

## UCMC Transplant Program - Infectious Prophylaxis Guidelines

*For the following recipients: (1) Pancreas Alone, (2) Pancreas after Kidney, and (3) Simultaneous Pancreas-Kidney*

	Patient Population		Medication	Dosing Regimen	
<b>Peri-operative</b>	All non-penicillin-allergic		Ceftriaxone	Pre-op ceftriaxone: 2 gm IV on call to OR Post-op ceftriaxone: 2 gm IV x 1 dose, given 24 hours after pre-op dose	
	Penicillin-allergic		Vancomycin AND ciprofloxacin	Pre-op:	<ul style="list-style-type: none"> <li>• Vancomycin: 20 mg/kg IV on call to OR</li> <li>• Ciprofloxacin: ≤ 80 kg: 400 mg IV on call to OR; &gt; 80 kg: 600 mg IV on call to OR</li> </ul>
				Post-op:	<ul style="list-style-type: none"> <li>• Vancomycin: 15 mg/kg IV x 1 dose, given 12 hours after pre-op dose; then dosed per renal function for 48-hour total duration</li> <li>• Ciprofloxacin: 400 mg IV x 1 dose, given 12 hours after pre-op dose; then dosed per renal function for 48-hour total duration</li> </ul>
All		Fluconazole <sup>1</sup>	200 mg IV x 1 dose	1 dose	
<b>Fungal</b> <small>Initiate POD1</small>	All		Fluconazole <sup>1</sup>	200 mg PO daily	1 month
<b>Toxo (Donor or Recipient IgG+)</b>	All non-sulfa-allergic		Bactrim SS <sup>2</sup>	1 tablet PO daily	6 months
	Sulfa-allergic		Atovaquone	1500 mg PO daily	6 months
<b>PJP</b> <small>Initiate POD 1-2</small>	All non-sulfa-allergic		Bactrim SS <sup>2</sup>	1 tablet PO daily	6 months (lifelong in HIV+ recipients)
	Sulfa-allergic		Dapsone <sup>3</sup> Pentamidine <sup>4</sup> Atovaquone	100 mg PO daily 300 mg by nebulization once monthly 1500 mg PO daily	6 months (lifelong in HIV+ recipients)
<b>CMV</b> <small>Initiate POD 1-2 If concern for renal function or marrow suppression adjust dose as described below</small>	High risk	CMV IgG Donor + / Recipient -	Valganciclovir <sup>5,6</sup>	900 mg PO daily <sup>7</sup>	6 months (monitoring <sup>8</sup> )
	Intermediate risk	CMV IgG Donor + / Recipient + CMV IgG Donor - / Recipient +	Valganciclovir <sup>5,6</sup>	900 mg PO daily <sup>7</sup>	3 months (monitoring <sup>8</sup> )
	Low risk	CMV IgG Donor - / Recipient -	Acyclovir <sup>5</sup>	800 mg PO twice daily <sup>7</sup>	Depends on EBV serostatus <sup>9</sup>

<sup>1</sup> **Fluconazole dose adjustments:** CrCl < 50 = 100 mg PO daily; CVVH = 400 mg PO daily  
HD = 200mg PO 3x week; administer after each dialysis session on dialysis days only

<sup>2</sup> **Bactrim (trimethoprim-sulfamethoxazole) SS (single strength) dose adjustments:**

- CrCl < 30 = 1 tablet SS PO Mon, Wed, Fri; CVVH or CVVHD= no dose adjustment
- HD = 1 tablet PO 3x weekly after HD (dialysis days only)
- Leukopenia = refer to leukopenia management guidelines

<sup>3</sup> **Dapsone:** do not check G6PD routinely; only in those of Mediterranean descent

<sup>4</sup> **Pentamidine:** premedicate with albuterol 2.5 mg by nebulization.

<sup>5</sup> **Anti-viral dose adjustments:** ONLY for renal dysfunction (refer to table for dose adjustments)

- LEUKOPENIA = refer to leukopenia management guidelines.
- IF PERSISTENT NEUTROPENIA: hold & monitor CMV RT Quant PCR weekly.
- LETERMIVIR: 2<sup>nd</sup> option for persistent neutropenia. Consider letermovir pending insurance and nonformulary approval and consult Txp ID. Letermovir use may require initiation of acyclovir for HSV prophylaxis if < POD #30 or undergoing rejection treatment and CMV PCR monitoring every 2 weeks.

<sup>6</sup> If unable to take PO valganciclovir: convert to ganciclovir 5 mg/kg IV day (adjust for renal function)

<sup>7</sup>Anti-viral renal dose adjustments:

CrCl (mL/min)	Valganciclovir PO	Ganciclovir IV	Acyclovir PO
>70	900 mg daily	5 mg/kg q 24 hour	800 mg 2x day
60-69	900 mg daily	2.5 mg/kg q 24 hours	800 mg 2x day
50-59	450 mg daily	2.5 mg/kg q 24 hours	800 mg 2x day
40-49	450 mg daily	1.25 mg/kg q 24 hours	800 mg 2x day
25-39	450 mg M-W-F	1.25 mg/kg q 24 hours	800 mg 2x day
10-24	450 mg twice weekly	0.625 mg/kg q 24 hours	400 mg 2x day
<10 or iHD	450 mg twice weekly after iHD	0.625 mg/kg 3x/week after iHD	400 mg 2x day after HD
PD	450 mg twice weekly	0.625 mg/kg 3x/week	400 mg 2x day
CVVH	450 mg q 48 hours	1.25 mg/kg q 24 hours	800 mg 2x day
CVVHD/HDF	450 mg daily	2.5 mg/kg q 24 hours	800 mg 2x day

<sup>8</sup>CMV monitoring (valganciclovir):

- If prophylaxis is held/delayed: monitor CMV RT Quant PCR weekly until resumed or initiated
- After completion of prophylaxis therapy: monitor CMV RT Quant PCR every 2 weeks x 3. If CMV viremia develops change CMV PCR monitoring to weekly (refer to CMV treatment guidelines)

<sup>9</sup>Acyclovir Duration

EBV	EBV IgG	Acyclovir Duration
High risk	Donor + / Recipient -	3 months
Intermediate risk or Low risk	Donor + / Recipient + Donor - / Recipient + Donor - / Recipient -	1 month