Appendix 3

Intravenous To Oral Antimicrobial Therapy Review And Switch (IVOS)

Does intravenous therapy need to continue? (see ACED)

YES

- Continue with IV antibiotics
- Continue to monitor closely
- Review need for IV therapy again after 24 hours (mark new review date on chart)

NO

- Switch to oral therapy, add Indication and intended duration
- Check for any interactions/allergies
- If in doubt seek advice from a pharmacist/microbiology
- Monitor patient’s progress following switch to oral therapy

Considerations for IV to oral switch - ACED

1) A - afebrile >24hours (Haemodynamically stable with no signs of fever)
2) C - clinically improving (markers normalising)
   a) Improving signs and symptoms of infection and patient’s general condition getting better
   b) Patient’s clinical markers improving after treatment with parenteral antimicrobial drugs:
      i) no unexplained tachycardia (heart rate less than 90 beats/minute in the past 12 hours)
      ii) blood pressure stable (in the past 24 hours)
      iii) respiratory rate less than 20 breaths/minute (in the past 24 hours)
      iv) white cell count 4–12 x 10^9/L or a high white cell count is falling (White cell count should show a trend towards normal; absence of such should not impede the switch if all other criteria are met and not neutropenic.
      v) falling C-reactive protein (CRP)
3) E - Eating and drinking, have a functional GI tract with no malabsorption and there is no interactions with other medications
   a) Suitable enteral antimicrobial drug available
   b) Patient can swallow and tolerate oral fluids or have fluids via a tube into the gut.
   c) Patient has no signs of malabsorption
4) D - Not suffering from certain deep-seated/high-risk infections (see table below)
   a) High tissue antimicrobial drug concentrations are not essential for infection being treated (i.e. it is not high-risk or deep-seated infection)

Exceptions to the above include the infections in the table below
(Oral switch may be appropriate in some of these infections on a case by case basis):

- Liver abscess
- Osteomyelitis, Septic arthritis
- Inadequately drained abscesses or empyema
- Gavulating pneumonia
- Staphylococcus aureus bacteraemia
- Severe necrotising soft tissue infections
- Severe infections during chemotherapy related neutropenia
- Infected implants/prosthesis
- Meningitis/encephalitis
- Intracranial abscesses
- Mediastinitis
- Endocarditis
- Legionella pneumonia
- Exacerbation of cystic fibrosis/bronchiectasis