



Exclusion Criteria: Consider additional and/or different evaluation/treatment

- Complex medical history
- Gestational Age <37 weeks
- Physical Exam suggestive of focal bacterial infection (omphalitis, mastitis, osteomyelitis, cellulitis)
- Exam concerning for meningitis (e.g. positional crying, ill appearance)

HSV Risk Assessment

- Hypothermia*
- Skin or oral lesions
- ANC <1000, thrombocytopenia, or increased ALT
- Maternal genital HSV or fever 48hrs before or after delivery

**Hypothermia: <36°C on repeat evaluation after controlling possible environmental issues*

HSV Testing

- Herpes Simplex I and II, PCR, Infant screen (eye, nose, mouth, anus)
- Herpes Simplex I and II, PCR, Plasma
- Herpes Simplex I and II, PCR, CSF
- Herpes Simplex I and II, PCR, Vesicle/Skin (if lesion is present)

Definitions

Elevated Inflammatory Markers:

ANC > 5200 OR
CRP > 20 mg/L, OR
Fever > = 38.5 C (101.3F)

If PCT available, it replaces CRP+fever and has different ANC cutoff:

PCT > 0.5 ng/mL, OR
ANC > 4000

Positive UA:

Any leukocyte esterase
WBC > 5/hpf
Positive gram stain

Positive CSF:

WBC > 8
Positive gram stain
or unable to interpret

Febrile infant ≤ 59 days old with
Fever ≥ 100.4F (38C)
See Exclusion Criteria

Triage RN Assessment:

ESI 1 or 2

*III Appearing

Sepsis Evaluation and Treatment
Consider Alternative Diagnoses
(Cardiac, Inborn Error of Metabolism, etc.)

RN & Provider Assessments:

- History & Physical
- HSV Risk Assessment (*see side bar*)
- Labs & IV placement: CBC, BCx, UA, UCx, CRP, RPP
- If ≤21 days or at risk: HSV, BMP and HFP

≤ 21 Days

22-28 Days

29-59 Days

Testing:

- Blood and urine as above, & perform LP
- CSF gram stain, culture, cell counts, protein, glucose, meningitis/encephalitis panel
- HSV testing (*see side bar*)

*There is not substantial evidence for universal testing and treatment in this age group. Our institution has chosen to implement in this way for this age group.

Treatment:

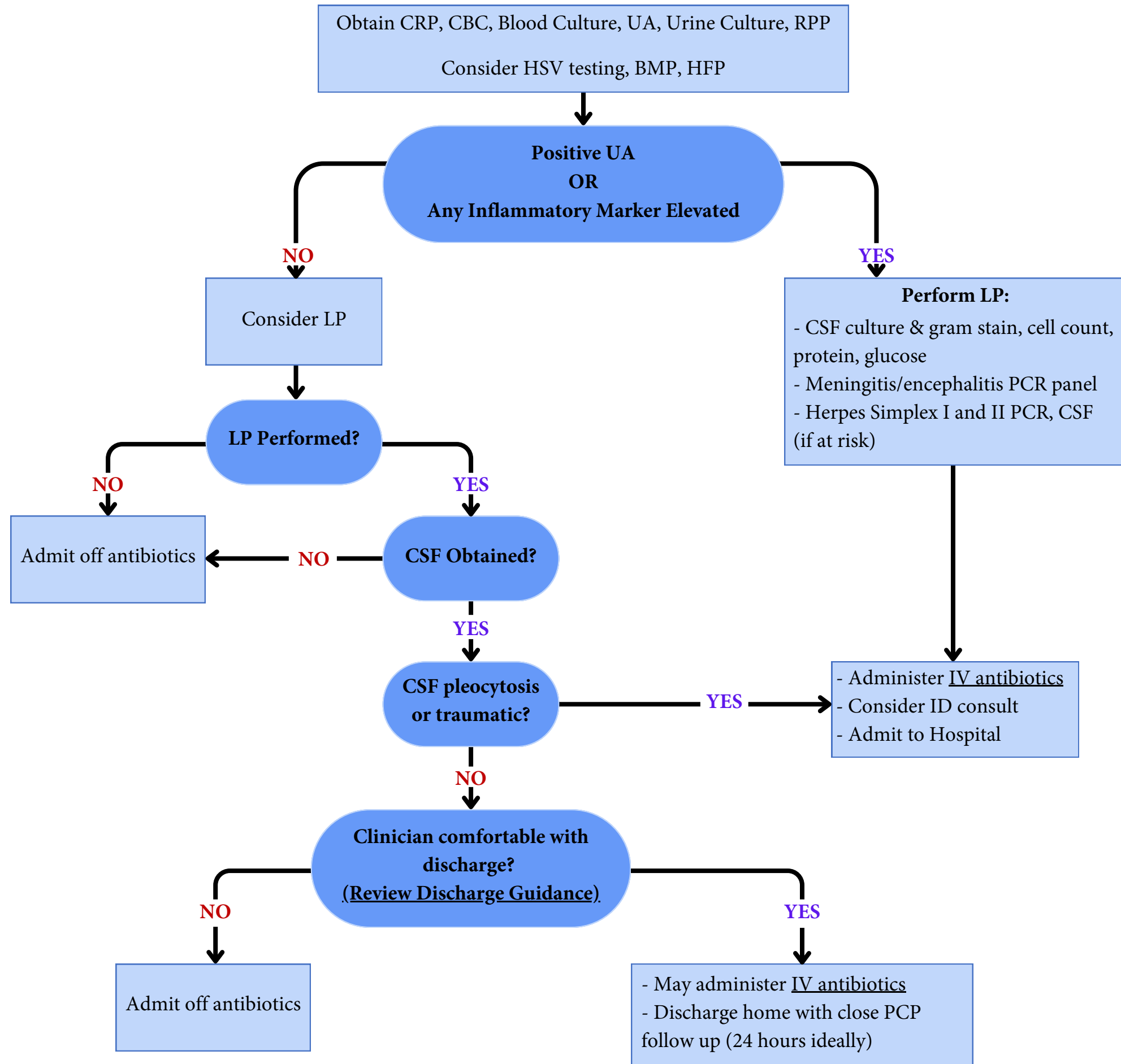
- Ampicillin AND
- Gentamicin OR Ceftazidime
 - Consider Ceftazidime if high suspicion for meningitis (CSF pleocytosis)
- Acyclovir if HSV testing sent

Admit to Hospitalist or PICU if ill



Febrile Infant 22-28 days-old

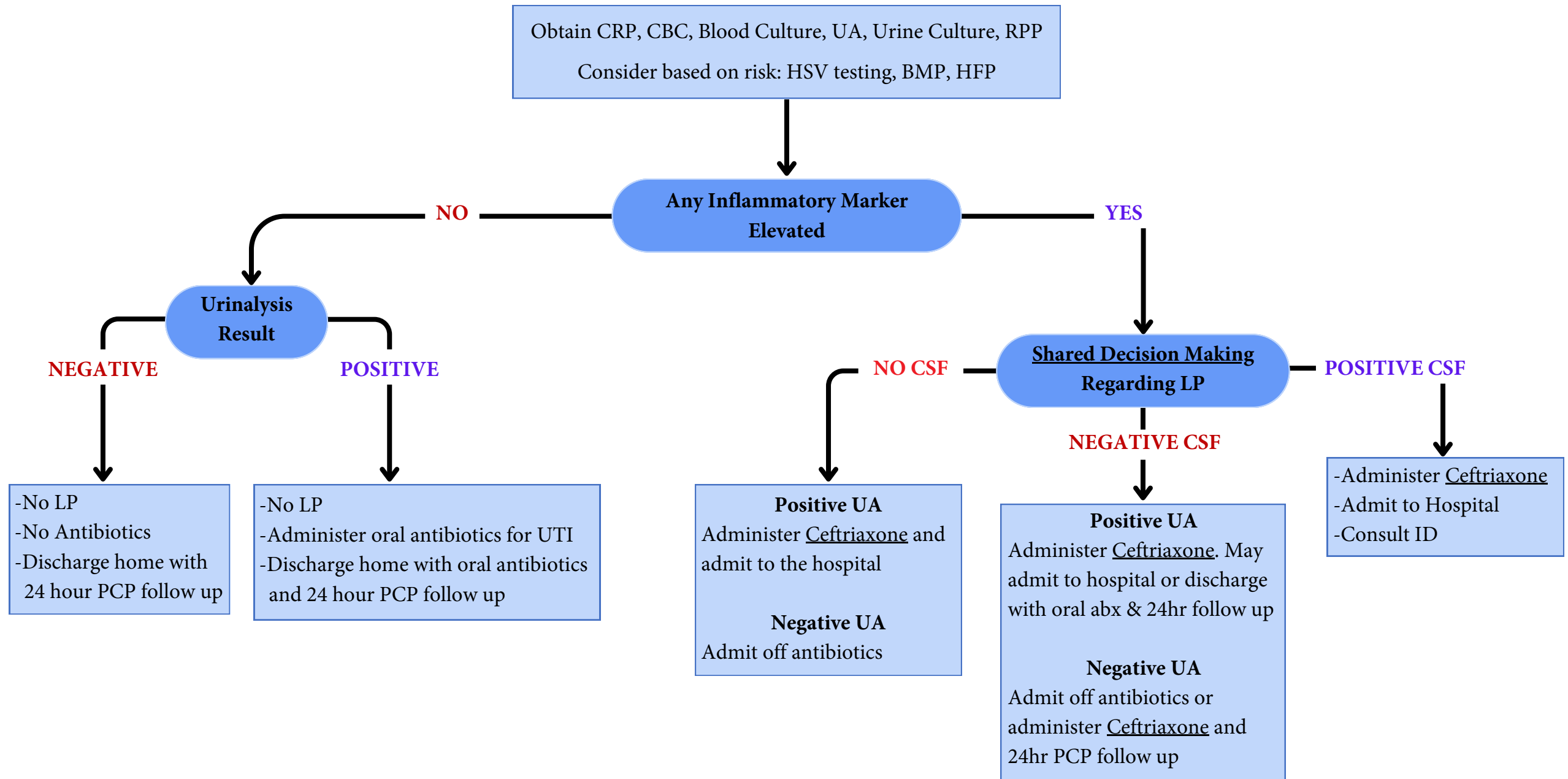
Last Revision 11/2024





Febrile Infant 29-59 days-old

Last Revision 11/2024



RESPIRATORY VIRAL GUIDANCE

- Bronchiolitis: well appearing infants with bronchiolitis may not require LP or antimicrobials. Use clinical appearance and degree of IM elevation to guide decision making.
- Positive RPP: results may factor into your decision to LP or admit patients. Aside from a decrease in IBI among febrile COVID-19 positive infants, there is not yet additional evidence to provide specific guidance on this topic.

SHARED DECISION-MAKING REGARDING LP

- Discuss risks and benefits of LP vs not obtaining LP (delayed diagnosis of meningitis) weighing patient specific factors including degree of IM elevation and RPP results if available.
- Discuss outcome of each decision
- Document discussion in EHR

Risk of SBI decreases every week of life. Rate of meningitis in low risk infants is <1%. Per AAP, obtaining LP if any IM is abnormal is a “weak recommendation.”

DISCHARGE GUIDANCE

- Remains well in ED
- Feeding well
- PCP contacted for follow up in 24 hours
- Family without concerns (reliable transportation, etc.)
- Vital signs repeated within 1 hour of discharge

INPATIENT OBSERVATION GUIDANCE

- Patients without identified source of fever: Observe for 24-36 hours after cultures drawn.
- Well appearing patients aged ≥ 22 days old with identified source of infection, consider discharge at 24 hours.

Antimicrobial	Postnatal Age		
	≤ 7 days	8 days-22 days	> 22 days
Ampicillin IV	100 mg/kg/dose every 8 hours	75 mg/kg/dose every 6 hours	
Gentamicin IV	4 mg/kg/dose every 24 hours		
Acyclovir IV	20 mg/kg/dose every 8 hours		
CefTAZidime IV	50 mg/kg/dose every 8 hours		
Ceftriaxone IV Meningitic Dosing			50 mg/kg every 12 hours
Ceftriaxone IV Standard Dosing			50 mg/kg every 24 hours

References

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GOALS

- Provide an institutional evidence-based guideline for the evaluation & management of febrile infants
- Improve the safety, timeliness, & efficiency of care for well appearing febrile infants by standardizing management decisions
- Improve efficiency and communication among the medical team
- Educate physicians, APPs, and nurses about the care of febrile infants

METRICS

- Rate of SBI and IBI identified
- Rate of missed SBI and IBI
- % patients with blood testing completed
- Rate of 72-hour revisits
- Rate of 22-28 day olds who do not receive LP
- Rate of 29-59 day olds who do receive LP
- Rate of LPs performed inpatient (that were not performed in ED)
- LOS: ED and Hospital