Antimicrobial Surgical Prophylaxis Policy, MP49 & Attachment A

Purpose: The antimicrobial surgical prophylaxis protocol establishes evidence-based standards for surgical prophylaxis at Nebraska Medicine. The protocol was adapted from the most recently published consensus guidelines from the American College of Surgeons (ACS), American Society of Health-System Pharmacists (ASHP), Society for Healthcare Epidemiology of America (SHEA), Infectious Disease Society of America (IDSA), Surgical Infection Society (SIS) and the Centers for Disease Control, then customized to Nebraska Medicine with the input of our Antimicrobial Stewardship Program in concert with the various surgical groups at the institution. The protocol established here-in will be implemented via standard order sets utilized within One Chart. Routine surgical prophylaxis and current and future surgical order sets are expected to conform to this guidance. **Click here** to jump to antibiotic recommendations for specific surgery types.

Antimicrobial Surgical Prophylaxis Initiation

- **Optimal timing**: Within 60 minutes before surgical incision
  - **Exceptions**: Fluoroquinolones and vancomycin (within 120 minutes before surgical incision)
- Successful prophylaxis necessitates that the antimicrobial agent achieves serum and tissue concentrations above the MIC for probable organisms associated with the specific procedure type at the time of incision as well as for the duration of the procedure.

Renal Dose Adjustment Guidance

The following table can be utilized to determine if adjustments are needed to antimicrobial surgical prophylaxis for both pre-op and post-op dosing.

Table 1: Renal Dosage Adjustment

Antimicrobial	Dosing Regimen with Normal Renal Function	Dosing Regimen with CrCl less than 50 ml/min	Dosing Regimen with CrCl less than 10 ml/min
Ampicillin/Sulbactam	3 g IV q6h	3 g IV q8h (CrCl 30-50) 3 g IV q12h (CrCl <30)	Only administer preop dose 3 g
Aztreonam	2 g IV q 8h	2 g IV q 12h (CrCl <30)	Only administer preop dose 2 g
Cefazolin <120 kg ≥120kg	 2 g IV q8h 3 g IV q8h	 2 g IV q12h 3 g IV q12h	 Only administer preop dose 2 g Only administer preop dose 3 g
Cefoxitin	2 g IV q6h	2 g IV q12h (CrCl <30)	Only administer preop dose 2 g
Clindamycin	900 mg IV 8h	900 mg IV 8h	900 mg IV 8h
Gentamicin □ *use actual body weight (ABW) unless the patient is > 20% over their ideal body weight (IBW), then use dosing body weight (DBW=IBW+[0.4(ABW)]*	Only administer preop dose 5mg/kg IV once	Only administer preop dose 5mg/kg IV once	Only administer preop dose **3mg/kg** IV once

Levofloxacin	500mg IV q24h	Only administer pre-op dose	Only administer pre-op dose
Metronidazole	500 mg IV q8h	500 mg IV q8h	500 mg IV q8h
Trimethoprim / Sulfamethoxazole	Trimethoprim component 160mg IV q12h	Only administer preop dose Trimethoprim 160mg	Only administer preop dose Trimethoprim 160mg
Vancomycin	15mg/kg IV q12h	Only administer preop dose (15mg/kg x 1)	Only administer preop dose (15mg/kg x 1)

¥ Dose adjustments based on renal dosage adjustments in antimicrobial guidebook

Patients Currently Receiving Antimicrobials:

Patients who are currently receiving therapeutic antimicrobials for infections remote to the site of surgery also need surgical prophylaxis to ensure adequate tissue levels at time of surgery. If the spectrum of the therapeutic regimen is appropriate for surgical prophylaxis based on the site of surgery then an additional dose should be given within 60 minutes before surgical incision. Therapeutic agents should be redosed per intra-operative redosing guidance (Table 2). Special attention must be paid to patients on dialysis or with renal failure who are receiving intermittent dosing of therapeutic antimicrobials such as vancomycin and aminoglycosides. Depending on recent doses and drug levels, an additional pre-operative dose may not be necessary. Questions regarding the need for an additional pre-operative dose of these agents should be discussed with the pharmacist.

Allergy to Beta-lactam Antibiotics

Beta-lactam antimicrobials, including cephalosporins, are the mainstay of surgical antimicrobial prophylaxis and are also the most commonly implicated drugs when allergic reactions occur. Cross-reactivity between penicillin and cephalosporins is rare and not usually a class effect, although reactions are more common amongst agents with similar side chains. Cefazolin does not share a similar side chain to any other beta-lactam and therefore can safely be administered to patients with most antibiotic allergies, unless there is a history of reaction to cefazolin. Additional allergy guidance can be found on the Clinical Pathways page of the Antimicrobial Stewardship website https://www.unmc.edu/intmed/divisions/id/asp/clinicalpath.html

Patients with antibiotic allergies should be carefully questioned about their history to determine whether a true allergy exists before selection of agents for prophylaxis. Alternatives to cephalosporins are based mainly on the antimicrobial activity profiles against predominant procedure-specific organisms and available clinical data. Refer to procedure-specific recommendations for patients with a severe beta-lactam allergy.

Severe allergy definition:

- Includes Ig-E mediated reactions (anaphylaxis, urticaria, bronchospasm, angioedema) and exfoliative dermatitis (Stevens-Johnson syndrome, toxic epidermal necrolysis)
- In the presence of antimicrobial allergies, guidance on alternatives are provided in the order sets
- These patients should generally not receive a beta-lactam from the same class for surgical prophylaxis

Non-severe allergy:

- Includes rash and other non-allergic reactions such as GI intolerance
- These patients can safely receive a beta-lactam for surgical prophylaxis

Intraoperative Antimicrobial Readministration Guidelines

In general, antimicrobials should be re-administered at intervals of 1-2 times the half-life of the drug to ensure adequate concentrations at incision closure. The following chart can be utilized to determine appropriate redosing intervals for antimicrobial surgical prophylaxis.

Note:

- Intraoperative redosing is needed to ensure adequate serum and tissue concentrations of the antimicrobial if the duration of the procedure exceeds two half-lives of the drug (see Table 2) or there is excessive blood loss during the procedure[1]
    - Excessive blood loss classified as >1500mL.
- Redosing interval should be measured from the time of administration of the preoperative dose, not from the beginning of the procedure[1]

- For patients with procedures expected to last greater than 8 hours, repeating interoperative doses after three half-lives or 1.5x the interval recommended in Table 2 should be considered.

Table 2 Intraoperative Redosing Guidance

Antimicrobial	Half-life with Normal Renal Function (h)	Half-life with End-stage Renal Disease (h)	Recommended Redosing Interval in Individuals with NORMAL Renal Function*
Ampicillin/sulbactam	0.8-1.3	unavailable	2 hours
Aztreonam	1.3-2.4	6-8	4 hours
Cefazolin	1.2-2.5	40-70	4 hours
Cefepime	2		4 hours
Cefoxitin	0.5-1.1	6.5-23	2 hours
Ceftriaxone	5.4-10.9		NA
Clindamycin	2-4	3-5	6 hours
Ertapenem	3-5		NA
Gentamicin	2-3	50-70	NA
Levofloxacin	6-8		NA
Meropenem	1-1.5		4 hours
Metronidazole	6-8	7-21; no change	8 hours
Piperacillin/tazobactam	0.7-1.2		2 hours
Trimethoprim/sulfamethoxazole	8-12	20-30	12 hours
Vancomycin	4-6	44.1-406.4	NA

*Recommended redosing intervals marked as “not applicable” (NA) are based on typical case length; for unusually long procedures, redosing may be needed

Alternative dosing strategy (ONLY if needed)

In the event that there is any issue with obtaining a precise and up-to-date weight through use of a scale, the following process should occur in order to prevent the delay of surgical start times.

If there is no documented weight for the current admission, the pharmacist will utilize last weight recorded in patient's inpatient or outpatient chart (if within last 3 months) and make note of the weight used for prophylaxis dose calculation in OneChart. If there is no weight for the current admission **and** no weight can be located in the patient's chart within the last 3 months, then the chart below shall direct dose entry for the surgical prophylaxis regimen.

<table>
<tr><th></th><th colspan="2">Pre-surgery</th><th>Post-surgery</th></tr>
<tr><th>Medication</th><th>No weight recorded in the chart or no recent* weight recorded in the chart</th><th>If urgent surgery necessary and the first option is not feasible</th><th></th></tr>
<tr><td>Cefazolin</td><td>Contact the nurse and ask to have the patient or patient's caregiver estimate his/her weight.
Give 2 grams for patients less than 120kg and give 3 grams for patients greater than or equal to 120kg. For those patients with a reported weight close to the weight cut-off, give 3 grams.</td><td>Use a flat dose of 2 g IV x 1.</td><td>Utilize updated weight for dosing</td></tr>
<tr><td>Gentamicin</td><td>Contact the nurse and ask to have the patient or patient's caregiver estimate his/her weight. Use the chart below to determine dose:
<table><tr><th>Weight Range (kg)</th><th>Dose</th></tr><tr><td>45 51</td><td>240</td></tr><tr><td>52 59</td><td>280</td></tr><tr><td>60 67</td><td>320</td></tr><tr><td>68 75</td><td>360</td></tr><tr><td>76 83</td><td>400</td></tr><tr><td>84 91</td><td>440</td></tr><tr><td>92 99</td><td>480</td></tr><tr><td>100 107</td><td>520</td></tr><tr><td>108 115</td><td>560</td></tr><tr><td>116 123</td><td>600</td></tr></table></td><td>Use flat dose of 300mg IV x 1 for those that are at least 50kg</td><td>No further doses needed for surgical prophylaxis indication</td></tr>
<tr><td>Vancomycin</td><td colspan="2">Contact the nurse and ask to have the patient or patient's caregiver estimate his/her weight.</td><td>Use flat dose of 1250mg IV x 1 for those patients who are at least 50kg</td><td>Utilize updated weight for dosing</td></tr>
</table>

**Recent is defined as within the past 3 months on an adult patient.*

Recommendations by Procedure: Prophylactic antibiotics should be discontinued at the end of the procedure, unless noted, as there is no evidence that antibiotic administration after incision closure decreases risk of surgical site infection for the vast majority of procedures. This recommendation is supported by numerous organizations including the CDC, WHO, Surgical Infection Society, Infectious Diseases Society of America, and the Society for Healthcare Epidemiology of America. Durations below account for preoperative AND postoperative dose administrations

Procedure	Recommendation
Cardiac: Pacemaker and cardiac device implants	□ cefazolin 2 g (3 g if greater than 120 kg) IV once Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV + vancomycin 15 mg/kg IV once Severe cephalosporin allergy: □ vancomycin 15 mg/kg IV once
Cardiac: Coronary artery bypass graft (CABG), CABG with valve implant, valve replacement, other cardiac procedures	□ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h + vancomycin 15 mg/kg IV q12h x 24h Severe cephalosporin allergy: □ vancomycin 15 mg/kg IV q12h x 24h + gentamicin 5 mg/kg IV once □ vancomycin 15 mg/kg IV q12h x 24h + levofloxacin 750 mg IV once
Cardiac: Ventricular Assist Device (LVAD/RVAD/BiVAD), Heart Transplant, or Total Artificial Heart	□ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 48h + vancomycin 15 mg/kg IV q12h X 48h Severe cephalosporin allergy: □ vancomycin 15 mg/kg IV q12h x 48h + levofloxacin 750 mg IV q24h X 48h
Kidney Transplant **Kidney Pancreas Transplant** **Living Donor Nephrectomy**	□ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h Severe cephalosporin allergy: □ Clindamycin 900 mg IV q8h + aztreonam 2 g q8h x 24h □ cefoxitin 2 g (3 g if greater than 120 kg) IV q6h x 24h Severe cephalosporin allergy: □ Clindamycin 900 mg IV q8h + aztreonam 2 g q8h x 24h □ cefazolin 2 g (3 g if greater than 120 kg) IV once Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV + vancomycin 15 mg/kg IV once Severe cephalosporin allergy: □ vancomycin 15 mg/kg IV once

Liver, Small Bowel Transplant Low-risk: Liver transplant not meeting criteria for high-risk below High-risk: Retransplant, patient requiring dialysis pretransplant, surgical choledochojejunostomyany or any small bowel transplant	Ampicillin-sulbactam 3g q6h x24h Penicillin Allergy: vancomycin 15mg/kg IV q12h + aztreonam 2 g IV q8h x 24 h Piperacillin-tazobactam 4.5g IV q 8h x24h +/- Fluconazole 200 mg IV q 24h Consult Transplant ID for more complicated situations. Penicillin Allergy: vancomycin 15mg/kg IV q12h + aztreonam 2 g IV q8h x 24 h
Lung Transplant	Vancomycin 15mg/kg IV q12h (pharmacy to dose) OR linezolid 600mg q12h x 7 days + cefepime 1g q 6h, piperacillin-tazobactam 4.5g q8h, OR meropenem 500mg q6h x 7 days, OR For Severe beta-lactam allergy: Aztreonam 2g q8h Add Tobramycin 5mg/kg q24h for patients with risk of multidrug resistant Gram negative organisms Consult Transplant ID for more complicated situations
Orthopedic: Clean procedures of hand, knee, and foot Internal fixation of fracture, total joint replacement, any implanted foreign body For open fractures see guidance document on antimicrobial stewardship website and associated order set	□ No prophylaxis indicated □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h** Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h + vancomycin 15 mg/kg IV q12h X 24h** Severe cephalosporin allergy: □ Vancomycin 15 mg/kg IV q12h x 24h** □ Clindamycin 900 mg IV X 24h** **initial infusion should be completed before tourniquet is inflated if used
Neurosurgery:	□ cefazolin 2 g (3 g if greater than 120 kg) IV once Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV + vancomycin 15 mg/kg IV once Severe cephalosporin allergy:

Craniotomy Complex craniotomy or placement of prosthetic material (shunts, intrathecal pumps, deep-brain stimulators, etc.)	□ Vancomycin 15 mg/kg IV once □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h <u>Known MRSA colonization</u>: □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h + vancomycin 15 mg/kg IV q12h x 24h <u>Severe cephalosporin allergy:</u> □ Vancomycin 15 mg/kg IV q12h x 24h
Spinal Procedures: Simple (laminectomy, discectomy) Complicated procedures or placement of prosthetic material (spinal fusion)	□ cefazolin 2 g (3 g if greater than 120 kg) IV once <u>Known MRSA colonization</u>: □ cefazolin 2 g (3 g if greater than 120 kg) IV once + vancomycin 15 mg/kg IV once <u>Severe cephalosporin allergy:</u> □ Vancomycin 15 mg/kg IV q12h once □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h <u>Known MRSA colonization</u>: □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h + vancomycin 15 mg/kg IV q12h x 24h <u>Severe cephalosporin allergy:</u> □ Vancomycin 15 mg/kg IV q12h x 24h
Thoracic: Non-cardiac	□ cefazolin 2 g (3 g if greater than 120 kg) IV once <u>Known MRSA colonization</u>: □ cefazolin 2 g (3 g if greater than 120 kg) IV once + vancomycin 15 mg/kg IV once <u>Severe cephalosporin allergy:</u> □ Vancomycin 15 mg/kg IV once
Vascular: brachiocephalic procedures without prosthetic material, angiogram, vascular stenting, thrombolysis, IVC filter and CVC placement Amputation (lower extremity for ischemia), arterial surgery, graft placement or repair	□ None □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h <u>Known MRSA colonization</u>: □ cefazolin 2 g (3 g if greater than 120 kg) IV q8h x 24h + vancomycin 15 mg/kg IV q12h X 24h <u>Severe cephalosporin allergy:</u> Vancomycin 15 mg/kg IV q12h x 24h + gentamicin 5 mg/kg IV once

Abdominal: Biliary procedures including high risk laparoscopic cholecystectomy, small bowel surgery, uncomplicated appendicitis, colorectal surgery	□ cefoxitin 2 g IV once Severe cephalosporin allergy: □ Levofloxacin 500 mg IV once + Metronidazole 500 mg IV once
Gastroduodenal: PEG placement, bariatric procedures, gastroduodenal procedures	□ cefazolin 2 g (3 g if greater than 120 kg) IV once Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV once + vancomycin 15 mg/kg IV once Severe cephalosporin allergy: □ Vancomycin 15 mg/kg IV once OR □ Clindamycin 900 mg IV + gentamicin 5 mg/kg IV once

General: any implanted foreign body (e.g. hernia patch)	□ cefazolin 2 g (3 g if greater than 120 kg) IV once Known MRSA colonization: □ cefazolin 2 g (3 g if greater than 120 kg) IV once + vancomycin 15 mg/kg IV once Severe beta-lactam cephalosporin allergy: Vancomycin 15 mg/kg IV once
Gynecological: hysterectomy (abdominal, vaginal, or laparoscopic), oncologic procedures not entering the bowel (procedures which involve resection of bowel should use "abdominal")	□ cefazolin 2 g (3 g if greater than 120 kg) IV once Severe beta-lactam cephalosporin allergy: □ clindamycin 900 mg IV + gentamicin 5 mg/kg once
Suction D and C	□ doxycycline 100 mg IV once and 200 mg orally 2 hours after procedure
Urogynecologic procedures	□ clindamycin 900 mg IV + gentamicin 5 mg/kg once
Cesarean section [antibiotics should be administered as for other procedures (within 60 minutes prior to incision); *before* cord clamping]	□ cefazolin 2 g (3 g if greater than 120 kg) IV once □ add azithromycin 500mg for non-elective C-section **only** Severe cephalosporin allergy: □ clindamycin 900 mg IV + gentamicin 5 mg/kg once □ add azithromycin 500mg for non-elective C-section **only**
Head and Neck: Clean procedures (thyroidectomy, etc.)	□ None
Clean with prosthesis placement (neck dissections, parotidectomy)	□ cefazolin 2 g (3 g if greater than 120 kg) IV once Severe cephalosporin allergy: □ clindamycin 900 mg IV once
Clean-contaminated procedures	□ cefazolin 2 g (3 g if greater than 120 kg) IV q8h + metronidazole 500 mg IV q8h x24h (5d acceptable for free flap procedures) □ Ampicillin/sulbactam 3g IV q6h x 24h

(oropharyngeal mucosa is compromised) Skull base with dural resection	Severe beta-lactam/cephalosporin allergy: □ Clindamycin 900 mg IV q8h x 24h (5d acceptable for free flap procedures) □ Ceftriaxone 2 g IV q12h + metronidazole 500 mg IV q8h x24h Known MRSA colonization: □ Ceftriaxone 2 g IV q12h + metronidazole 500 mg IV q8h + vancomycin 15 mg/kg IV q12h x 24h Severe cephalosporin allergy: □ Aztreonam 2 g IV q8h + metronidazole 500 mg IV q8h + vancomycin 15 mg/kg IV q12h x 24h
Urologic: Cystoscopy with risk factors for infection or significant manipulation (biopsy, resection, dilation, stent placement, lithotripsy) Trans-rectal Prostate Biopsy	□ Levofloxacin 500 mg PO/IV once □ Ceftriaxone 1g IV once Severe cephalosporin allergy: □ Levofloxacin 500 mg PO/IV once

References:

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2. Ban KA, Minei JP, Laronga C, et al. American College of Surgeons and Surgical Infection Society: Surgical Site Infection Guidelines, 2016 Update. J Am College Surgeons. 2017; 244(1):59-74. *DOI:*10.1016/j.jamcollsurg.2016.10.029
3. Berrios-Torres SI, Umscheid CA, Bratzler DW, et al. Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection, 2017. JAMA Surg. 2017;152:784-791 https://www.cdc.gov/infection-control/hcp/surgical-site-infection/index.html
4. Lexicomp. Wolters Kluwer Health. 2024.

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