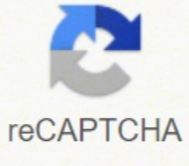




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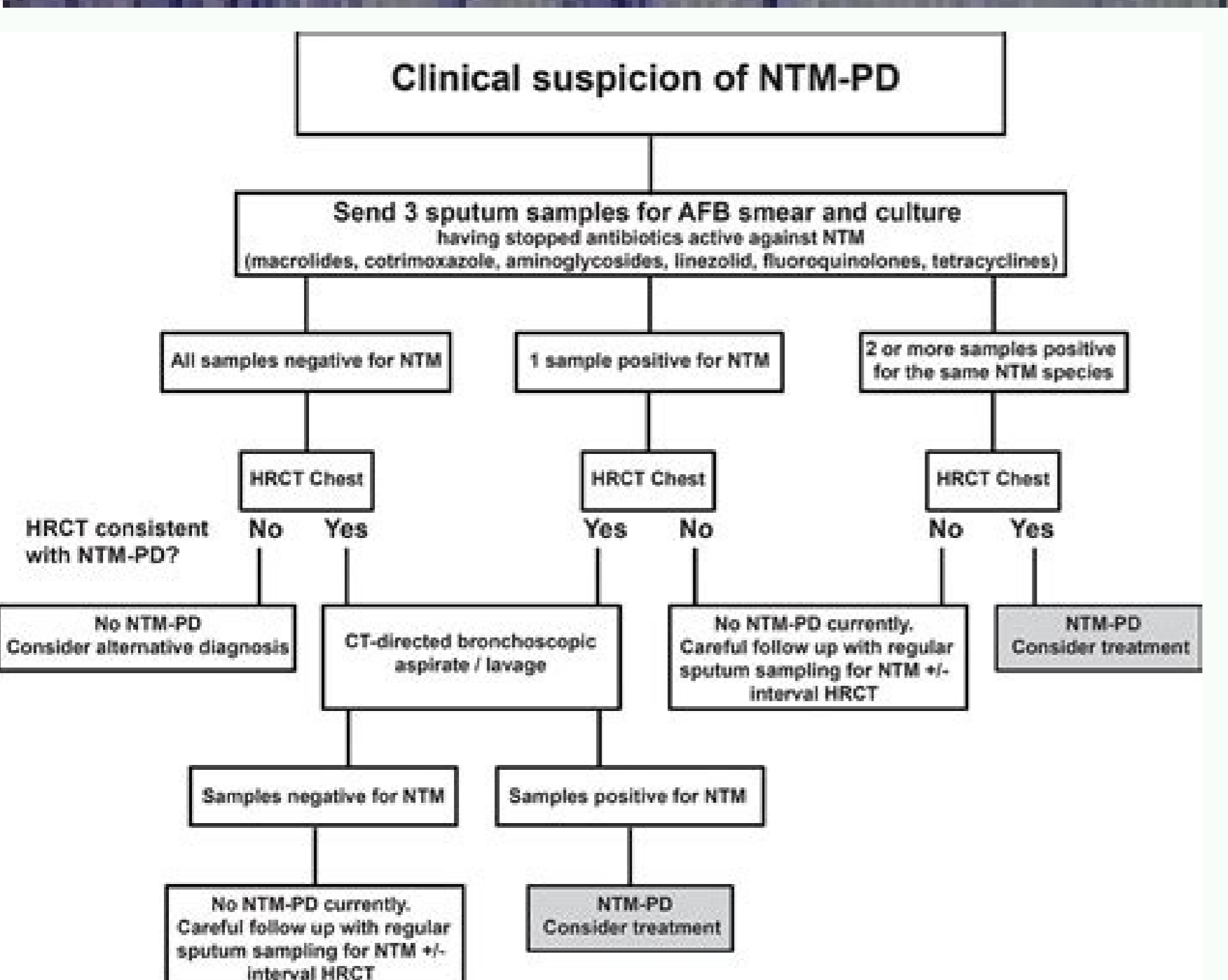
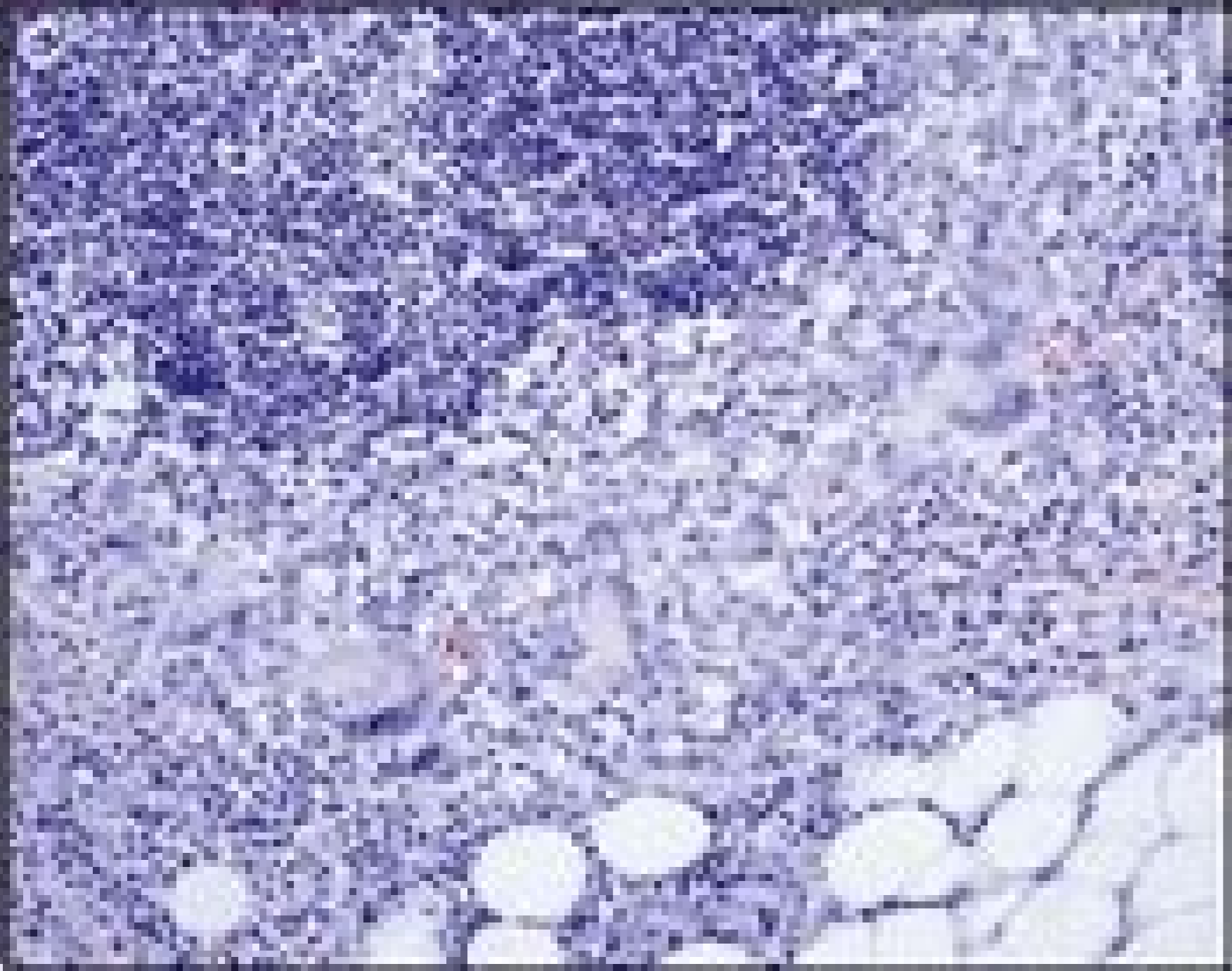
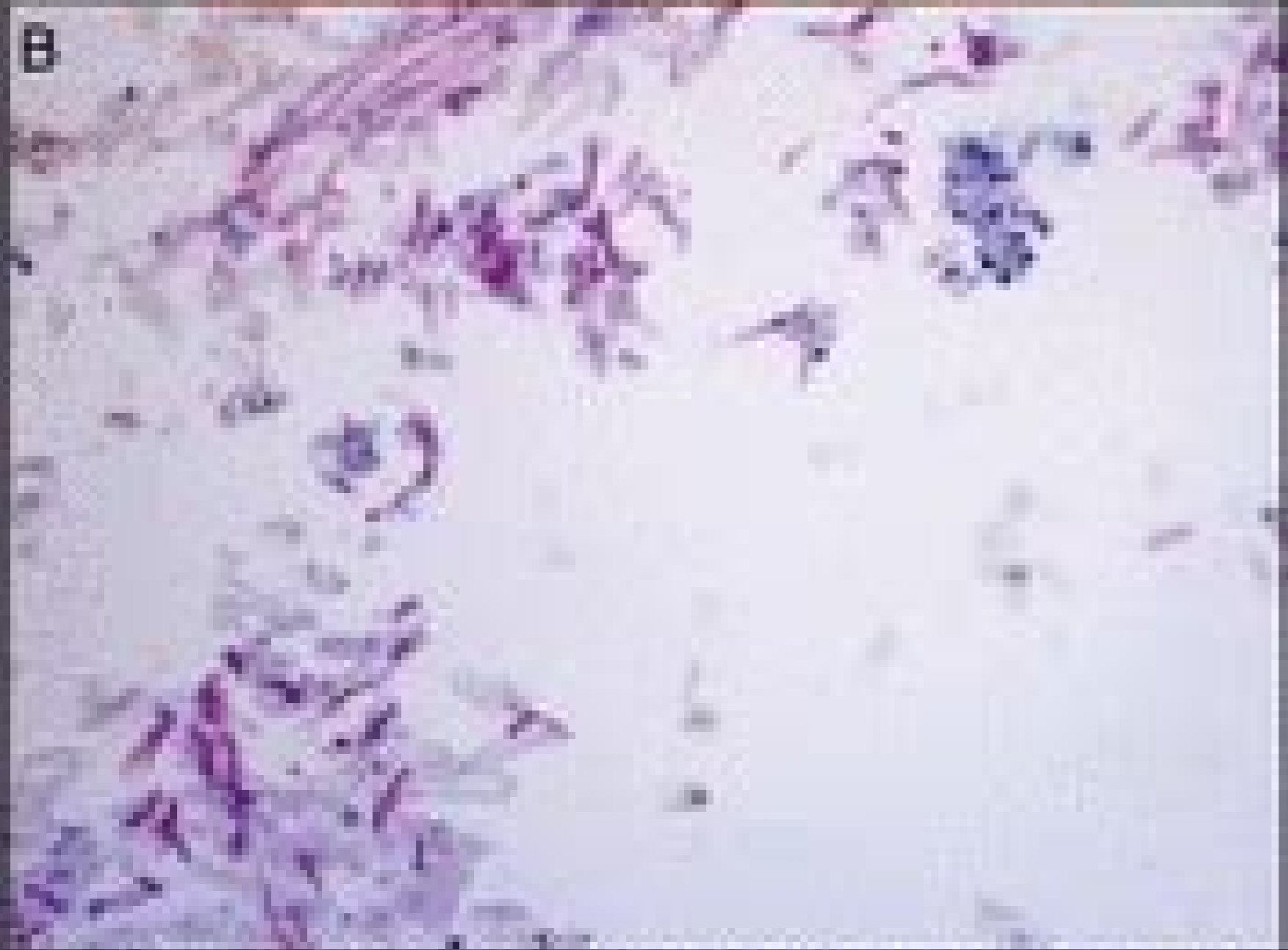


ULCERA DEL PIE DIABÉTICO  
CLASIFICACIÓN DE LA INFECCIÓN

IWG	IDSA	Descripción	Afectación
0	no	Herida sin infección	
1	leve	Eritema, dolor o induración < 2 cm	Piel, tejido subcutáneo
2	moderada	Celulitis > 2 cm, linfangitis, fascitis, absceso	Músculo, tendón, articulación o hueso
3	grave	SRIS (fiebre, taquicardia, hipotensión...)	idem a 2

IWG: International Working Group on Diabetic Foot  
IDSA: Infectious Disease Society of America

Lavery y cols. Validation of the IDSA Diabetic foot infection classification system. CID 2007;44-562-565



Intra abdominal infection guidelines 2017 idsa.

Last updated: May 25, 2021 Usual organisms: E.coli (>80%); others include K. D. Clinical Gastroenterology and Hepatology 2016; 14(11). Clin Infect Dis. aureus First-line empiric therapy: Second-line empiric therapy (if allergic or intolerant to above): Stepdown to oral therapy when improving: Cephalexin 500 mg PO QID/Clindamycin 300-450 mg PO QID (in the presence of significant penicillin allergy) Usual duration of therapy is 7 days Usually caused by S. Antibiotic Notes Ceftriaxone 2 g IV q12h PLUS Vancomycin 2g IV load, then 1 g IV q8h\* Continuous infusion of vancomycin is recommended - please see Vancomycin dosing guidelines for details Ampicillin 2 g IV q4h\* (in patients at risk for Listeria infection) Addition of ampicillin for coverage of Listeria is recommended in patients with the following risk factors: - age > 50 years - pregnancy - immunocompromise \*dose adjustment required in renal impairment - see vancomycin and/or ampicillin dosing guidelines Beta-Lactam Allergy Individuals with prior immediate hypersensitivity reactions to penicillins may still receive non-cross reactive cephalosporins, including ceftriaxone. 2012 Infectious Diseases Society of America clinical practice guideline for the diagnosis and treatment of diabetic foot infections. The role of antibiotics is best established for patients with purulent sputum (usually green) and those who will be admitted to hospital due to severity of their illness 1-3. Rev Neurol Dis. mirabilis, Enterococcus spp, and S. Clin Infect Dis.2016; 63(5):e61-e114 Rotstein et al. These patients should receive pre-empiric treatment for SBP. Epub ahead of print. Am J Respir Crit Care Med 2000; 162: 511-15. Administer ceftriaxone first, ampicillin second (if indicated), then vancomycin last. Switch therapy with ciprofloxacin vs. pneumoniae 10 days - Penicillin-susceptible (MIC ≤ 0.06 µg/mL) Penicillin G 4 MU IV q4h - Penicillin-resistant (MIC ≥ 0.12 µg/mL) AND Ceftriaxone-susceptible (MIC < 0.5 µg/mL) Ceftriaxone 2 g IV q12h - Penicillin-resistant (MIC ≥ 0.12 µg/mL) AND Ceftriaxone-resistant (MIC ≥ 1.0 µg/mL) Vancomycin 1 g IV q8h PLUS Ceftriaxone 2 g IV q12h Neisseria meningitidis 7 days - Penicillin-susceptible (MIC < 0.12 µg/mL) Penicillin G 4 MU IV q4h - Penicillin-resistant (MIC ≥ 0.12 µg/mL) Ceftriaxone 2 g IV q12h Listeria monocytogenes 21 days - Cephalosporins are not effective Ampicillin 2 g IV q4h ± Gentamicin 1 - 1.5 mg/kg IV q8h References Beckham JD, Tyler KL, IDSA. Relationship of sputum color to nature and outpatient management of acute exacerbations of COPD. Review article: spontaneous bacterial peritonitis - bacteriology, diagnosis, treatment, risk factors and prevention. heart failure). Dever JB, Sheikh MY. Hospital-acquired pneumonia: microbiological data and potential adequacy of antimicrobial regimens. The following guidelines are intended for the empiric management of SBP. Ewig et al. Moussaoui et al. Empiric Therapy for Patients who require Inpatient Management Obtain urine culture to confirm susceptibility First-line empiric therapy\*: Ceftriaxone 1g IV Q24H +/- Ampicillin 2 g IV Q6H (enterococcal coverage should be considered for pyelonephritis in men, presence of catheter or in hemodynamic instability) Second-line empiric therapy\* (if allergic or intolerant to the above): Gentamicin 7 mg/kg IV Q24HOR Ciprofloxacin 500 mg PO BID Step down to appropriate oral antibiotics when patient is afebrile and hemodynamically stable, based on culture and susceptibility results Usual duration of therapy is 7 days for uncomplicated pyelonephritis; complicated infections (e.g. abnormal genitourinary tract) require 10-14 days of therapy and occasionally longer, in consultation with Urology and Infectious Diseases \*Suggest coverage for extended-spectrum beta-lactamase (ESBL) producing organisms in the following circumstances: Known ESBL colonization Previous urine culture of ESBL-producing organism within previous 6 months Septic shock First-line empiric therapy for suspected ESBL- Listeria monocytogenes should also be considered in the immunocompromised, pregnant or elderly patient. Adjuvantive Therapy Dexamethasone (10 mg q6h x 4 days) is indicated in patients with suspected community-acquired bacterial meningitis. 2012; 50(8):2695-701. Amoxicillin-clavulanic acid versus cefotaxime in the therapy of bacterial infections in cirrhotic patients. An acute exacerbation of COPD (AECOPD) is defined by an acute worsening of cough or dyspnea or increased sputum production. Dexamethasone should be discontinued if an alternate causative pathogen is established. In addition to diarrhea, the organism can produce severe complications (systemic inflammatory response syndrome, shock, toxic mega colon, bowel perforation and death (mortality > 30%), difficile infection Severe & complicated

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