

GUIDELINES FOR TREATMENT HAP/VAP AND TRACHEITIS IN PEDIATRIC ICUs

Pneumonia: new or progressive infiltrates and increased vent settings
Tracheitis: increased secretions and difficulty weaning the vent, without infiltrate

Clinical Suspicion of VAP → OBTAIN respiratory culture (mini-BAL or ET aspirate) and collect MRSA swab*, procalcitonin, and/or CRP
*If none collected within the past 7 days

If NO recent antibiotic therapy OR hospital stay < 72 hours

- ceftriaxone**[^] 50-75mg/kg IV Q24H, max per dose 2,000mg
- consider addition of **vancomycin** 15mg/kg IV Q6H, max per dose 1,500mg. If history of MRSA or MRSA screen positive.
[^]if less than 2 months old treat with **ceftazidime** 50mg/kg IV Q8 - 12H

If recent broad spectrum antibiotic therapy OR hospital stay ≥ 72 hours OR known colonization with multidrug resistant pathogens

- cefepime** 50mg/kg IV Q8H, max per dose 2,000mg
- consider addition of **vancomycin** 15mg/kg IV Q6H if know history of MRSA or MRSA screen positive

- Once Mini-BAL or ET aspirate culture has resulted **narrow therapy** to microbiologically confirmed pathogen(s)
- If respiratory cultures are negative, low procalcitonin and CRP, consider discontinuing antibiotics

Duration of antibiotic therapy for pneumonia is 5 - 7 days and tracheitis 3 – 5 days

EXCLUSIONS for mini-BAL: ECLS, lung surgery, significant airway bleeding, ETT ≤ 3.5

Relative Contraindications

- * FiO₂ >0.6 and/or PEEP > 10, HFOV * h/o total or segmental lung resection
- * Intracranial hypertension * Severe pulmonary hypertension
- * Status asthmaticus * Anticoagulation or platelets < 50,000
- * Hemodynamic instability * Scheduled bronchoscopy