**Fever Without Source in Infants < 28 Days Care Guidelines For Emergency Department Management**

**Inclusion Criteria:** Previously healthy children 0-28 days of age who have:
- Fever 38.0 °C or greater
- No apparent focus of infection

**Exclusion Criteria:** PICU status, < 37 weeks gestation

**Assessment**
- ESI level 2
- Vital signs
- Hemodynamic stability
- Signs of sepsis
- Determination of risk for SBI
- Continuous pulse oximetry if respiratory distress, hypoxia present or pneumonia is suspected

**Interventions**
- Blood and urine cultures
- CBC with diff, U/A
- Lumbar puncture/send CSF
- CXR if signs of pneumonia
- Apnea monitor
- Stool culture if diarrhea plus blood or mucus

**Antibiotics**
- Ampicillin AND Cefotaxime

**Antibiotic Dosing Guidance**

**Ampicillin**
- 50 mg/kg IV q 12 hours
- < 7 days, <2000g
- > 7 days, <1200g
  - OR
- 50 mg/kg IV q 8 hours
- < 7 days, > 2000g
- > 7 days, 1200g-2000g
- > 7 days, > 2000g, non-meningitis
  - OR
- 100 mg/kg IV q 8 hours
- < 7 days any weight, GBS meningitis
  - OR
- 100 mg/kg IV q 6 hours
- > 7 days any weight, GBS meningitis

**Cefotaxime**
- 50 mg/kg IV q 12 hours
- < 7 days, < 2000g
- > 7 days, < 1200g
  - OR
- 50 mg/kg IV q 8 hours
- < 7 days, > 2000g
- > 7 days, 1200-2000g
  - OR
- 50 mg/kg IV q 6 hours
- > 7 days, > 2000g, non-meningitis
  - OR
- 75 mg/kg IV q 6 hours

**Signs of Pneumonia**
- Respiratory signs (i.e. abnormal breath sounds, tachypnea)
- Respiratory symptoms (i.e. cough)
- Respiratory distress
- SO2 < 95%

**Significant Additional Management for Suspected Bacterial Meningitis**
- ICU monitoring
- Conservative fluid management
- Electrolyte monitoring
- Frequent neuro checks, serial head circumference

**Admission Criteria**
- Medical Surgical Unit
- Hemodynamically stable
- No suspicion for bacterial meningitis

*Reassess the appropriateness of Care Guidelines as condition changes and 24 hours after admission. This guideline is a tool to aid clinical decision making. It is not a standard of care. The physician should deviate from the guideline when clinical judgment so indicates.*

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References
Fever Without Source in Infants < 90 Days
Care Guideline


CHOC Children's Evidence Based Medicine Committee

Statement on Acyclovir Therapy in Neonates

**Neonates < 4 weeks with fever:**
Parenteral acyclovir (20 mg/kg IV q8hours) should be added empirically to antibiotics for neonates admitted with fever in the following situations;

1. Clinical signs of sepsis, toxic (including hypothermia, apneas, hypotension, other signs of shock)
2. Seizure
3. Maternal HSV
4. Physical exam findings consistent with Herpes simplex involvement (skin, eye, mucous membrane)
5. CSF pleocytosis with negative gram stain and consistent with aseptic meningitis.

Anytime acyclovir therapy is started on neonates one should perform a lumbar puncture and send the cerebrospinal fluid for HSV PCR.

In high risk situations where there is concern for disseminated HSV or SEM disease please send whole blood for HSV PCR, obtain swabs for HSV viral culture of at least 3 different mucous membrane (i.e. mouth, conjunctiva, nasopharynx, rectum), and any skin lesions and a panel 18. Obtain an Infectious Disease Consult.

Because of the risk of renal toxicity, patients on intravenous acyclovir should receive maintenance IV fluids and have urine dipped for heme q shift to evaluate for early evidence of nephrotoxicity.

In the absence of the above findings, in the neonates admitted with fever, the following scenarios demand specific attention.

1. Traumatic lumbar puncture: attempts to interpret traumatic CSF may lead to serious misdiagnoses. CSF with RBC > 2000 should be interpreted with caution and should be dealt with on an individual basis.
2. Unsuccessful lumbar puncture: same as above; increased LFTs and low platelets would be suggestive of disseminated HSV. These neonates are addressed above.
3. Strongly consider adding acyclovir in the presence of:
   a. Decreased platelets
   b. Increased liver function tests (LFTs), if done
   c. Pneumonia

In these scenarios when the infant appears more ill than would be expected, the physician's judgment should be used to determine acyclovir use on a case by case basis.

Obtain an Infectious Disease consult if Acyclovir is to be continued more than 48 hours or if index of suspicion for HSV is high.

**Afebrile Neonates**
Acyclovir should empirically be given to patients admitted with seizure and or physical exam findings consistent with Herpes simplex involvement (skin, eye, mucous membrane) and/or altered mental status.
References:


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