Lymphadenitis

Clinically stable patients with lymphadenitis requiring IV antibiotics can be managed through HITH. As with all HITH admissions, this requires a safe home environment and consent from caregivers. **Children can go straight from ED to HITH**.

The Royal Children's Hospital Melbourne

HITH (Wallaby) admission criteria and protocol

Wallaby not appropriate

- Airway compromise
- Not tolerating oral intake
- Infants < 3 months old
- Fluctuant abscess requiring drainage

→ Admit under appropriate team

Wallaby possible

- Lives > 60km from RCH, or social complexity
- Allergy to ceftriaxone (discuss alternatives)
- International patient – needs Wallaby AUM and executive approval. Not for overnight admission

→ Contact HITH fellow in hours on 52784 or HITH consultant on call after hours.

Wallaby appropriate

- Lymphadenitis that has progressed rapidly or where oral antibiotics have failed
- Fever is not a contraindication
- 'Potential' abscess is not a contraindication as this can be monitored while on HITH

→ Contact HITH fellow in-hours on 52784 or HITH consultant on call after hours. Complete EMR HITH referral

Prior to family leaving hospital:

- IV cannula appropriately secured and patent
- First dose of ceftriaxone 50mg/kg (max 2g) given
- Clinical photo +/- area of erythema marked if appropriate and saved to patient EMR
- Admission accepted by HITH Fellow/Consultant (in person 9-5pm, phone consult after hours)
- HITH order set on EMR completed:
  - Preselected: Adrenaline 1:1000 (1mg/ml) 10mcg/kg IM PRN
    Sodium chloride flush 0.5-2ml IV PRN
  - Ceftriaxone 50mg/kg (max 2g) IV OD
  - EMR HITH Referral & 'Transfer order reconciliation' completed
  - HITH bed request

HITH protocol – nursing and medical

Daily care requirements

IV ceftriaxone 50mg/kg OD as per Paediatric Injectable Guideline

Daily review with photo documentation and assessment of fluctuance

Phone support available 24/7 for family to escalate their concerns – phone calls to come to HITH AUM in hours, ED AUM after hours and escalate to HITH consultant on call as required

Medical care requirements

Daily review (phone/telehealth/home visit)

Script for oral cephalexin (25mg/kg TDS for 7 days) to be available to take to first patient visit

If not responding to IV antibiotics after 48h or develops fluctuance, arrange USS

Red flags for escalation

New systemic symptoms or features of Kawasaki disease develop – contact medical team

Other potential issues

IV failure – medical team to review to determine if still requires parenteral antibiotics. If so, consider IM ceftriaxone or arrange IV re-site

Nausea and pallor with 5 min push – slow administration to 20 mins (do not label with drug allergy)

Anaphylaxis – administer IM adrenaline and call ambulance (will need allergy referral)

Readmission

Progression of fluctuance (needs consideration of incision and drainage), or new Kawasaki-like symptoms/signs

If child requires transfer back to hospital, the HITH team will hand over care to the appropriate medical team and inform the bed manager

If urgent review required, HITH will discharge and send patient to ED and inform ED

Discharge plan

Discharge once afebrile & clinically improving (usually after 48-72 hours of IV therapy)

Switch to oral cephalexin 25mg/kg TDS to complete 10 days total treatment

GP follow-up upon completion of antibiotic course

Last update Aug 2022