### Drug Susceptibility Data

#### Enterococcus spp.

| Drug            | 
|----------------|--------------------------------------------------|
| **Vancomycin** | 
| Resistance     | Sensitivity                                      |
| 8-16 MU IV Q24h | <1000 mcg/mL                                      |

#### Coagulase-negative staphylococcus

| Drug            | 
|----------------|--------------------------------------------------|
| **Vancomycin** | 
| Resistance     | Sensitivity                                      |
| 8-16 MU IV Q24h | <1000 mcg/mL                                      |

#### Acinetobacter baumannii

| Drug            | 
|----------------|--------------------------------------------------|
| **Vancomycin** | 
| Resistance     | Sensitivity                                      |
| 8-16 MU IV Q24h | <1000 mcg/mL                                      |

#### Proteus mirabilis

| Drug            | 
|----------------|--------------------------------------------------|
| **Vancomycin** | 
| Resistance     | Sensitivity                                      |
| 8-16 MU IV Q24h | <1000 mcg/mL                                      |

#### Escherichia coli

| Drug            | 
|----------------|--------------------------------------------------|
| **Vancomycin** | 
| Resistance     | Sensitivity                                      |
| 8-16 MU IV Q24h | <1000 mcg/mL                                      |

#### Staphylococcus aureus

| Drug            | 
|----------------|--------------------------------------------------|
| **Vancomycin** | 
| Resistance     | Sensitivity                                      |
| 8-16 MU IV Q24h | <1000 mcg/mL                                      |

### Liposomal Amphotericin B: Indications

- **Uncomplicated Gram Positive**: Use in patients who have received prior therapy and are at high risk of infection. 
- **Complicated Gram Positive**: Use in patients who have received prior therapy and are at high risk of infection. 
- **Uncomplicated Gram Negative**: Use in patients who have not received prior therapy. 
- **Complicated Gram Negative**: Use in patients who have not received prior therapy.

### Liposomal Amphotericin B: Dosing

- **IV-PO**: Start with 5 mg/kg IV x1, then 2.5 mg/kg Q12h if no adverse effects.
- **Infusion**: Start with 5 mg/kg Q8h, then 5 mg/kg Q12h.

### Cefazolin: Indications

- For monotherapy or as part of a combination regimen.

### Cefazolin: Dosing

- **IV-PO**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Infusion**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Clindamycin: Indications

- For treatment of MRSA infections.

### Clindamycin: Dosing

- **IV-PO**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Infusion**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Linezolid: Indications

- For treatment of MRSA infections.

### Linezolid: Dosing

- **IV-PO**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Infusion**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Daptomycin: Indications

- For treatment of MRSA infections.

### Daptomycin: Dosing

- **IV-PO**: Start with 500 mg IV/PO Q12h, then 250 mg IV/PO Q12h.
- **Infusion**: Start with 500 mg IV/PO Q12h, then 250 mg IV/PO Q12h.

### Vancomycin: Indications

- For treatment of MRSA infections.

### Vancomycin: Dosing

- **IV-PO**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Infusion**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Gentamicin: Indications

- For treatment of gram-negative infections.

### Gentamicin: Dosing

- **IV-PO**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Infusion**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Extended interval dosing (preferred)

- **Vancomycin**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Gentamicin**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Traditional dosing

- **Vancomycin**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.
- **Gentamicin**: Start with 500 mg IV/PO Q8h, then 250 mg IV/PO Q8h.

### Common Contraindications and Precautions

- **Vancomycin**: Avoid in patients with severe renal impairment. 
- **Gentamicin**: Avoid in patients with severe renal impairment.

### Adverse Effects

- **Vancomycin**: Nephrotoxicity, ototoxicity, superinfections. 
- **Gentamicin**: Nephrotoxicity, ototoxicity, superinfections.

### Additional Information

- For complete drug information, refer to the appropriate drug monograph or consult a pharmacist or healthcare provider.
58% of enterococcal bloodstream were caused by empirically added to the regimen since failures due to highly resistant isolates have been reported with ceftriaxone and cefotaxime. Calculated from fewer than the standard recommendation of 30 isolates.

In patients with meningitis, 89% of isolates are susceptible to ceftriaxone. In patient without meningitis, 99% of isolates are susceptible to ceftriaxone.

PO should be used when possible, as oral bioavailability >95%.

IV dose: LD=6 mg/kg/dose Q12h x 2 doses, then 4mg/kg/dose (AB W) Q12h.

TMP/SMX increment CareConnect.

*May consider TBW for serious consideration.

Traditional dosing or antibiotic combination when synergy dosing is required, recommend 1 mg/kg/dose IV Q8h. Gram- positive synergy PEAK = 3-4 mg/L and TROUGH = <1 mg/L. Peak levels should be drawn according to levels.

For serious infections due to MRSA (i.e. CNS infections, endocarditis, pneumonia, bacteremia, or osteomyelitis), target trough is 15-20 mcg/mL, ID consult recommended.

Systemic GNR infections

Target gentamicin and tobramycin levels: PEAK = 5-10 mg/L and TROUGH = < 1 mg/L. Target gentamicin levels in children should be lower than those in adults. Target tobramycin levels in children are not well established but should be lower than those in adults.

In obese patients consider using a weight-based PO regimen (4mg/kg Q12h) using ABW, consult T/S.

In patients with CrCl < 50 mL/min due to accumulation and renal toxicity. Voriconazole may require dose adjustment in hepatic dysfunction and has not been studied in patients with CrCl < 30 mL/min.

Vancomycin dosing & monitoring

- Administered as an intermittent dose over 4-6 hours.

- Treatment of invasive fungal infection

- Continuous infusion

- Vancomycin Q12h (CVVHD) 500mg x1 now then 500mg x1 Q12h (HD or CRRT)

- Vancomycin (HD or CRRT) 500mg x1 now then 500mg x1 Q12h

- No Change

See UCLA Guidebook for complete antibiogram: http://www.asp.mednet.ucla.edu/pages/anti-suscep-summ

Gram-negative isolates, non-urine isolates

Gram-positive isolates, non-urine isolates