Standing Orders for the Treatment of Peritoneal Access Exit Site Infection

1. **DEFINITION**
    a. Purulent drainage from peritoneal exit site indicates the presence of infection. Erythema, tenderness, or swelling may or may not represent infection. Clinical judgment is required.
    b. A tunnel infection may present as erythema, edema, or tenderness over the subcutaneous tract. All patients should be assessed for possible tunnel infection and peritonitis. If cuff is involved (pus squeezed out by compressing the cuff), it is considered a tunnel infection.
    c. If tunnel infection is suspected, obtain a Cell Count, gram stain and culture of PD effluent. (ICD10=K65.9)
2.

5. **SPECIFIC TREATMENT** (when culture results known)
   a. **Gram-positive Organism**
      i. Obtain MD prescription for oral antibiotics:
         1. Cephalexin 500 mg PO twice daily 14 days or longer until exit site infection has resolved, or:
         2. Trimethoprim/sulfamethoxazole 80/400 mg (SS) PO daily for 14 days or longer until exit site infection has resolved.
         3. If full resolution of infection is confirmed by clinical evaluation at 1 week, contact MD to consider shortening treatment duration to 7-10 days.
   b. Adjust therapy based on culture results and sensitivities.
   c. Twice daily exit site care.
   d. Evaluate the exit site weekly until the infection has resolved.
   e. For community acquired MRSA alternatives to trimethoprim/sulfamethoxazole include doxycycline 100 mg PO twice daily or clindamycin 300 mg PO three time

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Northwest Kidney Centers
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Addendum A

Common Antibiotics – Oral Dosing in PD for Exit-Site and Tunnel Infections

Amoxicillin	250–500 mg PO twice daily
Cephalexin	500 mg PO twice to three times daily
Ciprofloxacin	250 BID or 500mg PO Daily
Clarithromycin	500 mg PO loading dose, then 250 mg PO daily
Dicloxacillin	500 mg PO four times daily
Erythromycin	500 mg PO four times daily
Fluconazole	200 mg PO loading, then