



GUIDELINE

Surgical Prophylaxis – Skin, soft tissue and orthopaedic

Scope (Staff):	Clinical Staff – Medical, Nursing, Pharmacy
Scope (Area):	Perth Children's Hospital (PCH)

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this [disclaimer](#)

- These guidelines refer to recommended antibiotic use for surgical prophylaxis in the setting of elective or emergency skin, soft tissue and/or orthopaedic surgery. If evidence of active infection, please refer to either:
 - [Skin and soft tissue infections – paediatric empiric guidelines](#)
 - [Bone and joint infections – paediatric empiric guidelines](#)
- Surgical prophylaxis refers to a **single** preoperative dose given 0 to 60 minutes prior to surgical incision unless otherwise stated.⁽¹⁾
- Patients receiving broad spectrum antibiotics prior to surgery may not require additional surgical antibiotic prophylaxis. For patients already receiving beta-lactam antibiotics (e.g. cefazolin, piperacillin tazobactam or amoxicillin clavulanate) an additional dose can be given just prior to surgical incision if the last dose was given >3 hours prior to surgery.
- If **vancomycin** is required for surgical prophylaxis, start the vancomycin infusion within the 120 minutes before surgical incision (ideally at least 15 minutes before incision) to ensure adequate blood and tissue concentrations at the time of incision and allow potential infusion-related reactions to be recognised before induction of anaesthesia. The infusion can be completed after surgical incision.⁽¹⁾

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CLINICAL SCENARIO	DRUGS/DOSES			
	Standard Protocol	Known or Suspected MRSA ^a	Low Risk Penicillin allergy ^b	High Risk Penicillin allergy ^b
<i>Staphylococcus aureus</i> colonisation	Patients undergoing elective orthopaedic surgery with insertion of prosthetic material should be screened for <i>Staphylococcus aureus</i> carriage and undergo decolonisation/ load reduction 5 days prior to surgery as appropriate. Refer to Staphylococcus aureus Decolonisation for Procedures and Guideline for Staphylococcal decolonisation (MRSA and MSSA) for further information.			
Elective and emergency orthopaedic surgery with an implant	IV cefazolin 30mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	vancomycin ^c
	When an infected prosthesis is suspected, antibiotic prophylaxis should ideally be delayed until after the collection of specimens			
Elective and Emergency orthopaedic surgery without an implant	Prophylaxis not routinely recommended			
Spinal surgery (with or without instrumentation)	IV cefazolin 30mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	vancomycin ^c
Lower limb amputation	IV cefazolin 30mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours IF the limb is ischaemic, ADD IV metronidazole 12.5mg/kg (to a maximum of 500mg) as a single dose If surgery >12 hours, repeat dose intraoperatively at 12 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	vancomycin ^c AND gentamicin ^d ADD metronidazole ^e if ischaemic limb
	For patients already receiving antibiotics for an established infection additional surgical prophylaxis is not generally required. Metronidazole ^e should be added if the regimen doesn't have sufficient anaerobic cover.			

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CLINICAL SCENARIO	DRUGS/DOSES			
	Standard Protocol	Known or Suspected MRSA ^a	Low Risk Penicillin allergy ^b	High Risk Penicillin allergy ^b
Traumatic injuries Antibiotic prophylaxis should ideally be administered within 3 hours of injury.				
Open fracture – minimal contamination	IV cefazolin 50mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	clindamycin ^f
	Do not continue prophylaxis for more than 24 hours after definitive wound closure and should not exceed a total of 72 hours. If ongoing therapy is required, dose as per relevant ChAMP monograph			
Open fracture – heavily contaminated or foreign body (e.g. agricultural injury or sewerage contamination)	IV cefazolin 50mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours AND IV metronidazole 12.5mg/kg (to a maximum of 500mg) as a single dose If surgery >12 hours, repeat dose intraoperatively at 12 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	clindamycin ^f If surgery >6 hours, repeat dose intraoperatively at 6 hours
	Do not continue prophylaxis for more than 24 hours after definitive wound closure and should not exceed a total of 72 hours If ongoing therapy is required, dose as per relevant ChAMP monograph			
Open fracture – water exposure	IV cefepime 50mg/kg (to a maximum of 2grams) as a single dose IF heavily contaminated or foreign body ADD IV metronidazole 12.5mg/kg (to a maximum of 500mg) as a single dose If surgery >12 hours, repeat dose intraoperatively at 12 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	clindamycin ^f If surgery >6 hours, repeat dose intraoperatively at 6 hours AND ciprofloxacin ^g
	Do not continue prophylaxis for more than 24 hours after definitive wound closure and should not exceed a total of 72 hours. If ongoing therapy is required, dose as per relevant ChAMP monograph			

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CLINICAL SCENARIO	DRUGS/DOSES			
	Standard Protocol	Known or Suspected MRSA ^a	Low Risk Penicillin allergy ^b	High Risk Penicillin allergy ^b
Traumatic injuries Antibiotic prophylaxis should ideally be administered within 3 hours of injury.				
Acute burns requiring surgical debridement.	<p>Prophylaxis not routinely recommended If heavily contaminated, refer to “Traumatic wound requiring surgical management – with contamination” below</p> <p>Patients with severe burns often have altered pharmacokinetics. If ongoing antibiotic therapy is required for an infected burn, antibiotic dosing should be adjusted accordingly. Contact infectious diseases or pharmacy for advice.</p> <p>For any ongoing surgical procedures antibiotic choice should be guided by local epidemiology and the results of cultures and susceptibility testing</p>			
Traumatic wound requiring surgical cleaning and debridement – no contamination	IV cefazolin 50mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	clindamycin ^f If surgery >6 hours, repeat dose intraoperatively at 6 hours
	Cease prophylaxis after definitive wound closure			
Traumatic wound requiring surgical cleaning and debridement – with contamination	IV cefazolin 50mg/kg (to a maximum of 2 grams) as a single dose If surgery >3 hours, repeat dose intraoperatively at 3 hours AND IV metronidazole 12.5mg/kg (to a maximum of 500mg) as a single dose If surgery >12 hours, repeat dose intraoperatively at 12 hours	ADD vancomycin ^c to standard protocol	As per standard protocol	clindamycin ^f If surgery >6 hours, repeat dose intraoperatively at 6 hours
	Do not continue prophylaxis for more than 24 hours after definitive wound closure and should not exceed a total of 72 hours. If ongoing therapy is required, dose as per relevant ChAMP monograph			
Bite injury	Refer to Skin and Soft Tissue Infections			

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CLINICAL SCENARIO	DRUGS/DOSES			
	Standard Protocol	Known or Suspected MRSA ^a	Low Risk Penicillin allergy ^b	High Risk Penicillin allergy ^b
Wound not requiring surgical cleaning and debridement – no contamination	Prophylaxis not routinely recommended.			
Wound not requiring surgical cleaning and debridement - with contamination	Traumatic wounds that require examination and/or suture closure under anaesthesia do NOT routinely require IV surgical prophylaxis. Consider oral prophylaxis for contaminated wounds as outlined below.			
	Oral cefalexin 20mg/kg/dose (to a maximum of 750mg) 8 hourly for 24 hours	cotrimoxazole^h	As per standard protocol	cotrimoxazole^h
	Prophylaxis may be continued for a maximum of 72 hours for deep penetrating injuries (e.g. penetrating nail injuries) that are not able to be adequately debrided. For all other wounds, 24 hours of prophylaxis is recommended.			

- a) Children known or suspected to be colonised with MRSA may need to have their therapy/prophylaxis modified. Children suspected of having MRSA include:
- i. Children previously colonised with MRSA
 - ii. Household contacts of MRSA colonised individuals
 - iii. In children who reside in regions with higher MRSA rates (e.g. Kimberley, Goldfields and the Pilbara) a lower threshold for suspected MRSA should be given
 - iv. Children with recurrent skin infections or those unresponsive to ≥ 48 of beta-lactam therapy. For further advice, discuss with Microbiology or ID service
- b) Refer to the [ChAMP Beta-lactam Allergy Guideline](#):
- **Low risk allergy:** a delayed rash (>1hr after initial exposure) without mucosal or systemic involvement (without respiratory distress and/or cardiovascular compromise).
 - **High risk allergy:** an immediate rash (<1hr after exposure); anaphylaxis; severe cutaneous adverse reaction {e.g. Drug Rash with Eosinophilia and Systemic Symptoms (DRESS) and Stevens – Johnson syndrome (SJS) / Toxic Epidermal Necrolysis (TEN)} or other severe systemic reaction.
- c) IV [vancomycin 15mg/kg](#) (to a maximum initial dose of 750mg) given via slow infusion. Repeat dose if operation > 6 hours (**repeat dosing not required in the setting of abnormal renal function**). Commence the infusion within the 120 minutes before surgical incision (ideally at least 15 minutes before incision) to ensure adequate blood and tissue concentrations at the time of incision and allow potential infusion-related reactions to be recognised before induction of anaesthesia. The infusion can be completed after surgical incision. For patients requiring ongoing dosing, refer to the [vancomycin monograph](#)
- d) IV [gentamicin 2mg/kg](#) (to a maximum of 320mg) as a single dose
- e) IV [metronidazole 12.5mg/kg](#) (to a maximum of 500mg) as a single dose. If surgery >12 hours, repeat dose intraoperatively at 12 hours
- f) IV [clindamycin 15mg/kg](#) (to a maximum of 600mg) as a single dose. If surgery >6 hours, repeat dose intraoperatively at 6hours
- g) IV [ciprofloxacin 10mg/kg](#) (to a maximum of 400mg) as a single dose. ChAMP approval required.
- h) Oral [cotrimoxazole 4mg/kg/dose](#) (to a maximum of 160mg trimethoprim component) 12 hourly; equivalent to 0.5mL/kg/doses of Septrin® suspension. Prophylaxis may be continued for a maximum of 72 hours for deep penetrating injuries that are not able to be adequately debrided. For all other wounds, 24 hours of prophylaxis is recommended.

Related CAHS internal policies, procedures and guidelines
Antimicrobial Stewardship Policy
ChAMP Empiric Guidelines and Monographs
KEMH Neonatal Medication Protocols

References and related external legislation, policies, and guidelines
<p>1. Antibiotic Writing Group. Therapeutic Guidelines - Antibiotic. West Melbourne: Therapeutic Guidelines Ltd; 2020. Available from: http://online.tg.org.au.pklibresources.health.wa.gov.au/ip/</p> <p>2. Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, et al. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013;70(3):195-283.</p>

This document can be made available in alternative formats on request.

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