Chapter 10

Infections

Introduction

All wounds incurred on the battlefield are grossly contaminated with bacteria. Most will become infected unless appropriate treatment is initiated quickly.

The battlefield environment is conducive to wound infection due to the:

- Absence of “sterile” wounding agents on the battlefield. All foreign bodies (wounding projectile fragments, clothing, dirt) are contaminated with bacteria.
- High-energy projectile wounding:
  - devitalized tissue,
  - hematoma, and
  - tissue ischemia.
- Delay in casualty evacuation.

Diagnosis of a Wound Infection

- The four “-or’s”: dolor, rubor, calor, and tumor—pain and tenderness, redness, warmth, and swelling.
- Drainage or discharge, ranging from frank pus to the foul “dishwater” discharge of clostridial infection.
- Crepitus, radiographic evidence of soft-tissue gas, epidermal blistering, and/or epidermal necrosis are the hallmarks of necrotizing soft-tissue infection (eg, clostridial gas gangrene or necrotizing fasciitis).
- Systemic effects: fever, leukocytosis, unexplained tachycardia, or hypotension.
- Confirm diagnosis by Gram stain and culture, if available, and/or tissue biopsy.
Common Microorganisms Causing Battlefield Infections

- **Gram-positive cocci:**
  - staphylococci,
  - streptococci, and
  - enterococci.

- **Gram-negative rods:**
  - *Escherichia coli, Proteus, and Klebsiella.*
  - *Pseudomonas, Enterobacter, Acinetobacter, and Serratia* are common nosocomial pathogens usually expected among casualties who have been hospitalized for an extended period, not those fresh off the battlefield.

- *Salmonella, Shigella, and Vibrio* should be suspected in cases of bacterial dysentery.

- **Anaerobic gram-positive and gram-negative rods:**
  - *Clostridia,
  - Bacteroides,* and
  - *Prevotella* species.

- **Fungal species:** *Candida* species should be suspected in casualties hospitalized for prolonged periods, those malnourished or immunosuppressed, or those who have received broad-spectrum antibiotics, adrenocortical steroids, or parenteral nutrition. Empiric therapy should be considered in appropriate patients with presumptive evidence of fungal infection.

Common Patterns of Infection

- **Skin, soft tissue, muscle, and bone:** Primarily due to staphylococcal, streptococcal, and clostridial species. These infections include:
  - wound abscess,
  - cellulitis,
  - septic arthritis,
  - osteomyelitis,
  - necrotizing fasciitis, and
  - gas gangrene.

- **Intracranial:** Meningitis, encephalitis, and abscess—commonly from staphylococci and gram-negative rods—are difficult to treat due to the impervious nature of the meninges to common antibiotics.
- **Orofacial and neck**: Gram-positive cocci and mouth anaerobes are generally responsive to surgery and clindamycin.
- **Thoracic cavity**: Empyema (usually staphylococcal) and pneumonia (*Staphylococcus, Streptococcus*, and *Pseudomonas*), especially among those on prolonged mechanical ventilation or those casualties prone to aspiration (polymicrobial).
- **Intraabdominal**: Include posttraumatic or postoperative abscess and peritonitis due to *Enterococcus*, gram-negative rods, and anaerobic bacilli. *Clostridium difficile* is often responsible for a potentially severe diarrheal colitis that occurs following the administration of even one dose of antibiotic.
- **Systemic sepsis**: A syndrome caused by a bloodborne or severe regional infection resulting in a global inflammatory response (fever, leukocytosis, tachycardia, tachypnea, and possibly hypotension).
  - A similar inflammatory response without infection can be caused by a focus of retained necrotic tissue or the mere act of sustaining severe trauma.
  - Culprit microorganisms will not be recovered in all cases of sepsis syndrome.
  - Although typically associated with gram-negative organisms, any bacterial or fungal agent can cause sepsis.

**Prompt surgical source control, including debridement and drainage, are the cornerstones of prophylaxis/treatment of all war wound infections.**

**Treatment**

**General Principles**
- Surgical and antibiotic treatment should begin as early as possible, ideally within 3 hours after injury and be repeated in the prophylaxis of war wound infection.
- Optimally, surgical debridement should be achieved within 6 hours of injury.
- Following initial exploration and debridement, the wound should be sufficiently irrigated to ensure that all dead material, bacterial contamination, and foreign material have been washed from the wound.
Table 10-1. Recommendations to Prevent Infections Associated With Combat-Related Injuries Based on Level of Care

<table>
<thead>
<tr>
<th>Level of Care*</th>
<th>Care Category</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Role 1 field   | Initial care in the field | Bandage wounds with sterile dressings (avoid pressure over eye wounds)  
Stabilize fractures  
Transfer to surgical support as soon as feasible  
Postinjury antimicrobials | Provide single-dose point-of-injury antimicrobials if evacuation delayed or expected to be delayed |
| Role 1 treatment facility / Role 2 without surgical support | Postinjury antimicrobials | Provide IV antimicrobials as soon as possible (within 3 h)  
Provide tetanus toxoid and immune globulin as appropriate  
Enhance gram-negative coverage with aminoglycoside or fluoroquinolone not recommended  
Addition of penicillin to prevent clostridial gangrene or streptococcal infection not recommended  
Redose antimicrobials if large volume of blood produces resuscitation  
Use only topical antimicrobials for burns  
Debridement and irrigation | Irrigate wounds to remove gross contamination with normal saline, sterile, or potable water, under low pressure (bulb syringe or equivalent) without additives  
Do not attempt to remove retained deep soft-tissue fragments if criteria met;†  
provide Cefazolin 2 g IV x 1 dose |
| Role 2 with surgical support and Role 3 | Postinjury antimicrobials | Provide IV antimicrobials as soon as possible (within 3 h)  
Provide tetanus toxoid and immune globulin as appropriate  
Enhance gram-negative coverage with aminoglycoside or fluoroquinolone not recommended  
Addition of penicillin to prevent clostridial gangrene or streptococcal infection not recommended |

(Table 10-1 continues)
Table 10-1 continued

<table>
<thead>
<tr>
<th>Level of Care*</th>
<th>Care Category</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role 4</td>
<td>Postinjury antimicrobials</td>
<td>Complete course of postinjury antimicrobials</td>
</tr>
<tr>
<td></td>
<td>Debridement and irrigation</td>
<td>Irrigate wounds to remove contamination with normal saline or sterile water, under low pressure (5–10 PSI; eg, bulb syringe or gravity flow) without additives (use 3 L for each type I, 6 L for each type II, and 9 L for each type III extremity fractures)</td>
</tr>
</tbody>
</table>

(Table 10-1 continues)
Emergency War Surgery

Table 10-1 continued

<table>
<thead>
<tr>
<th>Level of Care*</th>
<th>Care Category</th>
<th>Recommendations</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Do not attempt to remove retained deep soft-tissue fragments if criteria met;† provide Cefazolin 2 g IV × 1 dose Do not obtain cultures unless infection suspected Surgical wound management Wounds should not be closed until 3–5 d postinjury Only dural and facial wounds should undergo primary closure NPWT can be used External fixation (temporary spanning) of femur/tibia fractures External fixation (temporary spanning) or splint immobilization of open humerus/forearm fractures</td>
</tr>
</tbody>
</table>

IV: intravenous; NPWT: negative pressure wound therapy; PSI: pounds per square inch.

*Role of care, level of care, and echelon of care are considered synonymous with role, currently the preferred US military term. Role 1—self-aid, buddy aid, combat lifesaver, and combat medic/corpsman care at the point-of-injury; physician/physician assistant care at battalion aid station (US Army) or shock trauma platoon (US Marine Corps [USMC]); no patient holding capacity. Role 2—medical company (includes forward support medical company, main support medical company, and area support medical company in US Army) or expeditionary medical support (US Air Force [USAF]); 72-h patient holding capacity, basic blood transfusion, radiography, and laboratory support. May be supplemented with surgical assets (Level 2b) (forward surgical team, US Army; mobile field surgical team, USAF; forward resuscitative surgical system, USMC). Role 3—combat support hospital (US Army), Air Force theater hospital (USAF), or casualty receiving ships (US Navy); full inpatient capacity with intensive care units and operating rooms. Role 4—regional hospital (Landstuhl Regional Medical Center, Germany) or US naval hospital ships, typically outside of the combat zone; general and specialized inpatient medical and surgical care. Role 5—care facilities within the United States, typically tertiary care medical centers. †Criteria for allowing retained fragments to remain behind: entry/exit wounds <2 cm; no bone, joint, vascular, and body cavity involvement; no high-risk etiology (eg, mine); no obvious infection; and assessible by X-ray.

<table>
<thead>
<tr>
<th>Injury</th>
<th>Preferred Agent(s)</th>
<th>Alternate Agent(s)</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremity wounds (include skin, soft tissue, and bone)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin, soft tissue, no open fractures</td>
<td>Cefazolin 2 g IV q6–8h†,‡</td>
<td>Clindamycin (300–450 mg PO TID or 600 mg IV q8h)</td>
<td>1–3 d</td>
</tr>
<tr>
<td>Skin, soft tissue, with open fractures, exposed bone, or open joints</td>
<td>Cefazolin 2 g IV q6–8h†,‡,§</td>
<td>Clindamycin 600 mg IV q8h</td>
<td>1–3 d</td>
</tr>
<tr>
<td>Thoracic wounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetrating chest injury without esophageal disruption</td>
<td>Cefazolin 2 g IV q6–8h†,‡</td>
<td>Clindamycin (300–450 mg PO TID or 600 mg IV q8h)</td>
<td>1 d</td>
</tr>
<tr>
<td>Penetrating chest injury with esophageal disruption</td>
<td>Cefazolin 2 g IV q6–8h†,‡ + metronidazole 500 mg IV q8–12h</td>
<td>Ertapenem 1 g IV × 1 dose or moxifloxacin 400 mg IV × 1 dose</td>
<td>1 d after definitive washout</td>
</tr>
<tr>
<td>Abdominal wounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetrating abdominal injury with suspected/known hollow viscus injury and soilage; may apply to rectal/perineal injuries as well</td>
<td>Cefazolin 2 g IV q6–8h†,‡ + metronidazole 500 mg IV q8–12h</td>
<td>Ertapenem 1 g IV × 1 dose or moxifloxacin 400 mg IV × 1 dose</td>
<td>1 d after definitive washout</td>
</tr>
<tr>
<td>Maxillofacial and neck wounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open maxillofacial fractures, or maxillofacial fractures with foreign body or fixation device</td>
<td>Cefazolin 2 g IV q6–8h†,‡</td>
<td>Clindamycin 600 mg IV q8h</td>
<td>1 d</td>
</tr>
</tbody>
</table>

(Table 10-2 continues)
<table>
<thead>
<tr>
<th>Injury</th>
<th>Preferred Agent(s)</th>
<th>Alternate Agent(s)</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central nervous system wounds</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetrating brain injury</td>
<td>Cefazolin 2 g IV q6–8h; consider adding metronidazole 500 mg IV q8–12h if gross contamination with organic debris</td>
<td>Ceftriaxone 2 g IV q24h; consider adding metronidazole 500 mg IV q8–12h if gross contamination with organic debris; for penicillin allergic patients, vancomycin 1 g IV q12h + ciprofloxacin 400 mg IV q8–12h</td>
<td>5 d or until CSF leak is closed, whichever is longer</td>
</tr>
<tr>
<td>Penetrating spinal cord injury</td>
<td>Cefazolin 2 g IV q6–8h; <strong>ADD</strong> metronidazole 500 mg IV q8–12h if abdominal cavity is involved</td>
<td>As above; <strong>ADD</strong> metronidazole 500 mg IV q8–12h if abdominal cavity is involved</td>
<td>5 d or until CSF leak is closed, whichever is longer</td>
</tr>
<tr>
<td><strong>Eye wounds</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Eye injury, burn, or abrasion</td>
<td>Topical: Erythromycin or Bacitra cin ophthalmic ointment QID and PRN for symptomatic relief Systemic: No systemic treatment required</td>
<td>Fluoroquinolone 1 drop QID</td>
<td>Until epithelium healed (no fluorescein staining)</td>
</tr>
<tr>
<td>Eye injury, penetrating</td>
<td>Levofloxacin 500 mg IV/PO once daily; before primary repair, no topical agents should be used unless directed by ophthalmology</td>
<td></td>
<td>7 d or until evaluated by a retinal specialist</td>
</tr>
</tbody>
</table>

*Note: Table 10-2 continues*
### Table 10-2 continued

<table>
<thead>
<tr>
<th>Injury</th>
<th>Preferred Agent(s)</th>
<th>Alternate Agent(s)</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superficial burns</td>
<td>Topical antimicrobials with twice daily dressing changes (include mafenide acetate or silver sulfadiazine; may alternate between the two), silver-impregnated dressing changed q3–5d, or Biobrane</td>
<td>Silver nitrate solution applied to dressings</td>
<td>Until healed</td>
</tr>
<tr>
<td>Deep partial-thickness burns</td>
<td>Topical antimicrobials with twice daily dressing changes, or silver-impregnated dressing changed q3–5d + excision and grafting</td>
<td>Silver nitrate solution applied to dressings + excision and grafting</td>
<td>Until healed or grafted</td>
</tr>
<tr>
<td>Full-thickness burns</td>
<td>Topical antimicrobials with twice daily dressing changes + excision and grafting</td>
<td>Silver nitrate solution applied to dressings + excision and grafting</td>
<td>Until healed or grafted</td>
</tr>
<tr>
<td><strong>Point-of-injury/delayed evacuation</strong></td>
<td></td>
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<tr>
<td>Expected delay to reach surgical care</td>
<td>Moxifloxacin 400 mg PO × 1 dose; ertapenem 1 g IV or IM if penetrating abdominal injury, shock, or unable to tolerate PO medications</td>
<td>Levofloxacin 500 mg PO × 1 dose; Cefotetan 2 g IV or IM q12h if penetrating abdominal injury, shock, or unable to tolerate PO medications</td>
<td>Single-dose therapy</td>
</tr>
</tbody>
</table>

*(Table 10-2 continues)*
Wounds should be irrigated to minimize gross contamination with saline or sterile water by bulb syringe or gravity flow from irrigant bag.

The skin is left open, and a lightly moistened sterile gauze dressing is applied.

For larger wounds, placement of a vacuum-assisted closure device may be indicated.

Antibiotics should be started as soon as possible after wounding, then continued for 24 hours, depending on the size, extent of destruction, and degree of contamination of the wound.
Table 10-3. Specific Antibiotic Coverage for Theater-Specific Concerns: Culture Specific Recommendations

<table>
<thead>
<tr>
<th>Culture</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbapenem-resistant</td>
<td>1st Line (if sensitive): Tobramycin 5–7 mg/kg qd × 10–14 days (monitor troughs if capable; goal, 2.0; otherwise, proceed to 2nd-line drug if Cr increases &gt;0.5)</td>
</tr>
<tr>
<td>Acinetobacter</td>
<td>2nd Line: Colistin 2.5–5.0 mg/kg/d in 2–4 divided doses</td>
</tr>
<tr>
<td></td>
<td>3rd Line: Tigecycline 100 mg load, then 50 mg qd × 10 days</td>
</tr>
<tr>
<td>MRSA pneumonia</td>
<td>1st Line: Linelozid 600 mg IV/PO BID (literature suggests linelozid offers a treatment advantage over vancomycin)</td>
</tr>
<tr>
<td></td>
<td>2nd Line: Vancomycin 15 mg/kg q12h × 10–14 days (maintain trough level of 15–20 μg/mL)</td>
</tr>
</tbody>
</table>

For SEPSIS (Empiric Treatment):
- Perform empiric cultures. Then initiate antibiotics within 4 hours.
- 1st Line: Carbapenem with antipseudomonal coverage imipenem 1 g q6h or meropenem 1 g q8h PLUS Amikacin 15–20 mg/kg/d or gentamicin 5–7 mg/kg/d. Consider adding vancomycin 15 mg/kg q12h if VAP suspected.

CRITICAL: But this should be based on individual site antibiogram.

BID: twice a day; Cr: creatine; IV: intravenous; MRSA: methicillin-resistant Staphylococcus aureus; PO: per os (by mouth); qd: every day; VAP: ventilator-associated pneumonia.

Data source: Reprinted, with minor modifications, from Appendix C, Specific Antibiotic Coverage for Theater-Specific Concerns, Clinical Practice Guidelines (Agency for Healthcare Research and Quality, Rockville, MD).

- If time from wounding to initiation of antibiotics is >6 hours, or time from wounding to surgery is >12 hours, give an antibiotics-using regimen for established infection.
- The choice of empiric antibiotic is dependent on the part of the body injured (Tables 10-1 to 10-3).
- Once a battlefield wound has become infected, treatment is two-fold: surgical and medical.
Emergency War Surgery

- Surgical strategy remains the same: Open the wound, remove infected and necrotic tissue, and inspect for foreign material.
- Drainage is generally used in abscess cavities to prevent premature closure and reformation.
- Empiric broad-spectrum antibiotic therapy is initiated against likely pathogens and continued for 7–10 days.
- Ideally, obtain cultures and tailor therapy to cover the actual pathogens recovered on Gram stain and culture. Routine bacteriology is often not available in forward medical facilities.
- Because *Bacteroides* and *Clostridia* are difficult to culture, tailor antibiotic therapy to cover these organisms.
- If the debrided wound still has possibly ischemic tissue or retained foreign material, the patient is returned to the OR every 1–2 days for redebridement, until absolute assurance of healthy, clean tissue is achieved.

**Specific Infections**
- Tetanus.
  - Battlefield wounds are “tetanus-prone” due to high levels of contamination with *Clostridium tetani*.
  - Bacteria grow anaerobically and release a CNS toxin that results in muscle spasm, trismus, neck rigidity, and back arching.
  - **In addition to surgical debridement of war wounds, additional prophylactic measures for tetanus-prone wounds include:**
    - Administration of 0.5 mL IM of *tetanus toxoid* if prior tetanus immunization is uncertain, less than three doses of tetanus vaccine or >5 years since the last dose.
    - Administration of 250–500 U IM of *tetanus immune globulin* in a separate syringe and at a separate site from the toxoid if prior tetanus immunization is uncertain or less than three doses.
  - Treatment for established tetanus includes:
    - IV antibiotics (penicillin G, 24 million U/d; or doxycycline, 100 mg bid; or metronidazole, 500 mg q6h for 7 days).
    - Tetanus immune globulin.
♦ Wound debridement as needed.
♦ IV diazepam to ameliorate the muscle spasm.
♦ Place patient in a dark, quiet room free of extraneous stimulation.
♦ May warrant endotracheal intubation, mechanical ventilation, and neuromuscular blockade.

- **Soft-tissue infections.**
  - **Cellulitis** is manifested by localized skin erythema, heat, tenderness, and swelling or induration.
    - Treatment: IV antibiotics against streptococcal and staphylococcal species (IV nafcillin, Cefazolin, or, in the penicillin-allergic patient, clindamycin or vancomycin).
  - **Postoperative wound infections** become evident by wound pain, redness, swelling, warmth, and/or foul or purulent discharge, with fever and/or leukocytosis.
    - Treatment: **Open the wound**, drain the infected fluid, and debride any necrotic tissue present.
    - The wound is left open and allowed to close via secondary intention.
  - **Necrotizing soft-tissue infections** are the most dreaded infections, resulting from battlefield wounding. These include **clostridial myonecrosis (gas gangrene)** and **polymicrobial infections** caused by *Streptococcus*, *Staphylococcus*, *Enterococcus*, *Enterobacteriaceae*, *Bacteroides*, and *Clostridia*.
    - The organisms create a rapidly advancing infection within the **subcutaneous tissues** and/or **muscle** by producing exotoxins that lead to bacteremia, toxemia, and septic shock.
    - **All layers of soft tissue can be involved**, including skin (blistering and necrosis), subcutaneous tissue (panniculitis), fascia (fasciitis), and muscle.
    - Clinical manifestations begin locally with severe pain, crepitus, and with *Clostridia*—a thin, brown, foul-smelling discharge.
    - The skin may be tense and shiny, showing pallor or a bronze color.
    - Systemic signs include fever, leukocytosis, mental obtundation, hemolytic anemia, and hypotension, progressing rapidly to multiple organ failure and death in untreated or undertreated cases.
The diagnosis is made by a history of severe unexpected wound pain combined with palpable or radiographic soft-tissue gas (air in subcutaneous tissue and/or muscle).

Absence of soft-tissue gas does not exclude diagnosis of necrotizing infection.

Treatment is surgical, including early, comprehensive, and repeated (every 24–48 hours) debridement of all dead and infected tissue, combined with antibiotics.

Excision of affected tissue must be as radical as necessary (including amputation or disarticulation) to remove all muscle that is discolored, noncontractile, nonbleeding, or suspicious.

Identification of causative organisms is often problematic: treatment must be aimed at all possible organisms.

IV antibiotic therapy.

Clindamycin, 900 mg q8h; plus penicillin G, 4 million U q4h; plus gentamicin, 5–7 mg/kg qd.

As a substitute for clindamycin: Metronidazole, 500 mg q6h.

As a substitute for penicillin: Ceftriaxone, 2.0 g q12h, or erythromycin, 1.0 g q6h.

As a substitute for gentamicin: Ciprofloxacin, 400 mg q12h.

Alternative regimen: Imipenem, 1 g IV q6h.

Intraabdominal infections.

Prevention.

Regimens (start as soon as possible and continue x 24 hours post-op):

Single agent: cefotetan, 1.0 g q12h; or ampicillin/sulbactam, 3 g q6h; or cefoxitin, 1.0 g q8h.

Triple agent: ampicillin, 2 g q6h; plus anaerobic coverage (metronidazole, 500 mg q6h; or clindamycin, 900 mg q8h); plus gentamicin, 5–7 mg/kg qd.

Established intraabdominal infection (peritonitis or abscess).

Same regimen as above, except continue for 7–10 days.

Drain all abscesses.

Pulmonary infections.
Empyema (generally streptococcal) following penetrating thoracic trauma is typically due to contamination from the projectile, chest tubes, or thoracotomy.

Diagnosis: loculations, air/fluid levels on radiograph, pleural aspirate.

Treatment.
- Chest tube initially, and thoracotomy if unsuccessful.
- Cefotaxime, or ceftriaxone, or cefoxitin, or imipenem.

Pneumonia is most frequently due to aspiration (eg, patients with head injury) and prolonged mechanical ventilation.

The diagnosis is made through radiograph finding of a new pulmonary infiltrate that does not clear with chest physiotherapy, combined with:
- Fever or leukocytosis.
- Sputum analysis showing copious bacteria and leukocytes.

Empiric therapy is directed toward likely pathogens.
- Aspiration: Streptococcal pneumonia, coliforms, and oral anaerobes are likely. IV antibiotics—such as ampicillin/sulbactam, clindamycin, or cefoxitin—have been proven effective.
- Ventilator-associated pneumonia: Staphylococcus, Pseudomonas, and other nosocomial Enterobacteriaceae. Broad coverage is best with such agents as imipenem, ceftazidime, or piperacillin/tazobactam plus ciprofloxacin. Vancomycin should also be initiated if concern for methicillin-resistant Staphylococcus aureus.

Systemic Sepsis
Sepsis can be defined as infection combined with a prolonged systemic inflammatory response that includes two or more of the following conditions:
- Tachycardia.
- Fever or hypothermia.
- Tachypnea or hyperventilation.
- Leukocytosis or acute leukopenia.

Progression to septic shock is manifest by systemic hypoperfusion: profound hypotension, mental obtundation, or lactic acidosis. Treatment is a three-pronged approach:
Emergency War Surgery

- Identify and eradicate the source.
- Administer broad-spectrum intravenous antibiotics for the most likely pathogens.
- Use intensive care unit support for failing organ systems, such as cardiovascular collapse, acute renal failure, and respiratory failure.

It is often difficult to identify the source of sepsis, but it is the most important factor in determining the outcome. Potential sources of occult infection include:

- An undrained collection of pus, such as a wound infection, intraabdominal abscess, sinusitis, or perianal abscess.
- Ventilator-associated pneumonia.
- Urinary tract infection.
- Disseminated fungal infection.
- Central intravenous catheter infection.
- Acalculous cholecystitis.

Intensive care support for sepsis involves vigorous resuscitation to restore perfusion to prevent multiple organ dysfunction. This requires optimization of hemodynamic parameters (pulmonary artery occlusion pressure, cardiac output, and oxygen delivery) to reverse anaerobic metabolism and lactic acidosis. Endpoints of resuscitation—such as urine output, base deficit, and blood lactate levels—guide successful treatment. Until the source for sepsis is identified and actual pathogens isolated, empiric therapy with broad-spectrum intravenous antibiotics is warranted. Suitable regimens might include the following:

- Imipenem, 1 g IV q6h.
- Piperacillin and clavulanate (Zosyn), 3.375 g q6h; or ceftazidime, 2.0 g q8h; or cefepime, 2.0 g q12h; plus gentamicin, 5–7 mg/kg qd (based on a once-daily dosing strategy and no renal impairment); or ciprofloxacin, 400 mg q12h.
- Addition of vancomycin, 15 mg/kg q12h, if methicillin-resistant *Staphylococcus aureus* is a likely pathogen.
- Addition of linezolid, 600 mg q12h, if vancomycin-resistant enterococcus is a likely pathogen.

Battlefield casualties are at high risk for infection. In particular, war wounds are predisposed to infection due to environmental
### Table 10-4. Spectrum and Dosage of Selected Antibiotic Agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Antibacterial Spectrum</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin G</td>
<td><em>Streptococcus pyogenes</em>, penicillin-sensitive <em>Streptococcus pneumoniae</em>, clostridial spp.</td>
<td>4 mU IV q4h</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>Enterococcal spp., streptococcal spp., <em>Proteus</em>, some <em>Escherichia coli</em>, Klebsiella</td>
<td>1–2 g IV q6h</td>
</tr>
<tr>
<td>Ampicillin/sulbactam</td>
<td>Enterococcal spp., streptococcal spp., <em>Staphylococcus</em>, <em>E coli</em>, <em>Proteus</em>, Klebsiella, clostridial spp., <em>Bacteroides/Prevotella</em> spp.</td>
<td>3 g IV q6h</td>
</tr>
<tr>
<td>Nafcillin</td>
<td>Staphylococcal spp.,* streptococcal spp.</td>
<td>1 g IV q4h</td>
</tr>
<tr>
<td>Piperacillin/clavulanate</td>
<td>Enterococcal spp., streptococcal spp., <em>Staphylococcus</em>, <em>E coli</em>, <em>Pseudomonas</em>, and other enterobacteriaceae, clostridial spp., <em>Bacteroides/Prevotella</em> spp.</td>
<td>3.375 g IV q6h</td>
</tr>
<tr>
<td>Imipenem</td>
<td>Enterococcal spp., streptococcal spp., <em>Staphylococcus</em>, <em>E coli</em>, <em>Pseudomonas</em>, and other enterobacteriaceae, clostridial spp., <em>Bacteroides/Prevotella</em> spp.</td>
<td>1 g IV q6h</td>
</tr>
<tr>
<td>Cefazolin</td>
<td>Staphylococcal spp.,* streptococcal spp., <em>E coli</em>, Klebsiella, <em>Proteus</em></td>
<td>2 g IV q8h</td>
</tr>
<tr>
<td>Cefoxitin</td>
<td>Staphylococcal spp.,* streptococcal spp., <em>E coli</em> and similar enterobacteriaceae, clostridial spp., <em>Bacteroides/Prevotella</em> spp.</td>
<td>1–2 g IV q6h</td>
</tr>
<tr>
<td>Ceftazidime</td>
<td>Streptococcal spp., <em>E coli</em>, <em>Pseudomonas</em>, and other enterobacteriaceae</td>
<td>2.0 g IV q8h</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>Streptococcal spp., staphylococcal spp.,* Neisseria spp., <em>E coli</em>, and most enterobacteriaceae (NOT <em>Pseudomonas</em>), clostridial spp.</td>
<td>1 g qd</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td><em>E coli</em>, <em>Pseudomonas</em>, and other enterobacteriaceae</td>
<td>400 mg q12h</td>
</tr>
<tr>
<td>Gentamicin</td>
<td><em>E coli</em>, <em>Pseudomonas</em>, and other enterobacteriaceae</td>
<td>5–7 mg/kg qd (based on once-daily dosing strategy and no renal impairment)</td>
</tr>
<tr>
<td>Vancomycin</td>
<td><em>Streptococcus</em>, enterococcal, and staphylococcal spp. (including MRSA, not VRE)</td>
<td>15 mg/kg q12h</td>
</tr>
<tr>
<td>Erthromycin</td>
<td><em>Streptococcus</em> spp., clostridial spp.</td>
<td>0.5–1.0 g q6h</td>
</tr>
<tr>
<td>Clindamycin</td>
<td><em>Streptococcus</em> spp., <em>Staphylococcus</em> spp.,* clostridial spp., <em>Bacteroides</em>, and <em>Prevotella</em> spp.</td>
<td>900 mg q8h</td>
</tr>
<tr>
<td>Metronidazole</td>
<td>Clostridial spp., <em>Bacteroides</em>, and <em>Prevotella</em> spp.</td>
<td>500 mg q6h</td>
</tr>
</tbody>
</table>

MRSA: methicillin-resistant *Staphylococcus aureus*; spp.: species; VRE: vancomycin-resistant enterococci.

**Note:** Dosage and dosage intervals are average recommendations. Individual dosing may vary.

*Not MRSA.
Emergency War Surgery

conditions on the battlefield, devitalized tissue, and foreign bodies in the wound. The key to avoiding wound infection is prompt and adequate wound exploration, removal of all foreign material, and excision of all dead tissue. All battlefield wounds and incisions, to include amputations, should have the skin left open. Antibiotics play an adjunctive role in the prophylaxis of wound and other infections in the battlefield medical treatment facility. Knowledge of likely pathogens for particular infections and sites, as well as optimal antibiotics to eradicate those pathogens (Table 10-4), will aid the battlefield clinician in averting and treating infections.

References


For Clinical Practice Guidelines, go to http://usaisr.amedd.army.mil/clinical_practice_guidelines.html