Febrile Neutropenia Emergency Letter

Treating team: Haematology/Oncology/other (circle)	
Treating consultant contact details:	
Diagnosis:	Date:

Attach patient details sticker before giving this letter to your patient

Allergies:

Dear Doctor / Triage nurse:

Medical emergency – risk of febrile neutropenia

This patient is currently receiving _____ chemotherapy and is presenting with a recorded temperature greater than or equal to 38°C.

- **He/She is likely to be profoundly neutropenic – at least priority 2 triage**
- **Administer empiric antibiotic therapy within 30 minutes of presentation** (see below) to avoid septic shock. Do not wait for blood results.
- Take blood cultures **before** starting antibiotics.

Investigations:

Step 1 (within 30 minutes of presentation)

- Septic screen:
  - Blood cultures from peripheral vein and CVC / PICC (if present) *prior to antibiotics* IF ABLE.
  - Complete blood count
  - MBA20
  - Lactate (if available)
- Secure IV access/fluid resuscitation

Step 2 (within 1-2 hours of presentation)

- Chest X-ray
- Sputum and urine specimen for MC&S
- Respiratory viral PCR if indicated clinically
- Other swabs (for culture / viral PVRs) as clinically indicated e.g. mouth, wounds, or lesion(s)

- Notify Haematology/Oncology registrar during working hours or on-call registrar/RMO after hours

Additional Clinical Information:

Please provide any additional relevant clinical information for this patient:

Initial therapy will need to be reviewed once results of investigations and blood cultures are available.

Empirical antibiotic therapy for Febrile Neutropenia [1-4]

No Penicillin / Cephalosporin Allergy	Moderate risk penicillin allergy History suggestive of moderate/low risk (delayed rash which is NOT urticarial or DRESS/SJS/TEN)*
Piperacillin/tazobactam 4.5g IV every six hours Note: Continue piperacillin/tazobactam as mono-therapy in stable patients See additional information below for patients with known or suspected MRSA colonisation/infection	**Cefepime 2g IV every eight hours** Note: Continue cefepime as mono-therapy in stable patients See additional information below for patients with known or suspected MRSA infection/colonisation
	High risk penicillin / cephalosporin allergy History suggestive of high risk (e.g. anaphylaxis, angioedema, bronchospasm, urticarial, DRESS/SJS/TEN)
	Vancomycin 25mg/kg IV (Actual Body Weight) up to a maximum of 3g for initial dose (See Table 2 in the Statewide Vancomycin Dosing Guidelines for subsequent doses) PLUS **Ciprofloxacin 400mg IV every twelve hours** Note: Continue vancomycin and ciprofloxacin as dual-therapy in stable patients.
	ADD **Metronidazole 500mg IV every twelve hours** in patients with features of intraabdominal infection (e.g. diverticulitis/typhlitis or perineal abscess/collection
NOTE: Unless specifically stated antibiotic doses in this guideline reflect recommendations for patients with NORMAL RENAL FUNCTION. Refer to Therapeutic Guidelines or AMH for dose adjustments in patients with renal impairment.	

Source: Febrile Neutropenia Management (Adults) Clinical Guideline – developed by South Australian expert Advisory Group on Antimicrobial Resistance (SAAGAR), Oct 2017