

The preprinted order wording that can be used as a reference or copy and paste for other health authorities who want to consider the wording for preprinted orders. It is a good starting point because VCH and PHC physicians/surgeons spent quite a bit of time coming to agreement on the wording

Antibiotic Prophylaxis: antibiotic infusion must be completed within 60 minutes prior to starting procedure

- Do not administer – Anesthesiologist to manage
- Patients less than 80 kg: ceFAZolin 1 g IV x 1 dose pre procedure
- Patients 80 to 120 kg: ceFAZolin 2 g IV x 1 dose pre procedure
- Patients more than 120 kg: ceFAZolin 3 g IV x 1 dose pre procedure

NOTE: ceFAZolin is the optimal prophylactic antibiotic in patients with penicillin allergy, including history of anaphylaxis. The only exceptions would be patients with a history of Stevens-Johnson syndrome/toxic epidermal necrolysis, other severe delayed reaction (e.g. severe neutropenia), or those with a specific anaphylactic allergy to ceFAZolin.

If ceFAZolin is determined to be contraindicated: Administer vancomycin with infusion pump

- vancomycin IV 15 mg/kg (rounded to nearest 250 mg) _____ mg x 1 dose. Start 2 hours pre procedure.

Outpatients: May take own medications morning of procedure with small sip of water

Inpatients: Give regular AM medications morning of procedure with small sip of water

Rationale for the change :

1. Anaphylactic reactions to cephalosporins are attributable to side-chains, not the preserved core structure of the drug
2. CeFAZolin does not share a side-chain with any beta-lactam and as a result is not expected to cross react with other members of the beta-lactam family
3. It is common for patients to report a penicillin allergy, however, when investigated 90% or more are found to be incorrect
4. Historic reports of cross reactivity with first generation cephalosporins are incorrect due to poorly run studies, impurities in formulations and reactivity with drugs that are no longer used
5. The likelihood of a new cephalosporin intolerance (0.5-4%) is statistically higher than the likelihood of cross reactivity (estimated between 0-0.3%)
6. There are several jurisdictions including the University of Washington and New Brunswick who have reported successful changing to a similar approach without adverse events
7. Using alternative agents is associated with higher rates of surgical site infections (approx. 50% higher)
8. Using alternative agents can be more toxic (e.g. 23% higher CDI rate) and affect OR flow (e.g. vancomycin)
9. Only patients with a history of anaphylactic reaction to cefazolin or a history of Stevens-Johnson or other severe, delayed reaction to beta-lactams should use alternative agents.