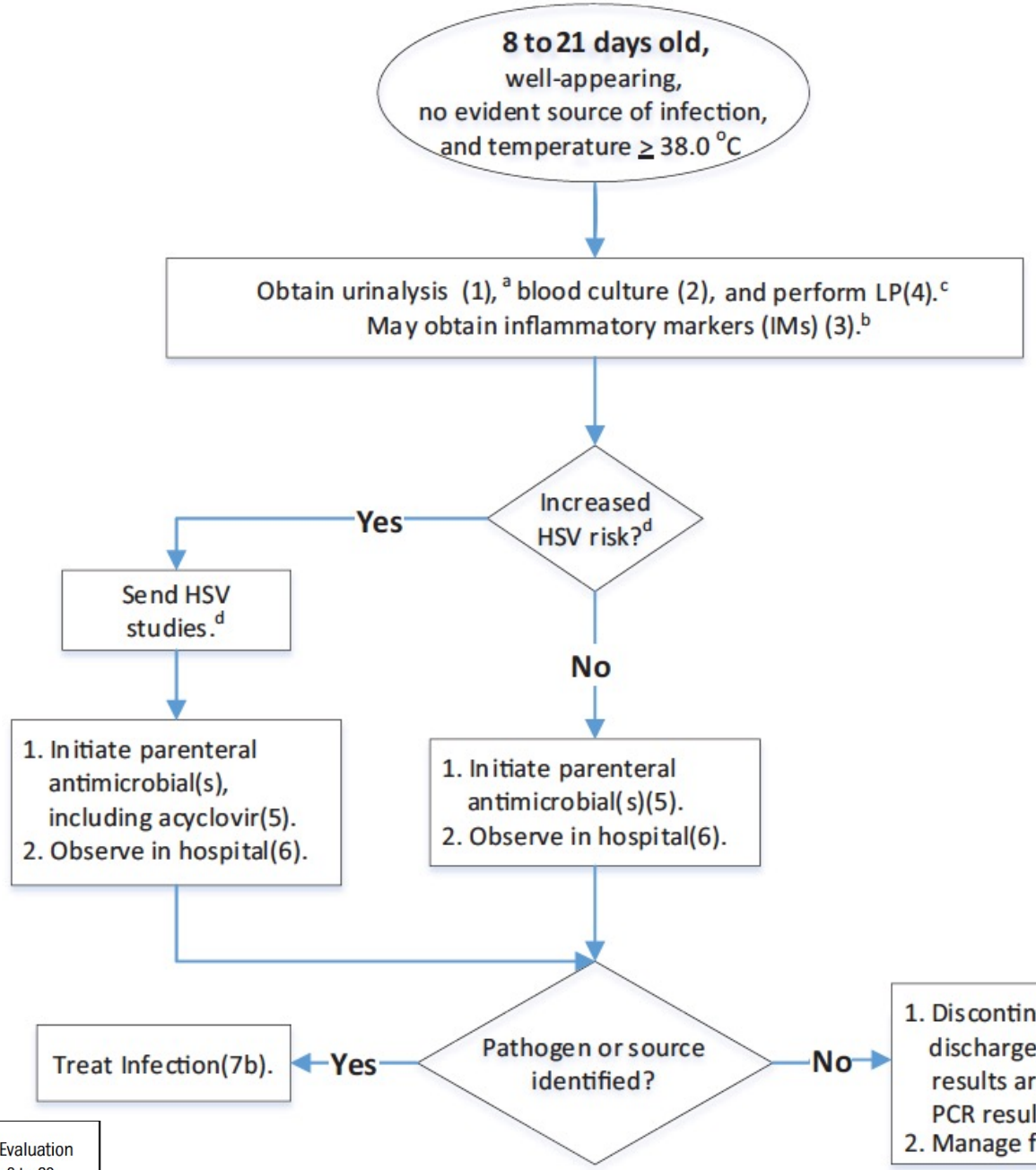
8-21 days old



Consider HSV

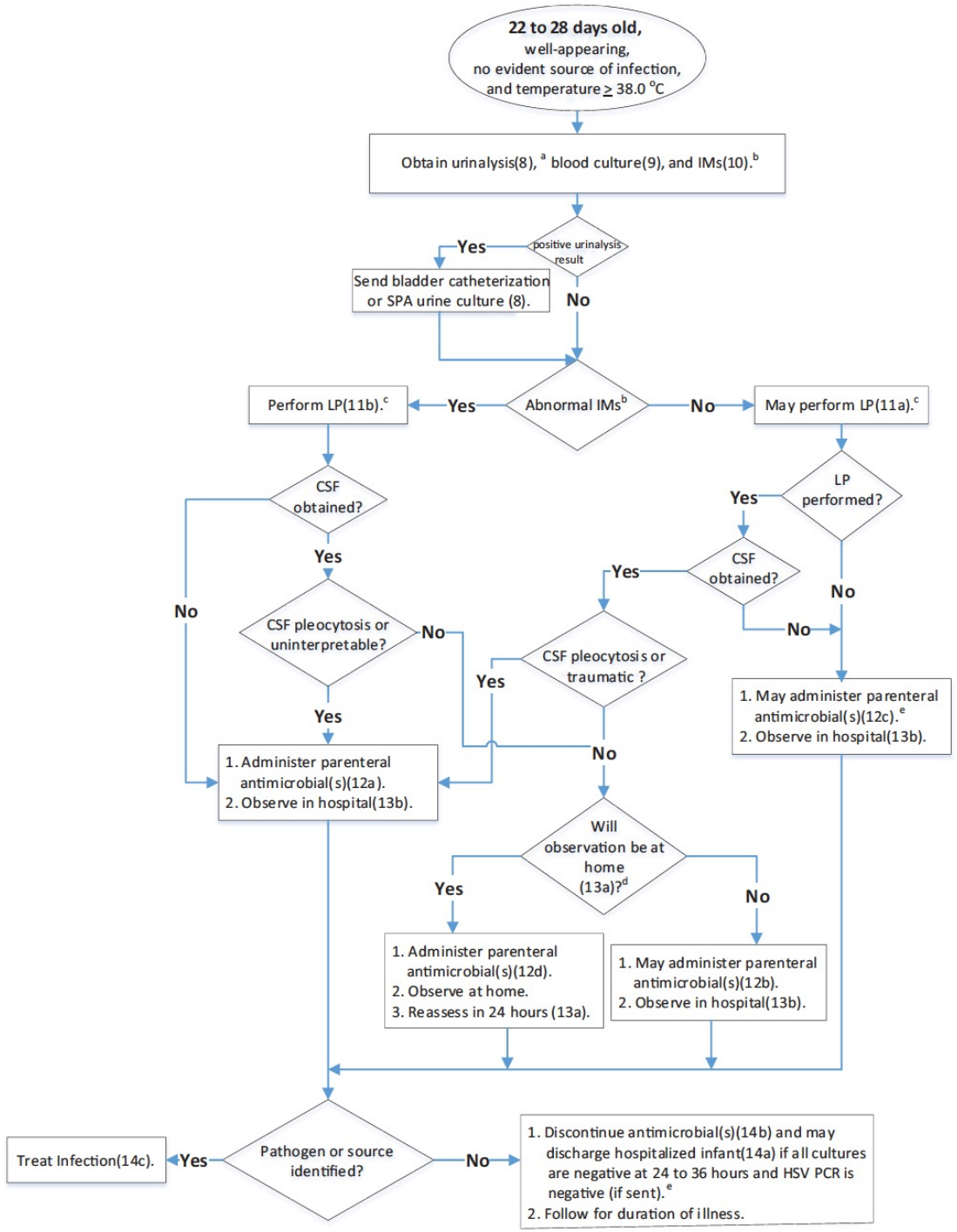
- Maternal h/o genital HSV lesions or fever 48 hrs before to 48 hrs after delivery
- Vesicles, mucous membrane ulcers
- Seizures
- Hypothermia
- CSF pleocytosis + negative gram stain
- Leukopenia
- Thrombocytopenia
- Elevated ALT

See 4th slide for recommended antibiotics

To cite: Pantell R H, Roberts K B, Adams W G, et al. Evaluation and Management of Well-Appearing Febrile Infants 8 to 60 Days Old . *Pediatrics*. 2021;148(2):e2021052228

22-28 days old

Consider and test/treat for HSV as for 8-21 day olds



Abnormal Inflammatory Markers

- Temp > 38.5
- Procalcitonin > 0.5 ng/mL
- CRP ≥ 20 mg/L
- ANC > 4500 or 5200

See 4th slide for recommended antibiotics

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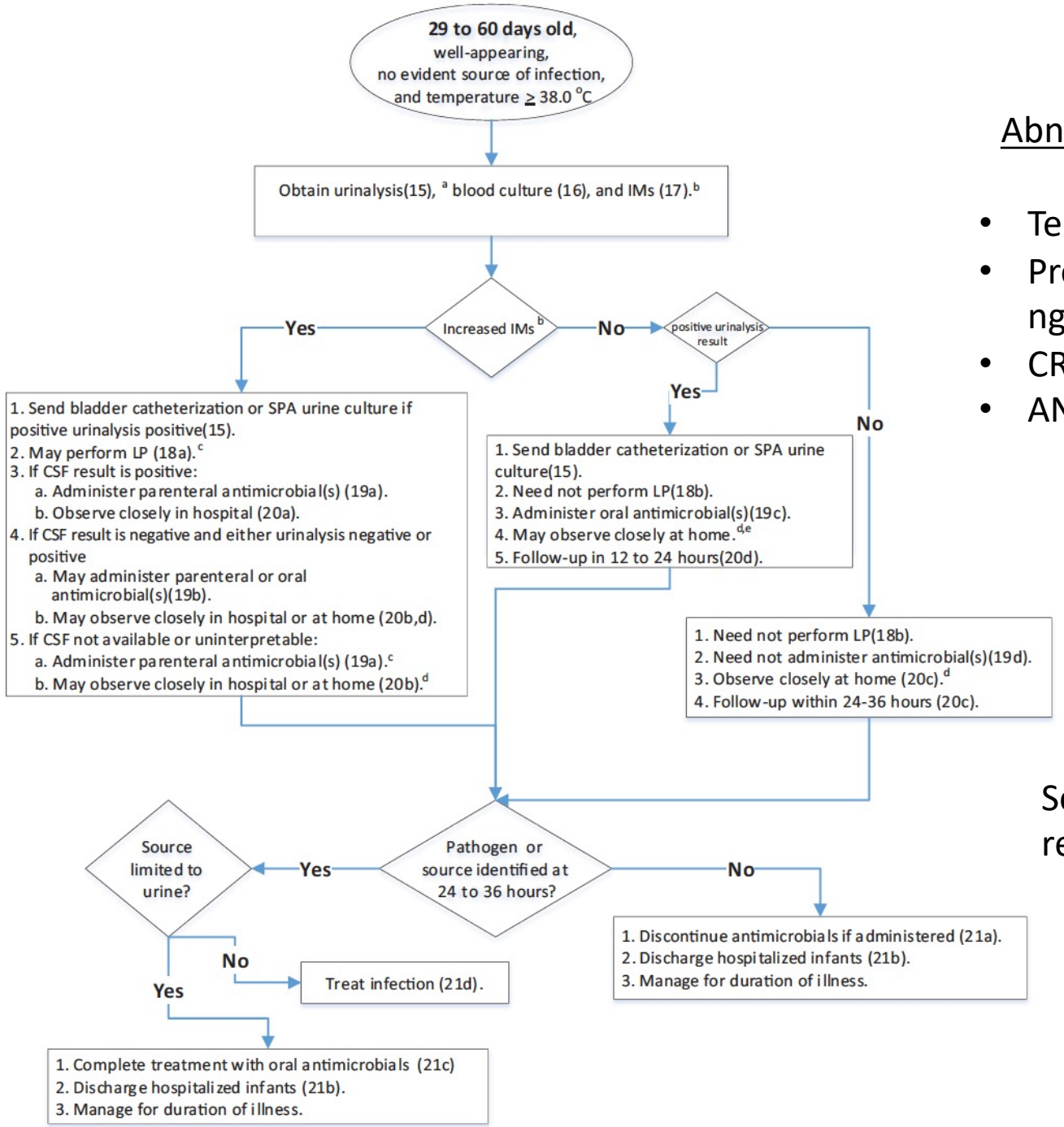
29-60 days old



Although rare, consider and test/treat for HSV as for 8-21 day olds

Abnormal Inflammatory Markers

- Temp > 38.5
- Procalcitonin > 0.5 ng/mL
- CRP ≥ 20 mg/L
- ANC > 4500 or 5200

See 4th slide for recommended antibiotics

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TABLE 3 Initial Empirical Antibacterial Therapy for Well-Appearing Febrile Infants 7 to 60 Days Old

Suspected Source of Infection	8–21 d Old	22–28 d Old	29–60 d Old
UTI[a]	Ampicillin IV or IM (150 mg/kg per d divided every 8 h) and either ceftazidime IV or IM (150 mg/kg per d divided every 8 h) or gentamicin IV or IM (4 mg/kg per dose every 24 h)	Ceftriaxone IV or IM (50 mg/kg per dose every 24 h)	Ceftriaxone IV or IM (50 mg/kg/dose every 24 h). Oral medications for infants older than 28 d.[b] Cephalexin 50–100 mg/kg per d in 4 doses or cefixime 8 mg/kg per d in 1 dose
No focus identified[c]	Ampicillin IV or IM (150 mg/kg per d divided every 8 h) and either ceftazidime IV or IM (150 mg/kg per d divided every 8 h) or gentamicin IV or IM (4 mg/kg per dose every 24 h)[d]	Ceftriaxone IV or IM (50 mg/kg per dose every 24 h)	Ceftriaxone IV or IM (50 mg/kg/dose every 24 h)
Bacterial meningitis[e]	Ampicillin IV or IM (300 mg/kg per d divided every 6 h) and ceftazidime IV or IM (150 mg/kg per d divided every 8 h)	Ampicillin IV or IM (300 mg/kg per d divided every 6 h) and ceftazidime IV or IM (150 mg/kg per d divided every 8 h)	Ceftriaxone IV (100 mg/kg or d once daily or divided every 12 h) or Ceftazidime IV (150 mg/kg or d divided every 6 h) and vancomycin[f] IV (60 mg/kg or d divided every 8 h)

Use of a local antibiogram, if available, can guide choices. Note: If a focus of infection such as pneumonia, cellulitis, gastroenteritis, or musculoskeletal infection is identified, different regimens that cover typical microbial pathogens for the site of infection should be administered. IM, intramuscular; IV, intravenous. Adapted from Bradley JS, Nelson JD, Barnett ED, et al, eds. *2019 Nelson's Pediatric Antimicrobial Therapy.* 25th ed. Itasca, IL: American Academy of Pediatrics; 2019; and Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases.* 31st ed. Itasca, IL: American Academy of Pediatrics; 2018.

[a] On the basis of urinalysis results.

[b] AAP Subcommittee on Urinary Tract Infection.[73]

[c] For example, possible bacteremia. For 22 to 28 day old infants, providers may decide that observation without initiation of therapy is appropriate after risk versus benefit discussion with the infant's parents or caregivers.

[d] Gentamicin may provide clinical benefit because of synergy with ampicillin against GBS and enterococcal species.

[e] On the basis of CSF analysis results. Some experts will add gentamicin or another aminoglycoside to this regimen, particularly if the CSF Gram stain reveals Gram-negative organisms.

[f] Vancomycin is part of empirical therapy because of the possibility of resistant *S pneumoniae*. It should be stopped if an organism other than *S pneumoniae* is identified, even if susceptibilities are still pending.

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