require antibacterial prophylaxis for dental treatment. The Working Party considers that it is unacceptable to expose patients to the adverse effects of antibacterials when there is no evidence that such prophylaxis is of any benefit, but that those who develop any intercurrent infection require prompt treatment with antibacterials to which the infecting organisms are sensitive.

The Working Party has commented that joint infections have rarely been shown to follow dental procedures and are even more rarely caused by oral streptococci.

Immunosuppression and indwelling intraperitoneal catheters

Advice of a Working Party of the British Society for Antimicrobial Chemotherapy is that patients who are immunosuppressed (including transplant patients) and patients with indwelling intraperitoneal catheters do not require antibacterial prophylaxis for dental treatment provided there is no other indication for prophylaxis.

The Working Party has commented that there is little evidence that dental treatment is followed by infection in immunosuppressed and immunodeficient patients nor is there evidence that dental treatment is followed by infection in patients with indwelling intraperitoneal catheters.

Blood infections, antibacterial therapy

Septicaemia (community-acquired)

- *Child* 1 *month*–18 *years*, aminoglycoside + amoxicillin p. 366 (*or* ampicillin p. 368) *or* cefotaxime p. 342 (*or* ceftriaxone p. 343) alone
- If pseudomonas or resistant micro-organisms suspected, use a broad-spectrum antipseudomonal beta-lactam antibacterial.
- If anaerobic infection suspected, add metronidazole p. 358.
- If Gram-positive infection suspected, add flucloxacillin p. 373 *or* vancomycin p. 349 (*or* teicoplanin p. 348).
- *Suggested duration of treatment* at least 5 days.

Septicaemia (hospital-acquired)

- *Child* 1 *month*–18 *years*, a broad-spectrum antipseudomonal beta-lactam antibacterial (e.g. piperacillin with tazobactam p. 362, ticarcillin with clavulanic acid p. 363, imipenem with cilastatin p. 336, *or* meropenem p. 337)
- If pseudomonas suspected, or if multiple-resistant organisms suspected, or if severe sepsis, add aminoglycoside.
- If meticillin-resistant *Staphylococcus aureus* suspected, add vancomycin (*or* teicoplanin).
- If anaerobic infection suspected, add metronidazole to a broad-spectrum cephalosporin.
- *Suggested duration of treatment* at least 5 days.

Septicaemia related to vascular catheter

- Vancomycin (*or* teicoplanin)
- If Gram-negative sepsis suspected, especially in the immunocompromised, add a broad-spectrum antipseudomonal beta-lactam.
- Consider removing vascular catheter, particularly if infection caused by *Staphylococcus aureus*, pseudomonas, or *Candida* species.

Meningococcal septicaemia

If meningococcal disease suspected, a single dose of benzylpenicillin sodium p. 364 should be given before urgent transfer to hospital, so long as this does not delay the transfer; cefotaxime may be an alternative in penicillin allergy; chloramphenicol p. 385 may be used if history of immediate hypersensitivity reaction to penicillin or to cephalosporins.

- Benzylpenicillin sodium or cefotaxime (*or* ceftriaxone)
- *If history of immediate hypersensitivity reaction to penicillin or to cephalosporins*, chloramphenicol

To eliminate nasopharyngeal carriage, ciprofloxacin p. 377, or rifampicin p. 396, or ceftriaxone may be used.

Septicaemia in neonates

- *Neonate less than* 72 *hours old*, benzylpenicillin sodium + gentamicin p. 333
- If Gram-negative septicaemia suspected, use benzylpenicillin sodium + gentamicin + cefotaxime; stop benzylpenicillin sodium if Gram-negative infection confirmed.
- *Suggested duration of treatment* usually 7 days.
- *Neonate more than* 72 *hours old*, flucloxacillin + gentamicin *or* amoxicillin (*or* ampicillin) + cefotaxime
- *Suggested duration of treatment* usually 7 days.

Cardiovascular system infections, antibacterial therapy

Endocarditis: initial 'blind' therapy

- Flucloxacillin p. 373 (*or* benzylpenicillin sodium p. 364 if symptoms less severe) + gentamicin p. 333
- *If cardiac prostheses present, or if penicillin-allergic, or if meticillin-resistant Staphylococcus aureus suspected*, vancomycin p. 349 + rifampicin p. 396 + gentamicin

Endocarditis caused by staphylococci

- Flucloxacillin
- Add rifampicin for at least 2 weeks in prosthetic valve endocarditis
- *Suggested duration of treatment* at least 4 weeks (at least 6 weeks for prosthetic valve endocarditis)
- *If penicillin-allergic or if meticillin-resistantStaphylococcus aureus*, vancomycin + rifampicin
- *Suggested duration of treatment* at least 4 weeks (at least 6 weeks for prosthetic valve endocarditis)

Endocarditis (native valve) caused by fully-sensitive streptococci e.g. viridans streptococci

- Benzylpenicillin sodium
- *Suggested duration of treatment* 4 weeks
- *Alternative if a large vegetation, intracardial abscess, or infected emboli are absent*, benzylpenicillin sodium + gentamicin
- *Suggested duration of treatment* 2 weeks
- *If penicillin-allergic*, vancomycin
- *Suggested duration of treatment* 4 weeks

Endocarditis (native valve) caused by less-sensitive streptococci

- Benzylpenicillin sodium + gentamicin
- *Suggested duration of treatment* 4–6 weeks (stop gentamicin after 2 weeks for micro-organisms moderately sensitive to penicillin)
- *If aminoglycoside cannot be used and if streptococci moderately sensitive to penicillin*, benzylpenicillin sodium
- *Suggested duration of treatment* 4 weeks
- *If penicillin-allergic or highly penicillin-resistant*, vancomycin (*or* teicoplanin p. 348) + gentamicin
- *Suggested duration of treatment* 4–6 weeks (stop gentamicin after 2 weeks for micro-organisms moderately sensitive to penicillin)