



Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Antimicrobial Management of Febrile Neutropenic Sepsis

Written by: Dr T Gbemre, Consultant Haematologist
Dr M Milupi, Consultant Microbiologist

Date: March 2021

Approved by: Drugs & Therapeutics Committee

Date: July 2021
Amended June 2026 and August 2026

Implementation Date: November 2021

For Review: November 2024

AMENDMENT FORM

Version	Date	Brief summary of changes	Author
3	August 2026	Changed to Caspofungin as 1 st line antifungal and Anidulafungin as 2 nd line due to changes in supply chain and cost	Dr B Subramanian
2	June 2026	Empirical antifungal changed from caspofungin to anidulafungin due to supply issues	Dr B Subramanian Kar Loon Yee
1	March 2021	New policy	Dr T Gbemre Dr M Milupi

Antimicrobial Management of Febrile Neutropenic Sepsis

[Read in conjunction with PAT/EC 5 Febrile Neutropenic Patients Management Guidelines]

Diagnosis of neutropenic sepsis (as per NICE guidelines Sept 2012) is made in patients having anticancer treatment whose neutrophil count is $0.5 \times 10^9/L$ or lower and who have either a temperature higher than $38^\circ C$ OR other signs or symptoms consistent with clinically significant sepsis.

This trust guideline includes patient with the above diagnosis and also includes patients who have a low neutrophil count of between 0.5 and $1.0 \times 10^9/L$, recent chemotherapy, a temperature of higher than $38^\circ C$ and clinically septic

Table I: Details the first line, second line antibiotic therapy and antifungal therapy. Also see [flowchart](#). First line antibiotic should be commenced within one hour in patients with sepsis – see sepsis IPOC. Doses used in renal impairment can be found in appendix 1

Table II: Prophylactic antiviral, antifungal and antibacterial therapy

The initial management should involve a thorough investigation looking for a source for sepsis and include the following:

- Detailed history and examination
 - Clinical examination to include skin, mouth, web-spaces , peri-anal area, Hickman line site, chest and abdomen
 - Blood cultures – taken from the central venous catheter, if present (through each lumen) and Peripheral cultures; OR via 2 separate venipunctures if no central venous catheter present
 - CXR
 - MSU/CSU
 - Sputum
 - Swab from Hickman site/skin lesions/mouth
 - Faeces
 - CT-sinus, chest, abdomen, pelvis OR brain
 - SARS CoV2
 - FBC, U/E, CRP, liver function tests and Lactate
 - During the Flu season – all patients admitted with a temperature should have a throat swab sent for respiratory viruses
 - If bronchoscopy performed, send BAL sample for: routine culture and sensitivity, AFB, Pneumocystis, respiratory viruses, fungal culture and galactomannan
- } If clinically indicated

Table I: TREATMENT	Category		
	Neutrophil count $\leq 0.5 \times 10^9/L$ AND Having anticancer treatment AND Temperature higher than 38°C OR other signs and symptoms consistent with clinical sepsis	Neutrophil count of between 0.5 and $1.0 \times 10^9/L$ AND Chemotherapy in the preceding 6 weeks AND Temperature greater than 38°C Clinical sepsis, no obvious focus of infection	Neutrophil count of between 0.5 and $1.0 \times 10^9/L$ AND Chemotherapy in the preceding 6 weeks, AND Temperature greater than 38°C Clinically well
FIRST LINE ANTIBIOTIC THERAPY	IV Piperacillin/Tazobactam 4.5g FOUR times daily		Oral Co-amoxiclav 625mg THREE times daily for 5 days
Non life -threatening penicillin allergy OR previous/current ESBL/AmpC carrier	IV Meropenem 1g THREE times daily		Oral Cefaclor MR 375mg TWICE daily + Metronidazole 400mg THREE times daily for 5 days If previous ESBL/AmpC, contact Microbiologist
Life-threatening allergy to penicillin	IV Ciprofloxacin 400mg TWICE daily AND IV Teicoplanin 12mg/kg (see Guidelines for Use of Teicoplanin)		Oral Levofloxacin 500mg TWICE daily for 5 days
Previous/current MRSA positive swab OR High suspicion of catheter related infection	ADD IV Teicoplanin 12mg/kg (see Guidelines for Use of Teicoplanin)		
SECOND LINE	If the temperature persists at 48hrs and clinically stable with no clinical deterioration then continue with the same antibiotic for another 24 hours. If bacterial aetiology is identified, then treat according to the organism identified (if significant) If temperature settles for ≥ 48 and is haemodynamically stable since admission and no bacterial aetiology identified, then stop antibiotics after ≥ 72 hrs, observe for at least 24-48hrs AND re-start IV antibiotics (first or second line as the case may be) if fever recurs If clinical deterioration at 48 hours or patient remains pyrexial after >96 hrs of 1st line therapy, then switch to second line therapy		
Antibiotic therapy	IV Meropenem 1g THREE times daily (if had Piperacillin/Tazobactam first line). Following all other first line regimes, discuss with Microbiologist.		

<u>THIRD LINE</u>	If temperature persists and patient continues to deteriorate after a further 5 days of 2nd line antibiotic therapy and no bacterial pathogen has been identified, repeat examination and investigate for fungal infections (see below) OR Where antifungal therapy is necessary because of possible invasive fungal infection, THEN consider antifungal therapy AND stop antibiotics after at least a total of 10 days (unless deep-seated infection) and continue to closely observe the patient and to re-start them if the patient deteriorates. Patients not responding to first line anti-fungal agents should be investigated for invasive aspergillosis and other fungal infections AND discussed with the Microbiologist • Bronchoalveolar lavage • galactomannan enzyme assay & 1,3 β-D Glucan (may be repeated after 1 week if initially negative) • HRCT – halo sign and air-crescent sign • Transthoracic percutaneous biopsy	
Antifungal therapy	<u>1st line</u> Caspofungin 70mg loading dose, then 50mg once daily if ≤ 80 kg or 70mg once daily if > 80 kg Administered by slow intravenous infusion over approximately one hour.	<u>2nd line</u> Anidulafungin 200mg loading dose on Day 1, then 100mg once daily thereafter Loading dose: administered by intravenous infusion over approximately 3 hours Maintenance dose: administered by intravenous infusion over approximately 90 minutes
Invasive aspergillosis suspected	Voriconazole IV 6mg/kg TWICE daily for 2 doses, then 4mg/kg TWICE daily OR Voriconazole orally 400mg TWICE daily for 2 doses, then 200mg TWICE daily Check trough level after 5 to 7 days and monitor LFTs	
Antiviral therapy	Agent	Comments
Suspected herpes simplex virus lesions	IV Aciclovir 5mg/kg THREE times daily	Use IBW for dosing if overweight (i.e. if $> 20\%$ above IBW) Send swab in viral transport medium
Suspected varicella-zoster virus (chickenpox/shingles) infection	Aciclovir 10mg/kg 8-hourly by IV infusion	Use IBW for dosing if overweight (i.e. if $> 20\%$ above IBW) Exposure to chickenpox/shingles – see Policy for management of chickenpox/shingles PAT/IC 15 v2

Comments: Suspected CMV infection- discuss investigation with Microbiologist. If RSV positive, consider treatment with aerosolised Ribavirin

Table II: PROPHYLAXIS			
		AGENT	CAUTION
AML patients and Myelodysplastic Syndrome receiving intensive chemotherapy	First line	Posaconazole 100mg tablets Dose: 300mg TWICE daily on first day then 300mg once daily thereafter	Duration of therapy is based on recovery from neutropenia or immunosuppression. For patients with acute myelogenous leukemia or myelodysplastic syndromes, prophylaxis with posaconazole should start several days before the anticipated onset of neutropenia and continue for 7 days after the neutrophil count rises above 500 cells per mm ³ .
	Second line (if patient not tolerating the tablets)	Posaconazole suspension 200mg/5ml Dose: 200mg THREE times daily The syrup should ideally be taken with food to increase absorption	
Haematological malignancy where patients are receiving severely immunosuppressive chemotherapy		Oral Aciclovir 400mg TWICE daily OR 200mg FOUR times daily	
AML patients receiving intensive chemotherapy with neutrophil count of 0.5 x 10 ⁹ /L or less and continue until resolution of neutropenia		Oral Ciprofloxacin 500mg TWICE daily	High risk of <i>Clostridium difficile</i> infection - if diarrhoea develops consider stopping

Appendix 1: Drug Dosing in Renal Impairment:

<u>DRUG AND DOSE IN NORMAL RENAL FUNCTION</u>	<u>DOSE IN RENAL IMPAIRMENT</u>
IV Piperacillin/Tazobactam 4.5g FOUR times daily	<u>if CrCl = 20 to 40mls/min, reduce dose to 4.5g THREE times daily</u> <u>if CrCl ≤20ml/min, reduce dose to 4.5g TWICE daily</u>
IV Meropenem 1g THREE times daily	<u>if CrCl = 10 to 25mls/min, reduce dose to 1g BD</u> <u>if CrCl ≤10ml/min, reduce dose to 1g OD</u>
IV Ciprofloxacin 400mg TWICE daily	<u>if CrCl ≤10ml/min, reduce dose to 200mg TWICE daily</u>
IV Teicoplanin 12mg/kg	– see Guidelines for Use of Teicoplanin
IV Aciclovir 10mg/kg THREE times daily	If CrCl = 25 to 50mls/min, reduce dose to 10mg/kg TWICE daily If CrCl = 10 to 25ml/min, reduce dose 10mg/kg ONCE daily If CrCl < 10ml/min, reduce dose to 5mg/kg ONCE daily
IV Aciclovir 5mg/kg THREE times daily	If CrCl = 25 to 50mls/min, reduce dose to 5mg/kg TWICE daily If CrCl = 10 to 25ml/min, reduce dose 5mg/kg ONCE daily If CrCl < 10ml/min, reduce dose to 2.5mg/kg ONCE daily
Caspofungin	No dose adjustment is necessary in renal impairment
Anidulafungin	No dosage adjustment is necessary in renal or liver impairment

Fig 1. Flow chart for first and second line antimicrobial management of febrile neutropenic sepsis

