

Empiric Treatment of Suspected Hospital-Onset Infection in Pediatric Patients with Acute Liver Failure or Early Post-Liver Transplantation

Applies to non-neonatal patients with acute liver failure > 48 hours into hospitalization and/or pediatric patients < 2 months s/p liver transplantation (for any indication)

Pediatric Hepatology service should be consulted if not already aware of patient

See separate algorithm for neonatal and pediatric patients with suspected infection at initial evaluation for acute liver failure

See separate algorithm for suspected infection in pre-transplant patients with biliary atresia

Initial Evaluation:
Obtain cultures before antibiotics when possible

Physical examination
 Blood culture - all CVC lumens + peripheral
 U/A with reflex to culture

If respiratory signs/symptoms:
 Routine culture of endotracheal aspirate if intubated
 Chest X-ray
 SARS-CoV-2 and other respiratory virus testing per hospital site algorithm

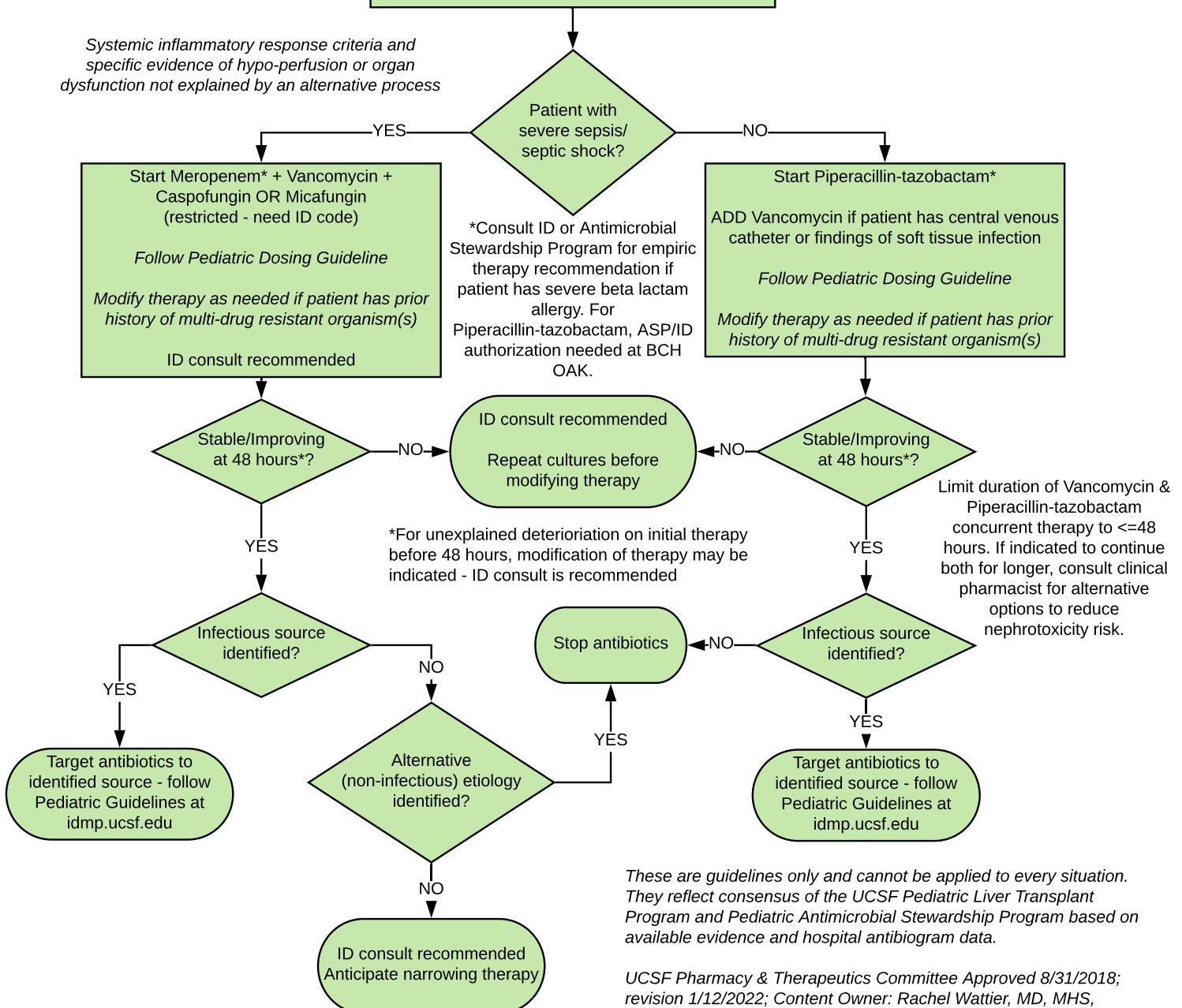
If ascites present: Paracentesis if able

If > 1 month post-transplant, send blood for CMV PCR, EBV PCR; adenovirus PCR if febrile

Additional evaluation should be considered based on patient characteristics + focal signs/symptoms

- ID consult recommended for:
- Severe/evolving presentation
 - Evaluation for opportunistic infection if > 1 month post-transplant or with previous transplant
 - Evaluation for donor-derived infection based on presentation + risk factors

Systemic inflammatory response criteria and specific evidence of hypo-perfusion or organ dysfunction not explained by an alternative process



These are guidelines only and cannot be applied to every situation. They reflect consensus of the UCSF Pediatric Liver Transplant Program and Pediatric Antimicrobial Stewardship Program based on available evidence and hospital antibiogram data.

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