithromycin</strong> 20mg/kg/dose (to a maximum of 1 gram) on day 1, followed by 10mg/kg/dose (to a maximum of 500mg) once daily for a further 6 days.</td>
</tr>
<tr>
<td><strong>Enteric fever – typhoid and paratyphoid or Salmonella – non typhoidal bacteraemia</strong></td>
<td>7-14 days total (IV and oral)</td>
<td><strong>IV ceftriaxone</strong> 50mg/kg/dose (to a maximum of 2 grams) 24 hourly, until afebrile and then 5 days of oral <strong>azithromycin</strong>. (if susceptible) as advised by Infectious Diseases or Clinical Microbiology services. <strong>Note:</strong> Contact Infectious Diseases or Clinical Microbiology for patients with an immediate penicillin allergy.</td>
</tr>
</tbody>
</table>
### Shigella species

<table>
<thead>
<tr>
<th>Duration</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 days</td>
<td>Treatment is recommended for all <em>Shigella</em> enteritis to reduce disease transmission. Oral co-trimoxazole 4mg/kg/dose of trimethoprim component (to a maximum of 160mg) 12 hourly. <strong>OR</strong> If confirmed resistance to co-trimoxazole use: Oral ciprofloxacin 12.5mg/kg/dose (to a maximum dose of 500mg) 12 hourly.</td>
</tr>
</tbody>
</table>

### Clinical Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>DRUGS/DOSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL SCENARIO</strong></td>
<td><strong>Usual duration</strong></td>
</tr>
<tr>
<td>Usual duration</td>
<td><em>Campylobacter</em> enteritis is self-limiting in many patients. Consider antibiotic therapy in infants, immunocompromised children or if enteritis is severe or prolonged. Oral azithromycin 10mg/kg/dose (to a maximum of 500mg) daily. <strong>OR</strong> Oral erythromycin 10mg/kg/dose (to a maximum of 500mg) four times a day.</td>
</tr>
<tr>
<td><strong>Giardiasis</strong></td>
<td>variable</td>
</tr>
</tbody>
</table>
| Clostridium difficile (mild to moderate) | 10 days | Asymptomatic colonisation of young infants is common.

Treatment of children < 2 years old should be discussed with Infectious Diseases or Clinical Microbiology services.

Precipitating factors (e.g. broad-spectrum antibiotics such as 3rd generation cephalosporins or carbapenems), should be modified or ceased, where possible.

In children with mild disease stopping antibiotic therapy is usually sufficient to resolve symptoms.

Oral **metronidazole** 10mg/kg/dose (to a maximum of 400mg) 8 hourly.

| Clostridium difficile (severe) | 10 days | Severe disease includes patients with a white cell count >15 x 10^9/L, severe abdominal pain, elevated creatinine, elevated lactate, low albumin, high fever or organ dysfunction.

Discuss **all severe patients** with Infectious Diseases or Clinical Microbiology services.

Oral **vancomycin** 5mg/kg/dose (to a maximum of 125mg) 6 hourly.

In complicated patients (e.g. hypotension, shock or ileus).

**ADD**

IV **metronidazole** 12.5mg/kg/dose (to a maximum of 500mg) 8 hourly.
<table>
<thead>
<tr>
<th>CLINICAL SCENARIO</th>
<th>Usual duration</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Protocol</strong> (Including patients with known or suspected MRSA, immediate\textsuperscript{a} or delayed\textsuperscript{b} penicillin allergy)</td>
<td>\textbf{Helicobacter pylori} infection is less common in children than in adults, with a prevalence of \textless5%. Children should only be tested for H. pylori when their symptoms are strongly suggestive and should be confirmed with endoscopy. <strong>Consider</strong> Oral \textbf{amoxicillin} 25mg/kg/dose (to a maximum of 1 gram) twice daily. \textbf{and} Oral \textbf{clarithromycin} 7.5mg/kg/dose (to a maximum of 500mg) twice daily. \textbf{and} a proton pump inhibitor In delayed or immediate penicillin allergy use oral \textbf{metronidazole} 10mg/kg/dose (to a maximum of 400mg) twice daily instead of amoxicillin.</td>
<td></td>
</tr>
<tr>
<td><strong>Clostridium difficile (recurrent)</strong></td>
<td>\textbf{Discuss with Infectious Diseases or Clinical Microbiology services.}</td>
<td></td>
</tr>
<tr>
<td><strong>Helicobacter pylori</strong></td>
<td>7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Perianal and fistulising disease in Crohn’s disease</strong></td>
<td>variable</td>
<td>Oral \textbf{metronidazole} 10mg/kg/dose (to a maximum of 400mg) twice daily. \textbf{OR} if refractory to metronidazole: Oral \textbf{ciprofloxacin} 12.5mg/kg/dose (to a maximum of 500mg) twice daily.</td>
</tr>
</tbody>
</table>

\begin{itemize}
  \item Children known or suspected to be colonised with MRSA may need to have their therapy/prophylaxis modified. Children suspected of having MRSA include:
    \begin{itemize}
      \item household contacts of MRSA colonised individuals and
      \item children with recurrent skin infections or those unresponsive to beta-lactam therapy.
    \end{itemize}
  
  \item An immediate (IgE mediated) reaction is characterised by the development of urticaria, angioedema, bronchospasm or anaphylaxis within 1 to 2 hours of drug administration.
  
  \item Delayed reactions including maculopapular or morbilliform rashes, drug fever and cytopenias and are more in keeping with other forms of immunological reactivity. Isolated
\end{itemize}
diarrhoea is not usually immune-mediated and does not contraindicate the future use of an antibiotic.

d. For disseminated infection (meningitis, septic arthritis) contact Infectious Diseases or Clinical Microbiology Services for advice.

e. Oral ciprofloxacin should only be used in those patients able to swallow tablets as ciprofloxacin is extremely unpalatable. Doses should be rounded to the nearest portion of a tablet. (Tablet strengths are 250mg and 500mg).

f. Oral vancomycin – IV solution may be administered orally for inpatients, those unable to swallow capsules or for doses <125mg. Capsules are PBS listed.

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**Related internal policies, procedures and guidelines**

Antimicrobial Stewardship Policy
ChAMP Empiric Guidelines

**References**


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Standards Applicable: NSQHS Standards: 🌟🌟🌟

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