ASP-016 ANMC Antibiotic Guidelines for Gastrointestinal Infection			
High Risk/Severe Criter	a Suspected	d Pathogens	Cultures
 Albumin <2.5 Age >70 yo Immunocompromised state Severe sepsis/septic shock 	Polymicrobial process: • Routi Enterobacterales for construction Enterococcus sp. • Culture Anaerobes* (including Bacteroides sp.) • Culture *Less significant for biliary sources unless bile duct to bowel anastomosis or fistula present • Routi		 Routinely obtaining cultures is not recommended for community-acquired infections. Cultures SHOULD be obtained in patients with nosocomial infection or who require operation for prior treatment failure
Antibiotic Selection			
	Mild-Moderate Risk	High Risk/Severe	Duration of Therapy
 Extra-biliary Source Appendicitis Diverticulitis Bowel perforation with peritonitis 	Preferred therapy: • Cefazolin 2gm IV q8hr PLUS • Metronidazole 500mg IV/PO q12hr Anaphylactic Beta-Lactam Allergy: • Levofloxacin 750mg IV/PO q24hr PLUS • Metronidazole 500mg IV/PO q12hr	 Preferred therapy: Piperacillin/Tazobactam 4.5gm IV of (extended infusion over 4 hours) Anaphylactic Beta-Lactam Allergy: Levofloxacin 750mg IV/PO q24hr Pl Metronidazole 500mg IV/PO q12hr 	 Adequate surgical source control achieved*: 4 days Retained focus of infection Guided by clinical response Consider ID consult Uncomplicated diverticulitis: 5 days
Biliary Source • Cholecystitis • Cholangitis	Preferred therapy: • Cefazolin 2gm IV q8hr Anaphylactic Beta-Lactam Allergy: • Levofloxacin 750mg IV/PO q24hr -If bilio-enteric anastomosis present ADD Metronidazole 500mg IV/PO q12hr	 Preferred therapy: Piperacillin/Tazobactam 4.5gm IV of (extended infusion over 4 hours) Anaphylactic Beta-Lactam Allergy: Levofloxacin 750mg IV/PO q24hr Pl Metronidazole 500mg IV/PO q12hr 	 ℓ8hr • Uncomplicated: ≤ 24 hours • Non-operative (uncomplicated) management: 5 days • Complicated: 7-14 days • Delayed clinical response • Inadequate source control* • Consider ID consult
Pediatric Dosing^		IV to PO Conversion	
 Cefazolin 30mg/kg/dose IV q8hr (max 2000mg/dose) Cephalexin 20mg/kg/dose PO q8hr (max 4000mg/day) Ceftriaxone 50mg/kg/dose IV q24hr (max 2000mg/dose) Levofloxacin 10mg/kg/dose IV/PO q24hr (q12hr if <5 yo) (max 750mg/dose) Metronidazole 10mg/kg IV/PO q12hr (max 500mg/dose) Piperacillin/Tazobactam[#] 112.5mg/kg/dose IV q8hr (max 3.375gm/dose) ^Pediatric abx selection is the same as adults, dosing is provided here for reference. 		 Cefazolin 2g IV q8hr→Cephalexin 1g PO TID Levofloxacin 750mg IV q24hr→Levofloxacin 750mg PO q24hr Metronidazole 500mg IV q12hr→Metronidazole 500mg PO q12hr Piperacillin/Tazobactam→Depends on clinical scenario; consider antimicrobial pharmacy or infectious diseases consultation 	
 Due to <i>E. coli</i> resistance >10%, empiric quinolone use alone is cautioned in high-risk/severe cases ANMC <i>E. coli</i> susceptibility please refer to ANMC Antibiogram on ASP intranet site Ampicillin-subbactam is not recommended for use because of high rates of resistance among community-acquired <i>E. coli</i> (65% susceptibility for ANMC 2024) *Source control as determined by operative surgeon (as defined per IDSA: single procedure or series of procedures that eliminate infectious foci, control factors that promote ongoing infection, and correct or control anastomatic derangements to restore normal physiologic function) # Piperacillin/tazobactam dosing is equivalent to 100mg/kg/dose piperacillin component. Dosing in Cerner based off of piperacillin/tazobactam combined. Empiric coverage of <i>Enterococcus</i> or <i>Candida</i> is NOT recommended for mild-moderate community-acquired intra-abdominal infections Empiric Enterococcal therapy is recommended for health-care associated infections with previous cephalosporin therapy, immunocompromised patients, and those with valvular heart disease or prosthetic intravascular materials. Bowel injuries from penetrating, blunt, or iatrogenic trauma repaired w/in 12hr or other intraoperative contamination of the operative field by enteric contents should be treated w/ abx for <24hrs. Use of ursodeoxycholic acid and/or antibiotics for the prevention of biliary stent occlusion or infection is NOT routinely recommended. Antimicrobial Stewardship Program Approved April 2017; Updated June 21, 2023; June 18, 2025 			

Joint Surgical Infection Society and Infectious Diseases Society of America Guidelines (CID 2010:50); Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery (ASHP 2013;70(3)); Trial of short-course antimicrobial therapy for intraabdominal infection (NEJM 2015;372:1996-2005)