Ver. 5/16/2019

Fluoroquinolone use

Fluoroquinolone use is an established target in stewardship literature due to increasing bacterial resistance, less-than appropriate use for penicillin (PCN) allergies, and associated side effects e.g., altered mental status in the elderly and risk of *C. Difficile* infection. If fluoroquinolones are required, choose levofloxacin over ciprofloxacin due to better activity against enteral *Streptococcus spp.*

Our current susceptibility rates for fluoroquinolones are:

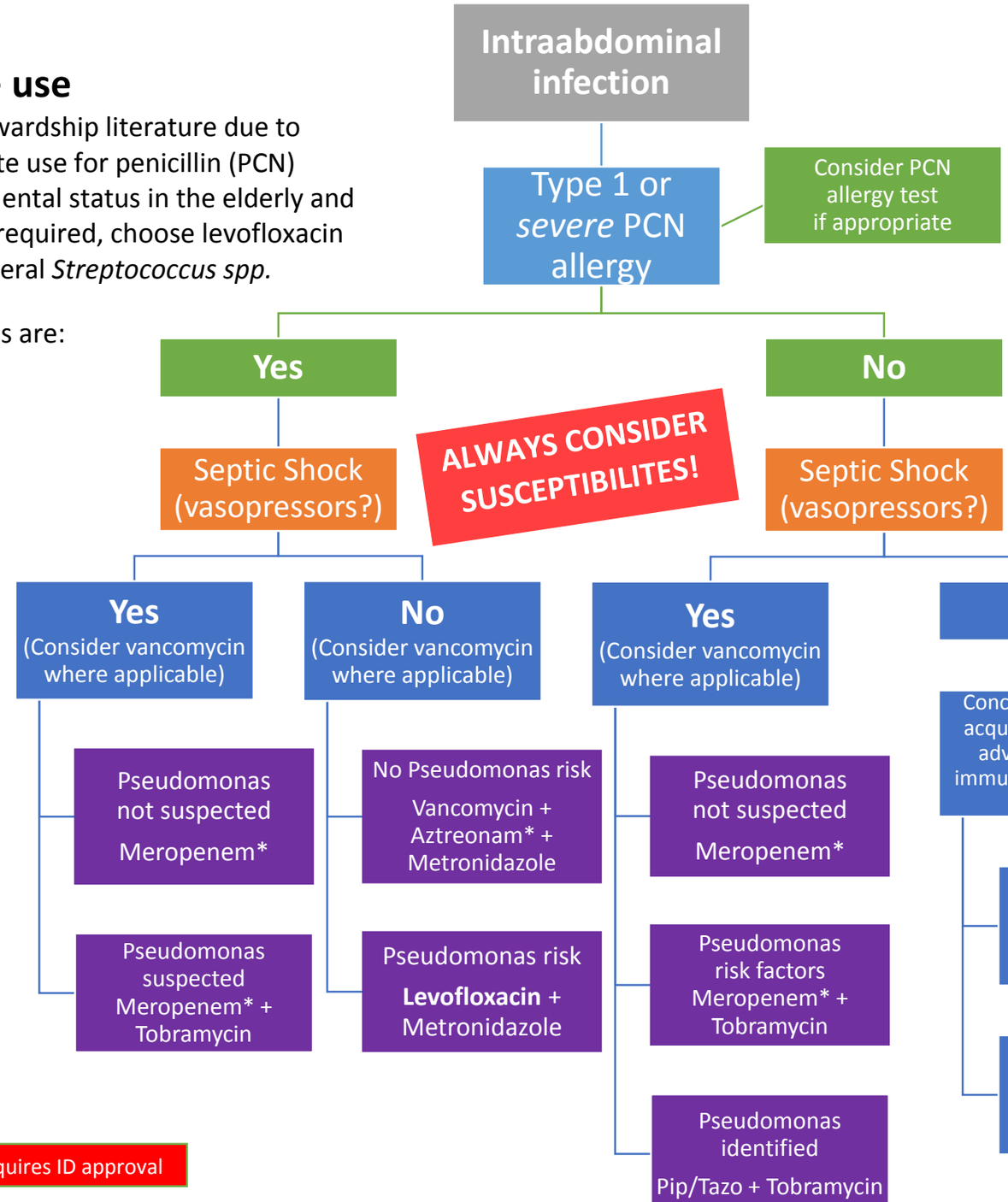
	Ciprofloxacin	Levofloxacin
E. coli	67%	70%
Pseudomonas	75%	73%

- Patients who report a possible type I PCN allergy e.g., hives/anaphylaxis **should be PCN-skin tested. Many patients will lose their PCN allergy if not exposed for >10 years.**
- **May *trial* ceftriaxone** if patient is not altered and cannot **personally recount PCN allergy reaction**

The FDA recently reiterated in a black box warning of an *increased risk of tendinitis and tendon rupture, particularly in patients > 60 years*

Intra-abdominal Infections
- Cholecystitis/cholangitis
- Appendicitis
- Diverticulitis
- Intra-abdominal/pelvic abscesses

Infectious diarrhea – do NOT use empiric ceftriaxone
(no Campylobacter coverage)



Oral Conversion:

If not bacteremic - IV Ceftriaxone + metronidazole may be converted to:

- Preferred: Cefpodoxime + metronidazole
- Alternative: Cephalexin + metronidazole

* Requires ID approval