Management: Fever without source
Less than 90 Days of Age and Temp ≥100.4
Criteria: Non toxic appearing,
Previously healthy,
Full term,
No focal bacterial infection

0-4 weeks: Full sepsis: (CBC/BC, UA/UC, LP studies) seasonal RSV/Flu
Temp 100.4 Optional Studies: CXR, Stool cx, Rectum/Nasopharynx/CSF Herpes PCR*

Treatment: Cefotaxime IV/IM 50mg/kg + Ampicillin IV/IM 50mg/kg (initial dose)
Dosing is for patients >35weeks gestation and > 2kg

Admit: All Patients

*Herpes Testing-Herpes infection risk factors: primary maternal infection, maternal fever, increased risk with vaginal delivery, prolonged ROM, use of scalp electrodes, skin, eye or mouth lesions, seizures, CSF pleocytosis, evidence of active oral herpes lesions in family members
*Herpes Treatment-Acyclovir 20mg/kg IV is recommended for febrile neonates ≤4 weeks who appear ill, have mucocutaneous vesicles, experience seizures, or have a CSF pleocytosis.

Children at this age have a 12% chance of having a serious bacterial infection SBI +RSV does not alter the risk of SBI in this age range

4-8 weeks: OPTIONS- Full or Partial Sepsis Evaluation
Temp 100.4 1. Full sepsis: (CBC/BC, UA/UC, LP studies) seasonal RSV/Flu and Optional CXR, Stool cx

Most febrile infants aged 4-8 weeks who present to the ED warrant a full sepsis work up for SBI because they are difficult to evaluate clinically and because ED physicians cannot ensure adequate follow-up. The threshold for performing an LP in these infants should be low, most of these infants will warrant CSF examination.

Treatment: Ceftriaxone IV/IM 50mg/kg + Ampicillin IV/IM50mg/kg (initial dose)
Premature infants ≤41 weeks current gest age use Cefotaxime instead of Ceftriaxone

Admit: Admit most infants, however may consider discharging home if all studies are normal and PMD and family have agreed to 24 hour follow up appointment

2. Partial Sepsis: CBC/BCx, UA/UCx, seasonal RSV/Flu and Optional CXR, Stool cx

In select cases, at the clinician's discretion, an LP may be omitted in low risk well-appearing infants after blood and urine studies have been obtained and when the following apply:

- Reliable follow-up is possible in 12-24 hours
- Clinicians are confident that parents or caretakers can comply with appropriate observation and follow-up
- No antibiotics have been started
- Labs are normal- see below Observe with no treatment

Observe with no treatment: WBC >5,000 and <15,000
Bands < 20 % of total Neutrophil count
ANC >1000
U/A < 5 WBC/hpf and neg nitrite
Stool <5 WBC/hpf (if diarrhea is present)

*Viral sources of fever in this age range decrease but do not eliminate the risk for SBI. Infants older than 28 days who are diagnosed with bronchiolitis or influenza and are well-appearing should undergo a laboratory evaluation, including complete blood cell (CBC) count with differential, blood culture, urinalysis, and urine culture. If the CBC count and urinalysis findings are benign, these patients can be initially managed without antibacterial therapy with close follow up.
**8-12 weeks:** Partial sepsis (CBC/BC, UA/UC) Seasonal RSV and Rapid Influenza
Optional CXR, stool cx
Temp 100.4

1. Observe with no treatment if  
   - WBC >5,000 and <15,000  
   - Bands are < 20% of total Neutrophil count  
   - ANC >1000  
   - U/A < 5 WBC/hpf  
   - Stool <5 WBC/hpf (if diarrhea is present)

2. LP studies for lethargy, irritability or signs of meningitis  
   Treatment: Ceftriaxone 50mg/kg IM/IV (initial dose)

3. Focal infection: (UTI, pneumonia, bone or joint)  
   Treatment: Ceftriaxone 50mg/kg IM/IV or appropriate tx for focal infection.  
   LP may not be necessary/ Discuss with hospitalist or PMD  
   Well appearing infants with UTI’s and good f/u may not require admission

**Viral sources of fever in this age range decrease but do not eliminate the risk for SBI**  
**Risk for meningitis in this age range is 4/1000 even with normal labs so LP should still be considered if clinically indicated**

**Disclaimer**

This clinical practice checklist/protocol/management/guideline is intended to assist physicians and other qualified health care providers in clinical decision-making by providing a generally accepted approach for the management of a given disease or condition. It should not, however, be considered the sole source of guidance in treating the patient as other approaches can be reasonably directed at obtaining the same results. The ultimate judgment regarding care of a particular patient must be made by the physician in light of the individual circumstances presented by the patient.
References


References used for antibiotic dosing:
