

## APPENDIX 8 Intravenous To Enteral Antibiotic Conversion

Before converting from intravenous to oral antibiotics, the following **SWITCH** criteria should be met:

- S**uitable oral alternative available
- W**hen patient afebrile > 24 hours
- I**nfectious condition suitable for oral treatment\*
- T**olerating oral/nasogastric food or fluid
- C**linical & lab trend towards improvement\*\*
- H**aematology/Oncology patients excluded

Benefits to SWITCH include decreased risk of infection from intravenous lines, decreased risk of thrombophlebitis, decreased patient discomfort, savings in nursing time and costs. Please consult the unit pharmacist or ICU specialist if you are unsure before SWITCHing.

Intravenous Antibiotic	Oral Option	Oral Bioavailability
Amoxicillin	Amoxicillin 500 mg - 1 g TDS	72-93%
Amoxicillin clavulanate	Amoxicillin clavulanate 625 mg TDS	72-93%
Benzylopenicillin	Amoxicillin 500 mg - 1 g TDS	
Cefuroxime	Usually amoxicillin clavulanate 625 mg TDS	
Cephazolin	Cephalexin 1 g TDS	90%
Clindamycin	Clindamycin 450 mg - 600 mg TDS - QDS	90%
Erythromycin	Erythromycin 400 mg QDS	
Fluconazole	Same as intravenous dose	90%
Flucloxacillin	Flucloxacillin 1 g TDS	
Metronidazole	Metronidazole 400 mg BD (400 mg TDS for <i>C.difficile</i> )	80%

\*Infections that are **unsuitable** for SWITCH include bone/joint/CNS infection, bacterial endocarditis, cystic fibrosis/bronchiectasis, undrained abscesses, infected prosthesis, *Staphylococcus aureus* bacteraemia

\*\*WBC 4 - 11 or improving, vital signs normal or normalising