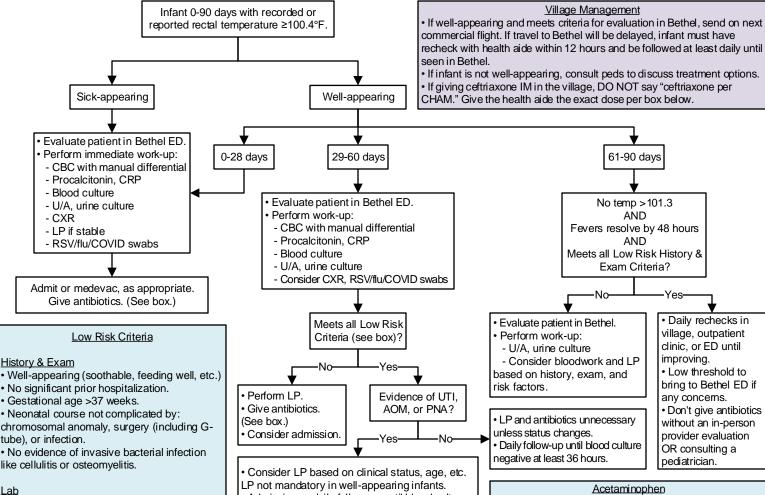
Yukon-Kuskokwim **HEALTH CORPORATION**

Clinical Guideline

Fever ≥ 100.4°F in Infants 0-90 Days



CSF

Absolute neutrophil count (ANC) 1000-4000

• Procalcitonin < 0.5

• CRP <2

- Do Multiplex PCR if any suspicion for meningitis.
- · See Harriet Lane (not the results in RAVEN) for normal results by day of life.
- If concerned for bacterial meningitis, consult pediatrics and strongly consider medevac.
- Do not use correction formulas for traumatic LPs.

- · Admission or daily follow-up until blood culture negative at least 36 hours.
- · If UTI, treat empirically with cephalexin or ceftriaxone, pending speciation of culture.
- If AOM or PNA, use clinical judgment to decide on antibiotic treatment (oral or parenteral).

NOTE: If 22-28 days old and well-appearing with low-risk lab criteria, recent studies allow deferral of LP if admitted ± antibiotics. Discuss with

pediatrician and family if considering this option.

- Acetaminophen should NOT be given prior to vaccines, as there is some evidence it blunts the immune response.
- Acetaminophen should NOT be given around-the-clock in this age group.
- Acetaminophen MAY be given after a fever has been documented and the infant evaluated by a health aide or provider EXCEPT in babies 61-90 days old who are being managed in the village as this may blunt the fever curve. If a child in the village is already scheduled to come to Bethel for further evaluation, acetaminophen may be given.

Special Circumstances

- 1. If fever within 48 hours of immunizations, well-appearing, and meets all history & exam low-risk criteria: no work-up necessary but must follow-up in village or Bethel within 12-24 hours. If fevers are rising or infant is not well-appearing, perform evaluation as above.
- 2. Pre-treatment with antibiotics but otherwise meeting low-risk criteria: infant must be observed a full 48 hours off antibiotics.
- 3. Unsuccessful LP: treat if appropriate and consider a repeat LP in 12-24 hours and determine treatment course based on cell counts. If repeat LP not performed or unsuccessful, either treat for 10-14 days with meningitic dosing of IV antibiotics or stop antibiotics at 48 hours and observe infant for an additional 48 hours off antibiotics. Consider admission.
- 4. If known HSV exposure, seizures, severe illness, hypothermia, lethargy, HSM, vesicular rash, conjunctivitis, interstitial pneumonitis, hepatitis, or thrombocytopenia: acyclovir 20 mg/kg IV Q8h with IVF, perform HSV work-up (CSF Multiplex PCR; CMP; blood HSV PCR; nasopharyngeal, conjunctival, and anal swabs and vesicle fluid for HSV PCR), and consult pediatrics.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by Clinical Guideline Committee 9/16/24. Click here to see the supplemental resources for this guideline. If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Antibiotic Treatment

- 0-7 days: Consult a pediatrician, pharmacist, or Neofax.
- 8-28 days:
- -If well-appearing and low suspicion for meningitis: ampicillin 50 mg/kg IV Q8h AND gentamicin 5 mg/kg IV
- -If well-appearing and any suspicion for meningitis: ampicillin 75 mg/kg IV Q6h AND cefepime 50 mg/kg IV
- -If ill-appearing and/or positive CSF Gram stain: please consult a pediatrician and/or a pharmacist.
- 29-90 days:
- -If low suspicion for meningitis: **ceftriaxone** 50 mg/kg
- -If concern for meningitis: **ceftriaxone** 100 mg/kg IV once then 50 mg/kg IV Q12h AND vancomycin 20 mg/kg IV Q8h. Continue IV/IM antibiotics until cultures are negative at least 36 hours and patient is clinically stable or until sensitivities are available to direct therapy.
- Dose #2 of ceftriaxone may be given 12-24 hours after dose #1.