

**Session Summary**

January 29, 2019

**The Joint Commission is taking comments on requirements for AS in ambulatory care:** https://www.jointcommission.org/antimicrobial\_stewardship\_%E2%80%93\_ambulatory\_health\_care\_ahc/

**Didactic:** Clinical Microbiology for the Non-microbiologist (“Pro-tips from a Non-microbiologist”)

Speaker: Rupali Jain, PharmD

Key Points:

?s: Is my patient’s illness due to a microbe? What is it? What is it susceptible to?

Blood cultures

A “set” is composed of an aerobic bottle and an anaerobic bottle. If anything grows, the bacteria is plated and then undergoes a variety of tests to identify.

Sometimes blood cultures are false positives due to common skin flora (eg. Coag-negative staph). *Staph aureus* does not fall into this category!

When susceptibilities return, look at the Rs and Ss. These are the best guide to what you can use. Some labs suppress some results, so if ?s, check with your lab for other data.

Not all labs report Minimum Inhibitory Concentrations (MICs) for with susceptibilities. Important to recognize that the susceptibility of an organism is based on a specific drug and a specific bug, so you cannot compare MICs between drugs or bugs to determine what is the “best” antimicrobial. Beyond Rs and Ss, there is also an “S-DD” designation. This indicates Susceptible-Dose Dependent, meaning the organism, based on the MIC, is susceptible to a higher dose of the drug.

There are also some MIC breakpoints (the level of drug that conveys susceptibility) that vary depending on source. Best example is *Strep pneumo*  and breakpoints used for CNS vs other body sites. This is due to penetration of the drug into the CNS.

* If not already, make friends with the lab team
* MIC ranges reflect serum concentrations, but focus on the source of the infection
* MICs are most useful for MDR or closed site infections

**Case Discussion:**

Lincoln Hospital

Case: 66 yo man with DM and bilateral foot infections involving bone s/p debridement. Deep cultures with E. coli, Staph epi (MRSE) and enterococcus.

Plan is for moxifloxacin + daptomycin. Question dapto dosing.

* Use actual body weight (this pt 111kg)
* FDA dosing 4-6 mg/kg, but for most serious infections ID uses 8-12 mg/kg
* Monitor CPK weekly
* Given osteomyelitis, ~6 week course if all goes well

Columbia Basin Hospital

Case #1: Wound culture guidelines?

* Tissue is always best
* Swabs sort of acceptable, but only from deep spaces
* Swabs have 0.05 ml and basic micro labs end up having to split that tiny amount to multiple plates
* OK to clean a wound with water or saline prior to deep swab

Case #2: Protocols for newborn sepsis

* Please see Reference SCH protocols for newborns
* For this specific case, for a baby who is clinically stable/well and has negative cultures at 48-36 hours from all recommended sites, discontinuing abx is recommended

References:

SCH Neonatal Fever Pathway: https://www.seattlechildrens.org/pdf/neonatal-fever-pathway.pdf

Thanks! The UW TASP Team