



Queensland  
Government

## Peritoneal Dialysis Peritonitis Clinical Pathway

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

Clinical pathways never replace clinical judgement.  
 Care outlined in this pathway **must be varied** if it not clinically appropriate for the individual patient.

**This form is to assess patients on peritoneal dialysis (PD) who present with any of the following symptoms (tick as appropriate)**  
 Cloudy effluent  Abdominal pain  Febrile  Systemically unwell **\*Concern for sepsis – escalate as per sepsis pathway**

Assessment	Completed	Initial Time (24hr)	Date
• Clinically assess the patient and check allergies	<input type="checkbox"/>		
• Collect sterile samples of PD effluent fluid to ensure timely culture for analysis after a dwell time of at least 2 hours » One anaerobic (orange top) and one aerobic (green top) blood culture bottles » Three sterile yellow top containers to total of 150mL » 5mL EDTA collection tube (purple top)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
• Store specimens at room temperature and send to microbiology with request: Sterile fluid culture + fluid in culture medium for M/C/S, WCC and differential Body site: Peritoneal dialysis fluid	<input type="checkbox"/>		
• If body temperature above 38°C – collect blood cultures from 2 different body sites	<input type="checkbox"/>		
• Inspect PD catheter exit site – swab site if signs of infection	<input type="checkbox"/>		
• Commence immediate empiric treatment using table below	<input type="checkbox"/>		
• Admit/transfer patient if any of the following (tick as appropriate) <input type="checkbox"/> Fever <b>OR</b> <input type="checkbox"/> Significant pain <b>OR</b> <input type="checkbox"/> Unable to perform own dialysis	<input type="checkbox"/>		
• Contact the Nephrologist of Peritoneal Dialysis unit covering the patient as soon as possible at the time of presentation	<input type="checkbox"/>		

**Immediate Empiric Treatment**

- Intraperitoneal (IP) administration is preferred route to expedite direct contact with peritoneal membrane as per ISPD guidelines. Negates need for IV access and allows for training of patients and/or their carer
- Antibiotic name, dose and frequency must be added to the patient's medication chart to be a valid prescription
- Dwell time for PD dialysate fluid bag containing antibiotics must be at least 6 hours
- Continue automated peritoneal dialysis (APD) if clinically appropriate
- For APD with no last fill – instil IP antibiotics/antimicrobial in 1000mL dialysate fluid (minimum of 200mL)

Indication	Drug	Dose	Route	Frequency	Comments
Empiric regime	Cefazolin	15mg/kg	IP	In ONE PD dialysate fluid bag every 24 hours	
	Gentamicin	0.6 mg/kg up to 50mg	IP	In ONE PD dialysate fluid bag every 24 hours	Once causative bacteria identified and sensitivity confirmed – prompt switch from empirical gentamicin is recommended to minimise risk of ototoxicity
Known/suspected MRSA or cephalosporin hypersensitivity	Vancomycin				30mg/kg up to 2 grams
*Gentamicin may be administered in the same bag as Vancomycin and Cefazolin without loss of bioactivity					
Antifungal prophylaxis – nystatin hypersensitivity	Nystatin	500,000 international units	PO	4 times per day	Commence with any/all antibiotic therapy for duration of that therapy
	Fluconazole tablets	200mg	PO	Every 48 hours	Ensure thorough drug interaction check before commencing Fluconazole
Optional	Heparin	500units/L	IP	Every PD exchange	If drained bags contain fibrin or clots – instil heparin into new PD fluid bag

**NB:** See page 13 for • Special precautions • Antibiotic Stability • Dose calculation

**Signature Log** To be completed by all staff who initial this pathway

Print name	Designation	Signature	Initials	Date	Print name	Designation	Signature	Initials	Date

DO NOT WRITE IN THIS BINDING MARGIN

v5.01 - 02/2025  
 WINC Code: 1NY33060



SW203

PERITONEAL DIALYSIS PERITONITIS CLINICAL PATHWAY



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## Immediate treatment for suspected PD peritonitis

### 0–6 hours

- Start intraperitoneal antibiotics as soon as possible
- Allow to dwell for at least 6 hours
- Ensure gram-positive and gram-negative coverage
- **Continue usual PD regimen adding culture specific antibiotics to long dwell**

Review WCC and differential as soon as available  
(culture to follow)

- If PD effluent fluid WCC above **100 x 10<sup>6</sup>/L** of which **50%** are neutrophils (PMN)

**Diagnosis of peritonitis is made**

### 6–8 hours

**OR**

**When results available for remote areas**  
(can take 3–5 days)

- Determine and prescribe ongoing antibiotic treatment
- Ensure follow-up arrangements are clear or patient admitted
- Review sensitivity results

## Treatment following culture results

**Antibiotic regimen depends on the results of the culture. Follow the links below to locate the correct regimen.**

*Antibiotic dosing – see appendix 2*

Culture negative on day 1 and 2      **Plan 1**    Go to page 3

*Staphylococcus aureus*      **Plan 2**    Go to page 4

*Streptococcus*      **Plan 3**    Go to page 5

Other gram-positive organism including coagulase negative *Staphylococcus* on culture      **Plan 4**    Go to page 6

*Enterococcus*      **Plan 5**    Go to page 7

Enteric gram-negative bacteria      **Plan 6**    Go to page 8

Environmental and other gram-negative bacteria      **Plan 7**    Go to page 9

*Pseudomonas spp.*      **Plan 8**    Go to page 10

Polymicrobial organisms      **Plan 9**    Go to page 11

Fungal organism      **Plan 10**    Go to page 12

### **Surgically remove PD catheter IF:**

- Gram stain shows fungal elements
- Exit site infection with the same organism

**Patient re-education after successful peritonitis treatment**

If patient remains unwell may need to be transferred to another facility

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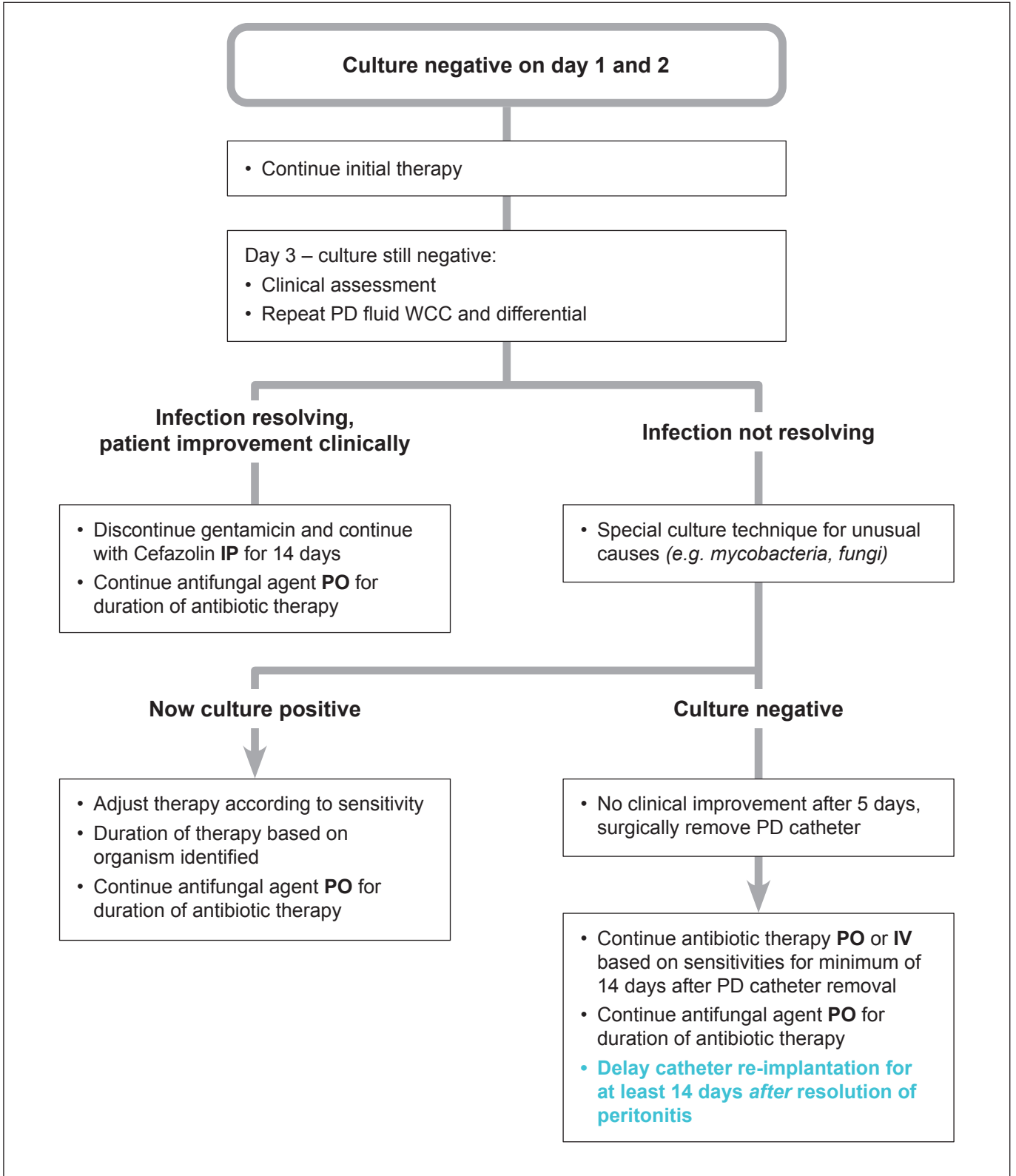
Sex:  M  F  I

Route of administration: Intrapertoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 1

Medical Officer (print name):	Designation:	Signature:	Date:
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Route of administration: Intra-peritoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 2

Medical Officer (print name):

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Date:

### *Staphylococcus aureus* on culture

- Continue gram-positive coverage **IP** based on sensitivities
- Stop gram-negative coverage (gentamicin)
- Assess exit site

- If methicillin resistant (MRSA) change to Vancomycin **IP**

- Assess clinical improvement:
  - » review symptoms
  - » review PD effluent
- Repeat dialysis effluent cell count and culture at day 3

#### Clinical improvement

- Symptoms resolved
- PD effluent clear

- Continue **IP** antibiotics based on sensitivities for minimum 21 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

#### No clinical improvements by 5 days on appropriate antibiotics

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on antibiotic therapy **PO** or **IV** based on sensitivities for minimum of 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy
- Delay catheter re-implantation for at least 14 days after resolution of peritonitis

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## Plan of Care 3

Medical Officer (print name):

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### Streptococcus on culture

- Continue Cefazolin **IP**
- Stop gram-negative coverage (gentamicin)
- Assess exit site

- If resistant or allergic to penicillin/cephalosporin:
- Change cefazolin to Vancomycin **IP**

- Assess clinical improvement:
  - » review symptoms
  - » review PD effluent
- Repeat dialysis effluent cell count and culture at day 3

#### Clinical improvement

- Symptoms resolved
- PD effluent clear

- Continue **IP** antibiotics based on sensitivities for minimum 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

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Route of administration: Intra-peritoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 4

Medical Officer (print name):

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### Other gram-positive organisms including coagulase-negative *Staphylococcus* on culture

- Continue gram-positive coverage **IP** - cefazolin (if flucloxacillin sensitive) OR vancomycin
- Stop gram-negative coverage (gentamicin)
- Assess exit site
- Review PD exchange technique – assess and re-educate

- Assess clinical improvement:
  - » review symptoms
  - » review PD effluent
- Repeat dialysis effluent cell count and culture at day 3

#### Clinical improvement

- Symptoms resolved
- PD effluent clear

- Continue **IP** antibiotics based on sensitivities for minimum 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

#### No clinical improvements by 5 days on appropriate antibiotics

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on antibiotic therapy **PO** or **IV** based on sensitivities for minimum of 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy
- **Delay catheter re-implantation for at least 14 days after resolution of peritonitis**

- **NB:** High risk of refractory and repeat peritonitis. Repeat coagulase-negative staph infections suggest colonisation of the PD catheter with biofilm – advise surgical removal of PD catheter
- **When PD effluent becomes clear and culture becomes negative – Consider simultaneous PD catheter removal and re-insertion of a new catheter as a single procedure ie ‘flip-flop’ under antibiotic coverage**

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Route of administration: Intraperitoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 5

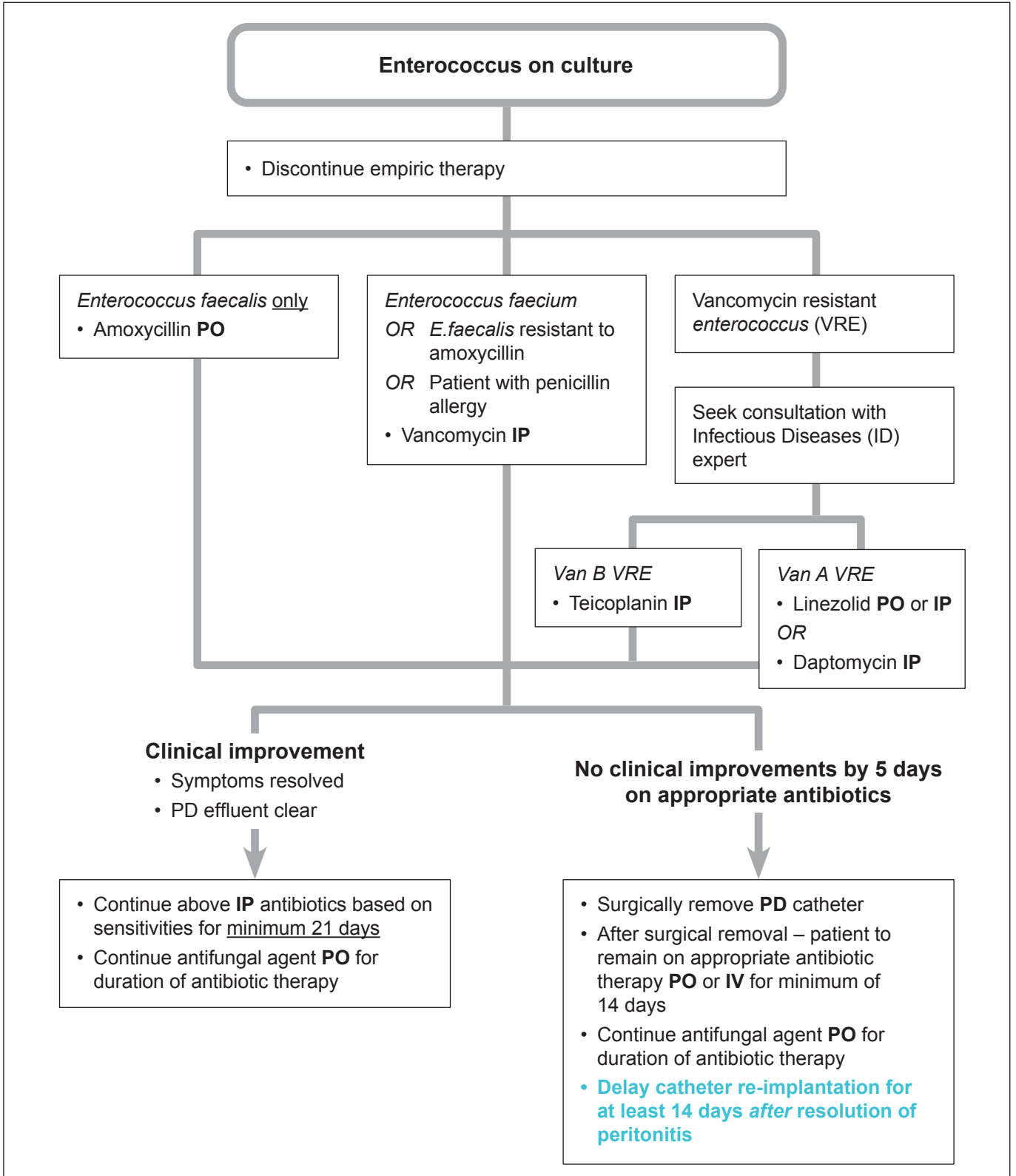
Medical Officer (print name):

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Route of administration: Intrapertoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 6

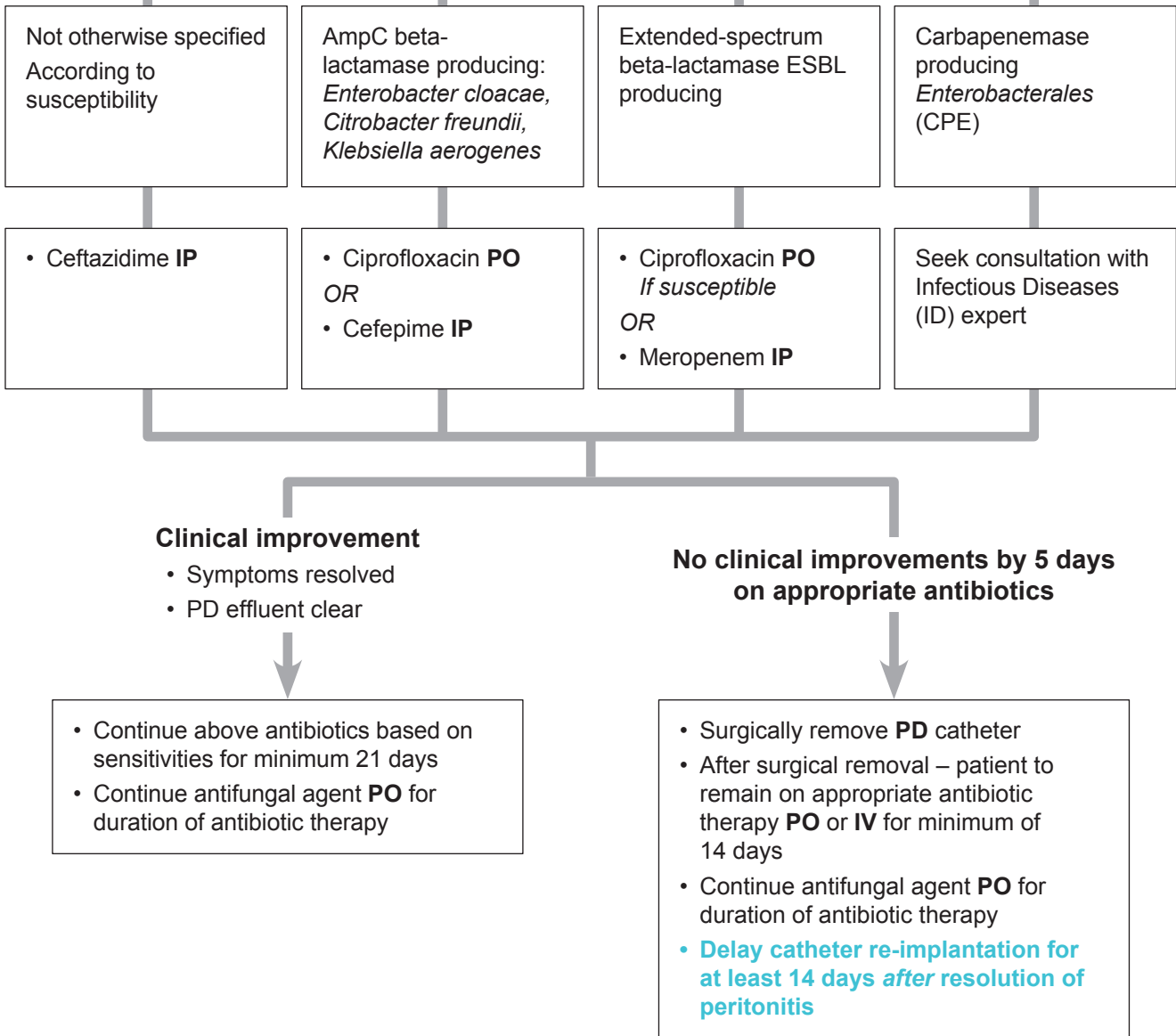
Medical Officer (print name):

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### Enteric gram-negative bacteria



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Route of administration: Intraperitoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 7

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### Environmental and other gram-negative bacteria

*Pseudomonas*  
(Refer to plan 8, next page)

*Acinetobacter* species

*Stenotrophomonas* species

- Ciprofloxacin **PO**
- OR
- Trimethoprim/Sulfamethoxazole **PO**
- OR
- Meropenem **IP**

- Seek advice from Infectious Diseases (ID) and commence **DUAL therapy**
- Trimethoprim/Sulfamethoxazole **PO PLUS**
  - Moxifloxacin **PO** OR
  - Minocycline **PO** as advised by Infectious Diseases (ID)

- Continue above **IP** antibiotics for minimum 21 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

**No clinical improvements by 3 days on appropriate antibiotics**

- Repeat dialysis effluent cell count and culture

Assess clinical improvement:

- Symptoms resolved
- PD effluent bags are clear
- BUT** persistent exit site infection

- Consider surgical salvage:
  - » surgical procedure to shave superficial cuff
  - » simultaneous removal and reinsertion of new catheter 'flip-flop'
- Assess/review exit site twice weekly

**No clinical improvements by 5 days on appropriate antibiotics**

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on appropriate antibiotic therapy **PO** or **IV** for minimum of 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy
- **Delay catheter re-implantation for at least 14 days after resolution of peritonitis**

**Refractory exit site infection**

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Route of administration: Intra-peritoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 8

Medical Officer (print name):

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### *Pseudomonas aeruginosa*

#### Without PD catheter infection (exit site/tunnel)

Dual therapy as guided by sensitivities. Use 2 antibiotics with different modes of action; e.g.:

- Ceftazidime **IP** or Cefepime **IP**

**PLUS**

- Ciprofloxacin **PO**

**NB. Discuss with Infectious Diseases (ID) expert:**

- Use of gentamicin or tobramycin after 3 days
- 'I' sensitivity (i.e. increased exposure – high likelihood of therapeutic success with increased/adjusted dosing regimen)

- Continue antibiotics **IP** based on sensitivities for minimum of 21 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

- Assess clinical improvement:
  - » review symptoms
  - » review PD effluent
- Repeat dialysis effluent cell count and culture at day 3 and day 5

#### With PD catheter infection (exit site/tunnel)

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on appropriate antibiotic therapy **PO** or **IV** for minimum of 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy
- **Delay catheter re-implantation for at least 14 days after resolution of peritonitis**

**Pseudomonas species are associated with the highest rate of biofilm production**

#### Clinical improvement

- Continue antibiotics **IP** based on sensitivities for minimum of 21 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

#### Peritonitis resolves but exit site/tunnel infection

- Consider surgical salvage:
  - » surgical procedure to shave superficial cuff
  - » simultaneous removal and reinsertion of new catheter 'flip-flop'
- Assess/review exit site twice weekly

#### Refractory exit site infection

#### No clinical improvements by day 5 on appropriate antibiotics

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on appropriate antibiotic therapy **PO** or **IV** for minimum of 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy
- **Delay catheter re-implantation for at least 14 days after resolution of peritonitis**

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Route of administration: Intrapertoneal IP Per Or

## Plan of Care 9

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### Polymicrobial peritonitis

Multiple gram-negative organisms or mixed gram-negative/gram-positive

- Consider gastro-intestinal (GI) pathology

- Change therapy to Metronidazole **PO** AND Ceftazidime **IP**

#### Urgent surgical assessment

If laparotomy indicates intra-abdominal pathology/abscess:

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on appropriate antibiotic therapy **PO** or **IV** for minimum of 21 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

Multiple gram-positive organisms

- Consider touch contamination
- Consider **PD** catheter infection/infiltration

- Continue antibiotic therapy based on sensitivities for minimum of 21 days

- Assess clinical improvement:
  - » review symptoms
  - » review **PD** effluent
- Repeat dialysis effluent cell count and culture at day 3 and day 5

Without exit site or tunnel infection

- Continue antibiotics for minimum of 21 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

With exit site or tunnel infection

- Surgically remove **PD** catheter
- After surgical removal – patient to remain on appropriate antibiotic therapy **PO** or **IV** for minimum of 14 days
- Continue antifungal agent **PO** for duration of antibiotic therapy

**Prolonged treatment with gentamicin/tobramycin should be avoided and treatment greater than 3 days should only proceed following direct advice from nephrologist or Infectious Diseases (ID) expert.**



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Route of administration: Intra-peritoneal **IP** Per Oral **PO** Intravenous **IV**

## Plan of Care 10

Medical Officer (print name):

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### Fungal organism on culture

- Surgically removal PD catheter immediately
- Seek consultation with Infectious Diseases (ID)
- Cease prophylactic antifungal therapy (nystatin)

Yeast  
*Candida* species

Mould  
Follow advice from Infectious Diseases (ID) expert

Fluconazole resistant species –  
*Candida glabrata*

Aspergillus species

Mucoromycetes

- Fluconazole **PO**

- Echinocandins **IV**  
OR
- Voriconazole **PO**

- Voriconazole **PO**

- Amphotericin B **IV**  
OR
- Posaconazole **PO**

- Continue above antibiotics based on sensitivities for minimum 14 days

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**High mortality rate associated with fungal peritonitis.**  
**Early removal of catheter associated with improved mortality and latent return to PD therapy.**  
**High biofilm production associated with fungal peritonitis.**

## Appendix 1: Special Precautions and Instructions

### Nursing Administration

- Antibiotic name, dose and frequency must be added to the patient's medication chart to be a valid prescription.
- Registered nursing staff are responsible for maintaining aseptic technique when adding antibiotics to each PD dialysate solution adhering to the National Safety and Quality Health Service (NSQHS) standards for medication safety.
- Registered nurses are responsible for the dedicated training of patients and/or carers in adding antibiotics to the PD dialysate using aseptic technique.
- Dwell time for PD dialysate fluid bag containing antibiotic must be at least 6 hours.
- Continue APD if clinically appropriate.
- For APD with no last fill, ISPD guidelines recommend a daytime fill of 1000mL dialysate fluid for administration of IP antibiotics. Caution is advised to monitor for PD fluid retention/absorption.

### Gentamicin 0.6mg/kg to 50mg maximum dose

- Gentamicin may be administered in the same bag as vancomycin or cefazolin without loss of bioactivity.
- Gentamicin serum levels are considered controversial as per ISPD guidelines.
- Use of gentamicin for prolonged periods should be avoided.
- Gentamicin treatment greater than 3 days should only proceed following direct advice from the nephrologist or Infectious Diseases (ID) expert.
- ISPD 2022 recommend adjunct administration of oral N-acetylcysteine (NAC) 600mg 12th hourly for prolonged use of gentamicin and vancomycin to reduce the risk of ototoxicity (ISPD, 2022.pg 125).

### Sterility

- The sterility of PD bags to which antibiotics have been added cannot be guaranteed unless prepared following specific processes in a sterile environment – *not routinely available outside compounding pharmacies.*
- Risk of secondary infection from microbial contamination of bags increases with the time from production, and the temperature of storage.
- Local processes that consider both sterility and stability should be followed when adding antibiotics to PD dialysate bags more than 24 hours in advance of the intended date of use.

### Antibiotic Stability in Peritoneal Dialysate Solution

**NB:** Health services are advised to consider the sterility and stability of preloaded peritoneal dialysate solution bags and the ability of patients to store large volumes within the temperature ranges advised below. Practical volumes limited to 2–3 days maximum supply are recommended.

Antibiotic	Dextrose-based solution		Icodextrin-based solution		Adding Heparin
	Room temp (4–25°C)	Refrigerated	Room temp (4–25°C)	Refrigerated	
Vancomycin	28 days	No data	14 days	14 days	No data
Gentamicin	14 days	14 days	7 days	14 days	No change
Cefazolin	8 days	14 days	7 days	14 days	No change
Cefepime	14 days	14 days	No data	No data	No data
Ceftazidime	4 days	7 days	2 days	14 days	No data
Piperacillin/Tazobactam	No data	7 days	No data	No data	No change

### Compatibility in Icodextrin-Containing Dialysis Solution

- Compatible with vancomycin, cefazolin, gentamicin, ampicillin, and amoxicillin.
- Exercise caution when prescribing amoxicillin, cefepime, and ceftazidime due to varying stability.

### Dose Calculation

- Treatment dose prescribed in mg per kg
  - » use patient weight on presentation to calculate dose per bag

### Preparation of Intraperitoneal medication

- Consider volume of dwell solution (e.g. dose ordered 1g in fill volume of 1500mL to be injected into a 2,500mL dialysate bag)
  - » calculate 1,000 divided by 1,500, then multiply by 2,500 = 1.666g (rounded up to 1.7g) per bag
- If no last fill - instil intraperitoneal (IP) antibiotics/antimicrobials in a minimum of 200mL dialysate

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## Appendix 2: Antibiotic Dosing Recommendations

Dwell time for PD dialysate fluid bag containing antibiotic must be at least 6 hours.

### Antibiotic Dosing Recommendations for Continuous Ambulatory Peritoneal Dialysis (CAPD)

Antibiotic type		Intraperitoneal IP dose	Systemic dosing when IP not suitable Oral PO OR Intravenously IV
Aminoglycosides	Amikacin	2mg/kg IP daily	
	Gentamicin	0.6mg/kg IP daily, maximum 50mg	
	Tobramycin	0.6mg/kg IP daily	
Cephalosporins	Cefazolin	15mg/kg IP daily	
	Cefepime	1g IP daily	
	Ceftazidime	1g–1.5g IP daily long dwell 20mg/kg IP daily short dwell	
	Cefotaxime	500mg–1g IP daily	
	Ceftriaxone	1g IP daily	
Penicillins	Amoxicillin		500mg PO 8th hourly
	Amoxicillin clavulanate		500mg/125mg PO 12th hourly OR 875mg/125mg PO 12th hourly
	Benzylpenicillin	No data	
Quinolones	Ciprofloxacin	500mg PO daily OR 750mg PO daily for patients for >90kg OR if organism is "I" or for <i>Pseudomonas spp.</i>	
	<b>Caution: Avoid co-administration with antacids or phosphate binders</b>		
Others	Aztreonam	2g daily	
	Daptomycin	300mg IP daily	4–6 mg/kg IV 48 hourly
	Linezolid		2 doses at 600mg 12th hourly PO OR 2 doses at 600mg IV 48 hourly; then 300mg 12th hourly
	Meropenem	1g IP daily	1gram IV daily
	Teicoplanin	15mg/Litre IP every 5 days	
	Trimethoprim/Sulfamethoxazole		160mg/800mg PO 12th hourly
	Vancomycin	15mg/kg IP every 5–7 days	<b>NB:</b> check serum levels
Antifungals	Nystatin	Empiric prophylaxis	500,000 international units PO 6th hourly
	Fluconazole	<b>Seek advice from Infectious Diseases (ID)</b>	400mg stat PO then 200mg daily
	Voriconazole		2 doses at 6mg/kg PO 12th hourly; then 4mg/kg 12th hourly

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### Intermittent Dosing of Antibiotics in Automated Peritoneal Dialysis (APD)

Drug	Intraperitoneal (IP) dose into last fill or daytime dwell
Cefazolin	15mg/kg IP daily
Cefepime	1g IP in one exchange daily – No data on stability in Icodextrin
Meropenem	500mg IP in one exchange daily
Tobramycin	1.5mg/kg in long dwell once then 0.5mg/kg IP daily
Vancomycin	15mg/kg IP in long dwell every 4 days. Check serum trough levels every 3 days – aim to keep serum trough levels above 15mg/L

**Acknowledgement:** International Society for Peritoneal Dialysis (ISPD).

- Li, P.K., Chow, K.M., Cho, Y., Fan, S., Figueiredo, A.E., Harris, T., Kanjanabuch, T., Kim, Y.-L., Madero, M., Malyszko, J., Mehrotra, R., Okpechi, I.G., Perl, J., Piraino, B., Runnegar, N., Teitelbaum, I., Wong, J.K.-W., Yu, X., & Johnson, D. W. (2022). ISPD peritonitis guideline recommendations:2022 update on prevention and treatment *Peritoneal Dialysis International*, 2022. 42(2) 110-153. <https://doi.org/10.1177/089686082211080586>
- Chow, K.M., Li, P.K., Cho, Y., Abu-Alfa, A., Bavanandan, S., Brown, E.A., Cullis, B., Edwards, D., Ethier, I., Hurst, H., Ito, Y., de Moraes, T.P., Morelle, J., Runnegar, N., Saxena, A., So, S.W., Tian, N., Johnson, D.W. (2023). ISPD Catheter-Related Infection Recommendations: 2023 Update. *Peritoneal dialysis International*, 0(0), 1-19. <https://doi.org/10.1177/08968608231172740>
- A/Prof. Cho, Y., Prof. Johnson, D.W., Dr. Runnegar, N., Dr. Garnham, K., Dr. Wilks, K., Lloyd, J., Rankine, J., Scuderi, C. & Lawrence McCabe, S. Queensland Health.