

Empiric Treatment of Suspected Infection in Pediatric Patients with End-Stage Liver Disease/Biliary Atresia

Applies to pre-transplant pediatric patients with known liver disease primarily at risk for infection with enteric organisms

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 hospital-onset infection in patients with acute liver failure or early post-transplantation

Initial Evaluation:
Obtain cultures before antibiotics when possible

Physical examination
 Blood culture - all CVC lumens + peripheral U/A + urine culture
 AST, ALT, total & direct bilirubin, GGT, alkaline phosphatase

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

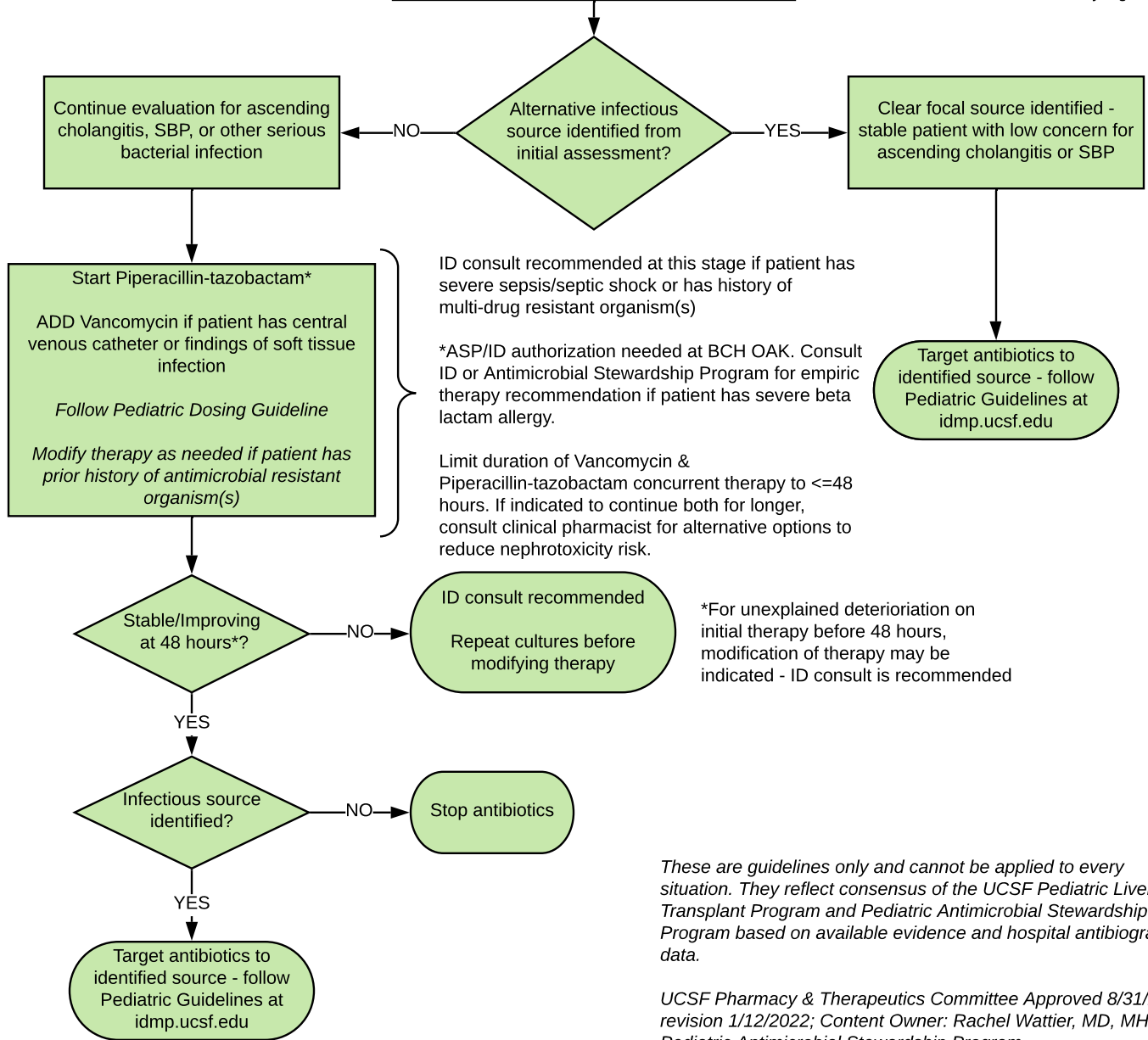
Avoid culturing long term biliary drains

Initial evaluation should determine likelihood of ascending cholangitis, vs. spontaneous bacterial peritonitis (SBP), vs. other community- or hospital-onset infectious source.

Ascending cholangitis should be suspected with fever and an increase in bilirubin from baseline

SBP should be suspected in a patient with ascites who has fever and abdominal pain/tenderness

If the patient is clinically stable and an obvious focal source is identified on exam (e.g. acute otitis media, URI), not all of the recommended evaluation may be needed. Use clinical judgement.



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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