National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines™)

Prevention and Treatment of Cancer-Related Infections

Version 2.2011

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National Comprehensive Cancer Network®

NCCN Guidelines™ Version 2.2011 Panel Members
Prevention and Treatment of Cancer-Related Infections

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NCCN Guidelines Panel Disclosures

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Prevention and Treatment of Cancer-Related Infections

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Clinical Trials: The NCCN believes that the best management for any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN member institutions, click here: nccn.org/clinical_trials/physician.html

NCCN Categories of Evidence and Consensus: All recommendations are Category 2A unless otherwise specified.

See NCCN Categories of Evidence and Consensus

Updates in the 2.2011 version of the Prevention and Treatment of Cancer-Related Infections guidelines from the 1.2011 version include:

MS-1
- **The discussion section was updated to reflect the changes in the algorithm.**

Updates in the 1.2011 version of the Prevention and Treatment of Cancer-Related Infections guidelines from the 1.2010 version include:

INF-1
- **Added "including cord blood" to allogeneic HSCT.**
- **Added "Consider penicillin and TMP/SMX (GVHD) under antimicrobial prophylaxis.**

INF-5
- **Changed "Patients with neoplastic disease" to "Recipients of prolonged corticosteroids..."**

FEV-4
- **Following Mouth/mucosal membrane pathway, added Biopsy "suspicious" lesions.**

FEV-10
- **Consider catheter removal for bloodstream infections with *Candida,* *S. aureus*, *Pseudomonas aeruginosa*, *Corynebacterium jeikeium*, *Acinetobacter*, *Bacillus* organisms, atypical mycobacteria, yeasts, molds, vancomycin-resistant enterococci, and *Stenotrophomonas maltophilia* - Removed the Category 2B designation.**
- **Footnote x is new to the page: "Some centers use higher dose (for example 150 mg)."**

FEV-11
- **Fever of unknown origin, stable: Continue current antibacterial therapy. Removed "modification of antibacterial therapy solely on the basis of neutropenic fever not required."**

FEV-A
- **Footnote c is new to the page: "Limited published data suggest utilizing higher doses up to 10 mg/kg."**
- **(page 2 of 4) Removed Doripenem.**

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OVERALL INFECTION RISK IN CANCER PATIENTS[a]	DISEASE / THERAPY EXAMPLES[b]	FEVER & NEUTROPENIA RISK CATEGORY (See FEV-3)	ANTIMICROBIAL PROPHYLAXIS[c,d,e,f,g,h]
Low	• Standard chemotherapy regimens for most solid tumors • Anticipated neutropenia less than 7 d	Low	• Bacterial - None • Fungal - None • Viral - None unless prior HSV episode
Intermediate	• Autologous HSCT • Lymphoma • Multiple myeloma • CLL • Purine analog therapy (ie, fludarabine, clofarabine, nelarabine, 2-CdA) • Anticipated neutropenia 7 to 10 d	Usually HIGH, but some experts suggest modifications depending on patient status. Purine analogs, intermediate risk when used as single agents; when combined with intensive chemotherapy regimens, the risk converts to high.	• Bacterial - Consider fluoroquinolone prophylaxis • Fungal - Consider fluconazole during neutropenia and for anticipated mucositis • Viral - During neutropenia and at least 30 d after HSCT
High	• Allogeneic HSCT including cord blood • Acute leukemia ▸ Induction ▸ Consolidation • Alemtuzumab therapy • GVHD treated with high dose steroids • Anticipated neutropenia greater than 10 d	Usually HIGH, but significant variability exists related to duration of neutropenia, immunosuppressive agents, and status of underlying malignancy	• Bacterial - Consider fluoroquinolone prophylaxis • Fungal - See INF-3 • Viral - during neutropenia and at least 30 d after HSCT • Consider penicillin and TMP/SMX (GVHD)

KEY: 2-CdA = chlorodeoxyadenosine (cladribine), CLL = chronic lymphocytic leukemia, CMV = cytomegalovirus, GVHD = graft versus host disease, HSCT = hematopoietic stem cell transplant, HSV = herpes simplex virus, VZV = varicella zoster virus.

[a] Categories of risk are based on several factors, including underlying malignancy, whether disease is in remission, duration of neutropenia, prior exposure to chemotherapy, and intensity of immunosuppressive therapy.

[b] Multiple immune deficits can co-exist in the same patient.

[c] Pneumocystis prophylaxis (See INF-4).

[d] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.

[e] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.

[f] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.

[g] Although data support levofloxacin prophylaxis for low- and intermediate-risk patients, the panel discourages this practice in low-risk patients (because of concerns about antimicrobial resistance); however, it can be considered in intermediate-risk patients.

[h] For patients who are intolerant to fluoroquinolone, consider TMP/SMX.

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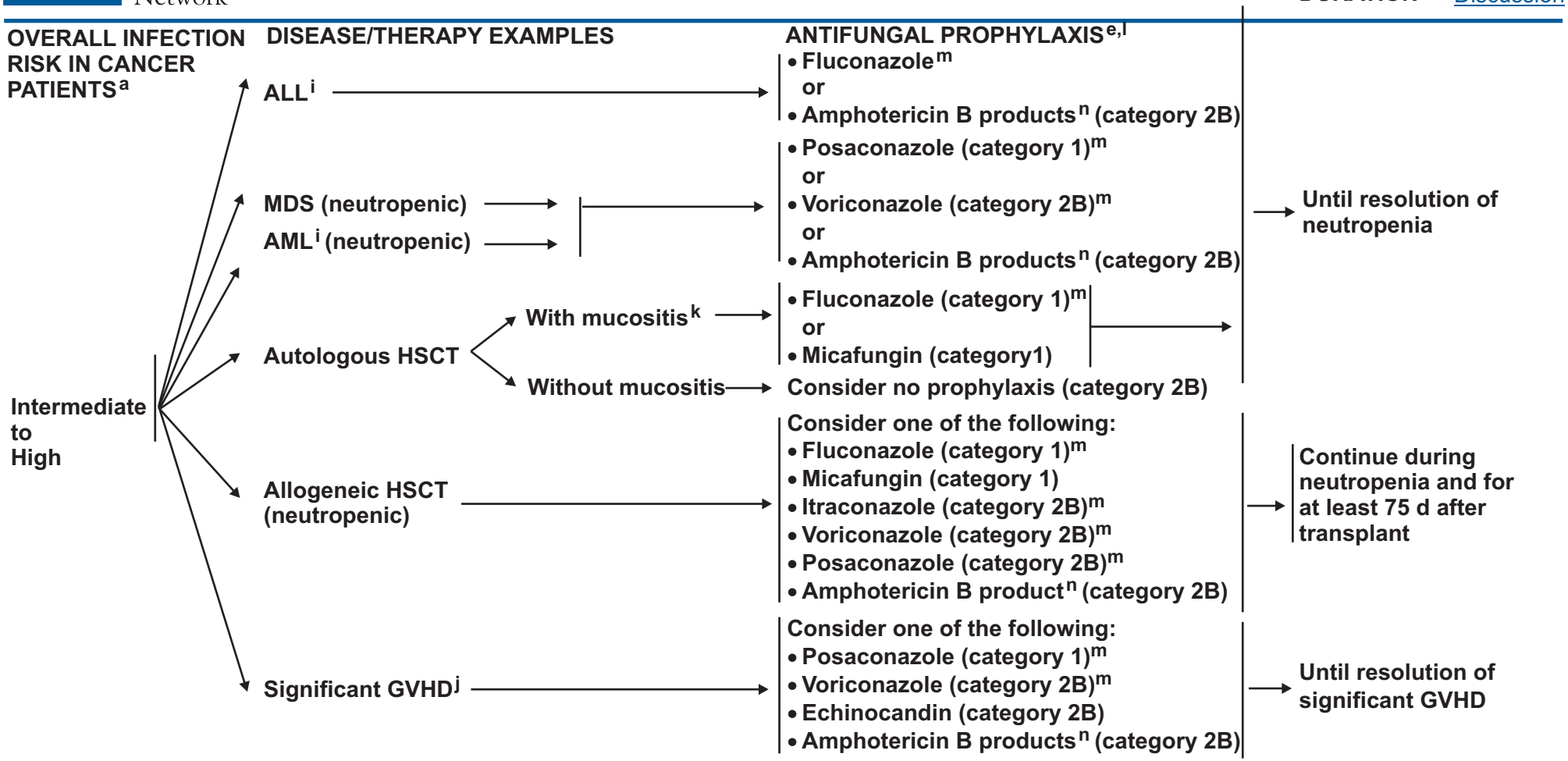

[a] Categories of risk are based on several factors, including underlying malignancy, whether disease is in remission, duration of neutropenia, prior exposure to chemotherapy, and intensity of immunosuppressive therapy.

[e] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.

[i] Recommendations on antifungal prophylaxis in patients with acute leukemia apply to those receiving induction or re-induction chemotherapy.

[k] Consider antifungal prophylaxis in all patients with GVHD receiving immunosuppressive therapy.

[k] Severe mucositis is a risk factor for candidemia in patients with hematologic malignancies and stem cell transplant recipients not receiving antifungal prophylaxis.

[l] There is substantial variability in practice among NCCN institutions. Physicians need to take into account local susceptibility patterns.

[m] Itraconazole, voriconazole, and posaconazole are more potent inhibitors of hepatic cytochrome P450 3A4 isoenzymes than fluconazole and may significantly decrease the clearance of several agents used to treat cancer.

[n] A lipid formulation is generally preferred based on less toxicity.

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OVERALL INFECTION RISK IN CANCER PATIENTS[a]	DISEASE / THERAPY EXAMPLES	VIRAL INFECTION	ANTIVIRAL PROPHYLAXIS	DURATION OF ANTIVIRAL PROPHYLAXIS[f]
Low	• Standard chemotherapy regimens for solid tumors	HSV	None unless prior HSV episode	During neutropenia
Intermediate	• Autologous HSCT • Lymphoma • Multiple Myeloma • CLL • Purine analog therapy (ie, fludarabine)	HSV VZV	Acyclovir Famciclovir Valacyclovir	During neutropenia and at least 30 d after HSCT
High	• Acute leukemia ► Induction ► Consolidation	HSV	Acyclovir Famciclovir Valacyclovir	During neutropenia
	Bortezomib	VZV	Acyclovir Famciclovir Valacyclovir	VZV prophylaxis • In allogeneic transplant recipients, acyclovir prophylaxis should be considered for the first year.
	• Alemtuzumab therapy • Allogeneic HSCT	HSV VZV CMV	Acyclovir Famciclovir[o] or Valacyclovir as HSV prophylaxis[p] (See INF-4) for CMV	HSV prophylaxis[p] • Minimum of 2 mo after alemtuzumab and until CD4 ≥ 200 cells/mcL • During neutropenia and at least 30 d after HSCT Pre-emptive therapy for CMV (See INF-4)

KEY: 2-CdA = chlorodeoxyadenosine (cladribine), CLL = chronic lymphocytic leukemia, CMV = cytomegalovirus, GVHD = graft versus host disease, HSCT = hematopoietic stem cell transplant, HSV = herpes simplex virus, VZV = varicella zoster virus.

[a] Categories of risk are based on several factors, including underlying malignancy, whether disease is in remission, duration of neutropenia, prior exposure to chemotherapy, and intensity of immunosuppressive therapy.

[f] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.

[o] Among allogeneic HSCT, there is more experience with acyclovir and valacyclovir than famciclovir.

[p] Agents used as HSV prophylaxis are also active against VZV (See FEV-C).

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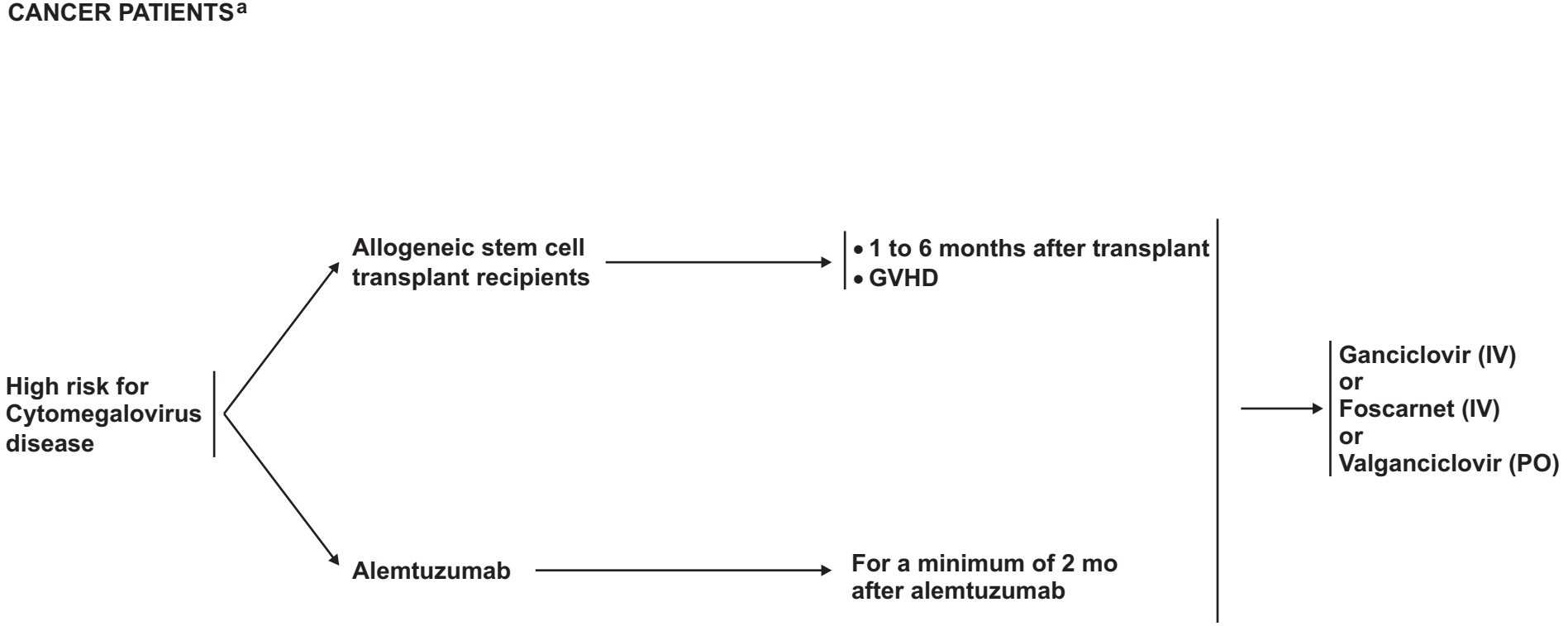
PREVENTION OF CYTOMEGALOVIRUS DISEASE



[a] Categories of risk are based on several factors, including underlying malignancy, whether disease is in remission, duration of neutropenia, prior exposure to chemotherapy, and intensity of immunosuppressive therapy.

[f] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.

[q] CMV surveillance consists of at least weekly monitoring of CMV by PCR or antigen testing.

[r] Duration of antiviral therapy generally is for at least 2 weeks and until CMV is no longer detected.

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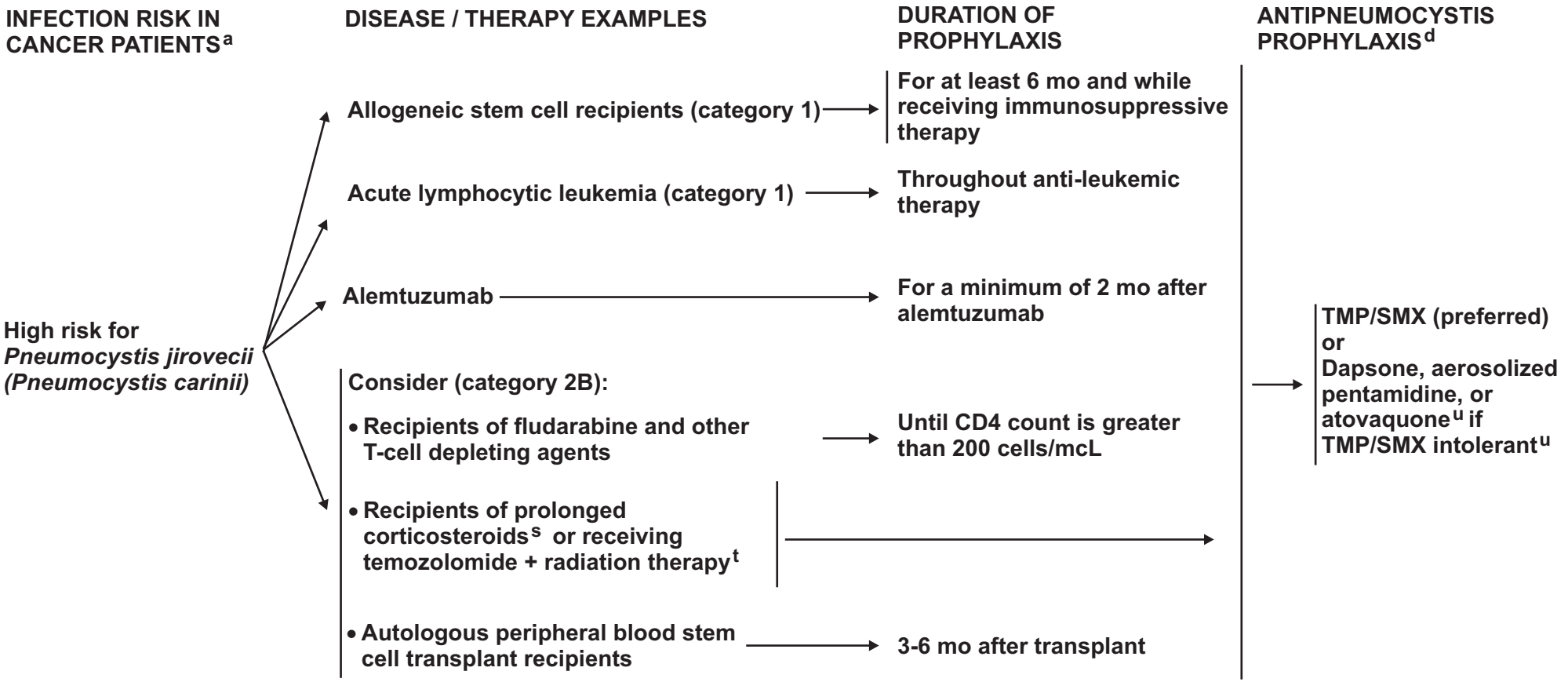

[a] Categories of risk are based on several factors, including underlying malignancy, whether disease is in remission, duration of neutropenia, prior exposure to chemotherapy, and intensity of immunosuppressive therapy.

[d] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.

[s] Risk of PCP is related to the daily dose and duration of corticosteroid therapy. Prophylaxis against PCP can be considered in patients receiving the prednisone equivalent of 20 mg or more daily for 4 or more weeks.

[t] PCP prophylaxis should be used when temozolomide is administered concomitantly with radiation therapy and should be continued until recovery from lymphocytopenia.

[u] Consider trimethoprim/sulfamethoxazole desensitization or dapsone, aerosolized pentamidine, or atovaquone when *Pneumocystis jirovecii* pneumonia prophylaxis is required, and patients are trimethoprim/sulfamethoxazole intolerant.

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CLINICAL PRESENTATION

Fever:
- **Single temperature**
  ≥ 38.3°C orally or
  ≥ 38.0°C over 1 h

Neutropenia:
- **< 500 neutrophils/mcL**
  or
  < 1,000 neutrophils/mcL and a predicted decline to ≤ 500/mcL over the next 48 h

→

INITIAL EVALUATION OF FEVER AND NEUTROPENIA

Site specific H&P including:
- **Intravascular access device**
- **Skin**
- **Lungs and sinus**
- **Alimentary canal (mouth, pharynx, esophagus, bowel, rectum)**
- **Perivaginal/perirectal**

Supplementary historical information:
- **Major comorbid illness**
- **Time since last chemotherapy administration**
- **History of prior documented infections**
- **Recent antibiotic therapy/prophylaxis**
- **Medications**
- **HIV status**
- **Exposures:**
  - **Others at home with similar symptoms**
  - **Pets**
  - **Travel**
  - **Tuberculosis exposure**
  - **Recent blood product administration**

Laboratory/radiology assessment:
- **CBC including differential, platelets, BUN, electrolytes, creatinine, and LFTs**
- **Consider chest x-ray, urinalysis, pulse oximetry**
- **Chest x-ray for all patients with respiratory symptoms**

→

MICROBIOLOGIC EVALUATION

- **Blood culture x 2 sets (one set consists of 2 bottles). Options include:**
  - **One peripheral + one catheter[a]**
    or
  - **Both peripheral**
    or
  - **Both catheter**
- **Urine (if symptoms, urinary catheter, abnormal urinalysis)**
- **Site-specific culture:**
  - **Diarrhea (*Clostridium difficile* assay, enteric pathogen screen)**
  - **Skin (aspirate/biopsy of skin lesions)**
  - **Vascular access cutaneous site with inflammation (consider routine/fungal/mycobacteria)**
- **Viral cultures:**
  - **Vesicular/ulcerated lesions on skin or mucosa**
  - **Throat or nasopharynx for respiratory virus symptoms, especially during outbreaks**

See Initial Therapy (FEV-2)

[a]Preferred for distinguishing catheter-related infections from secondary sources.

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INITIAL THERAPY FOR FEVER AND NEUTROPENIA[b,c]

Initial antibiotic therapy should be based on:

- Infection risk assessment (See FEV-3)
- Potential infecting organisms include vancomycin-resistant enterococcus (VRE) and extended spectrum beta-lactamase (ESBL)
- Colonization with or prior infection with methicillin-resistant *Staphylococcus aureus* (MRSA)
- Site of infection
- Local antibiotic susceptibility patterns
- Organ dysfunction/drug allergy
- Broad spectrum of activity
- Previous antibiotic therapy
- Antipseudomonal coverage
- Bactericidal

→

- **Intravenous antibiotic monotherapy (choose one):**
  - Imipenem/cilastatin (category 1)
  - Meropenem (category 1)
  - Piperacillin/tazobactam[d] (category 1)
  - Cefepime (category 1)[e]
  - Ceftazidime[f] (category 2B)
- **Intravenous antibiotic combination therapy:**
  - Aminoglycoside[g] + antipseudomonal penicillin (category 1) ± beta-lactamase inhibitor (category 1)
  - Aminoglycoside + extended-spectrum cephalosporin (cefepime, ceftazidime)
  - Ciprofloxacin + antipseudomonal penicillin (category 1)
  - Use of vancomycin, linezolid, daptomycin or quinupristin/dalfopristin is not routinely recommended[h,i]
- **Oral antibiotic combination therapy for low risk patients:**
  - Ciprofloxacin + amoxicillin/clavulanate (category 1) (for penicillin-allergic patients, may use ciprofloxacin + clindamycin)
  - Oral antibiotic regimen recommended should not be used if quinolone prophylaxis was used

→

Site-Specific Evaluation and Therapy:

Mouth, Esophagus and Sinus/Nasal (FEV-4)

Abdominal Pain, Perirectal Pain, Diarrhea, Vascular Access Devices (FEV-5)

Lung Infiltrates (FEV-6)

Cellulitis, Wound, Vesicular Lesions, Disseminated Papules or other lesions, Urinary Tract Symptoms, Central Nervous System Symptoms (FEV-7)

OR

Follow-up (FEV-8)

[b] Consider local antibiotic susceptibility patterns when choosing empirical therapy. At hospitals where infections by antibiotic resistant bacteria (eg, MRSA or drug-resistant gram-negative rods) are commonly observed, policies on initial empirical therapy of neutropenic fever may need to be tailored accordingly.

[c] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.

[d] May interfere with galactomannan measurement.

[e] Meta-analysis reported increased mortality associated with cefepime in randomized trials of neutropenic fever. Based on the results of the FDA's meta-analyses, the FDA has determined that cefepime remains an appropriate therapy for its approved indications.

[f] Weak Gram-positive coverage and increased breakthrough infections limit utility.

[g] Some authorities recommend avoidance of aminoglycosides because of potential nephrotoxicity, which may be diminished by once-daily administration. Once-a-day aminoglycoside therapy should be avoided for treatment of meningitis or endocarditis.

[h] Although there are published studies regarding the use of some of these agents in neutropenic patients, the NCCN panel strongly recommends that these agents should not be routinely used as initial empirical therapy for neutropenic fever because of concerns about resistance and breakthrough infections.

[i] See Appropriate Use of Vancomycin and Other Agents for Gram-positive Resistant Infections (FEV-D).

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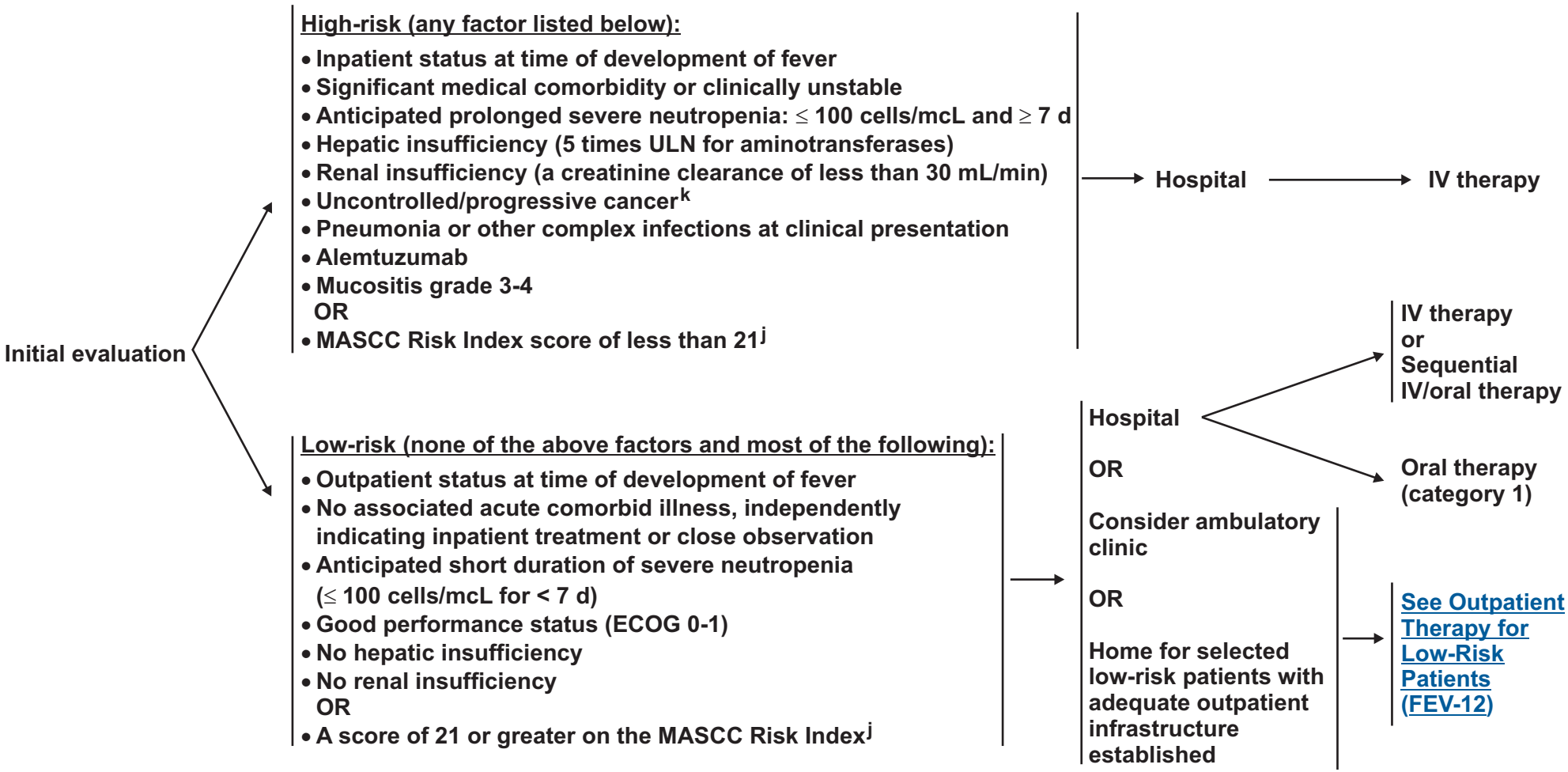

[j]Risk categorization refers to risk of serious complications, including mortality, in patients with neutropenic fever. See Risk Assessment Resources (FEV-E).

[k]Uncontrolled/progressive cancer is defined as any leukemic patient not in complete remission, or non-leukemic patients with evidence of disease progression after more than 2 courses of chemotherapy.

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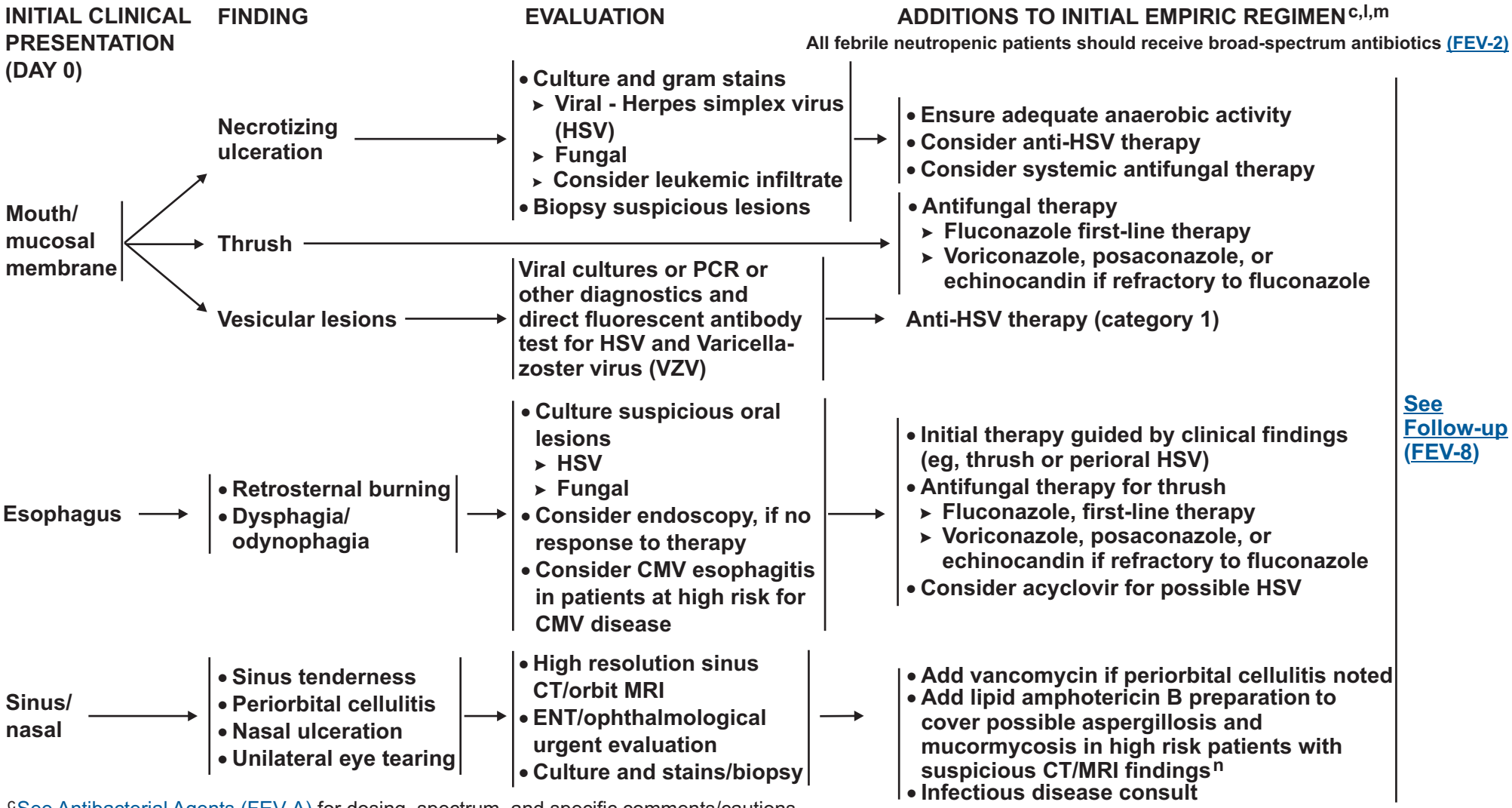

[c] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.
[l] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.
[m] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.
[n] Posaconazole can be considered for salvage therapy or for intolerance to amphotericin B formulations. Posaconazole is not approved by the FDA as either primary or salvage therapy for invasive fungal infections.

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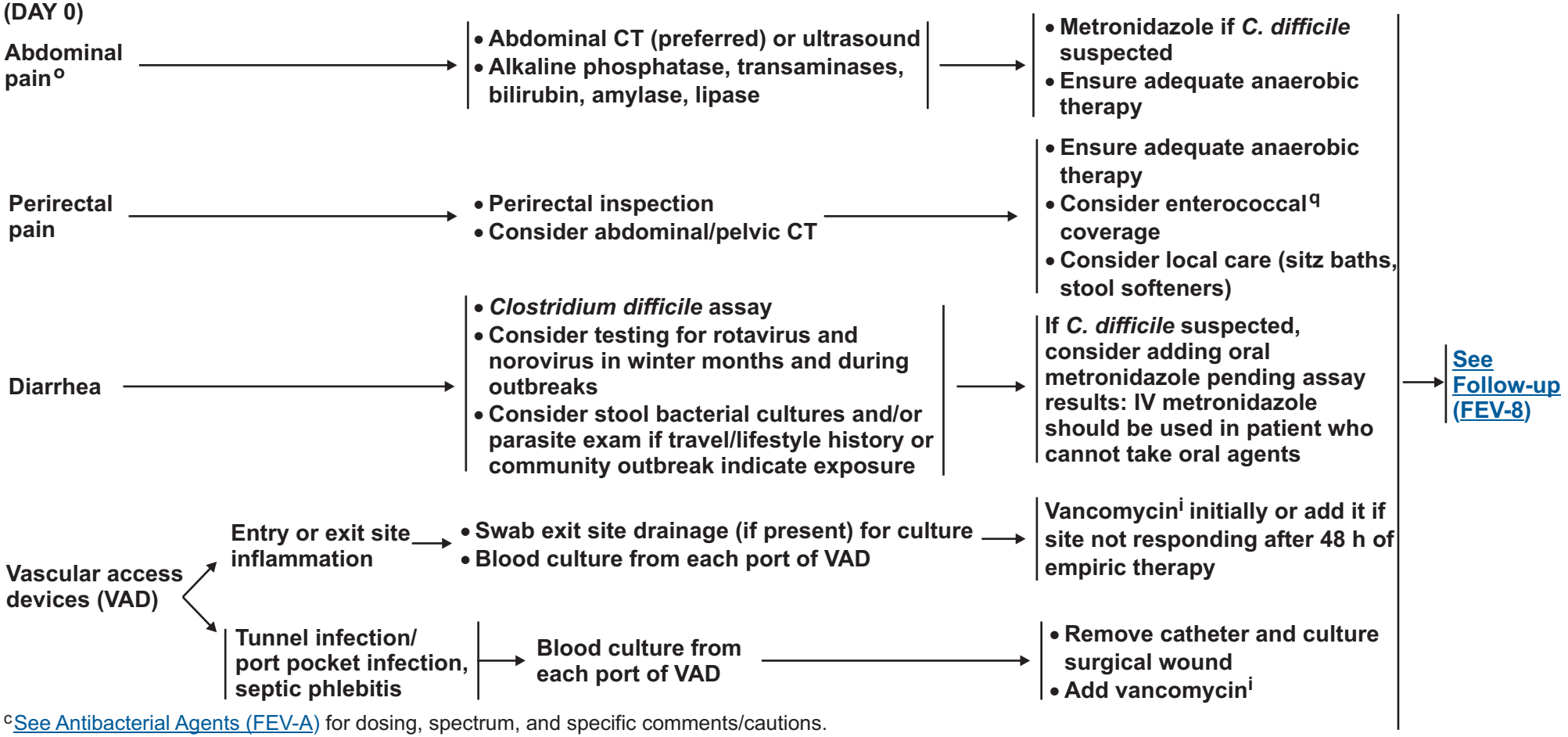

[c] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.
[i] See Appropriate Use of Vancomycin and Other Agents for Gram-positive Resistant Infections (FEV-D).
[l] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.
[m] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.
[o] Surgical and other subspecialty (eg, gastroenterology, interventional radiology) consultations should be considered for these situations as clinically indicated.
[p] Lab studies include CMV antigens/PCR and abdominal/pelvic CT.
[q] Enterococcal colonization must be differentiated from infection. Vancomycin use must be minimized because of the risk of vancomycin resistance.

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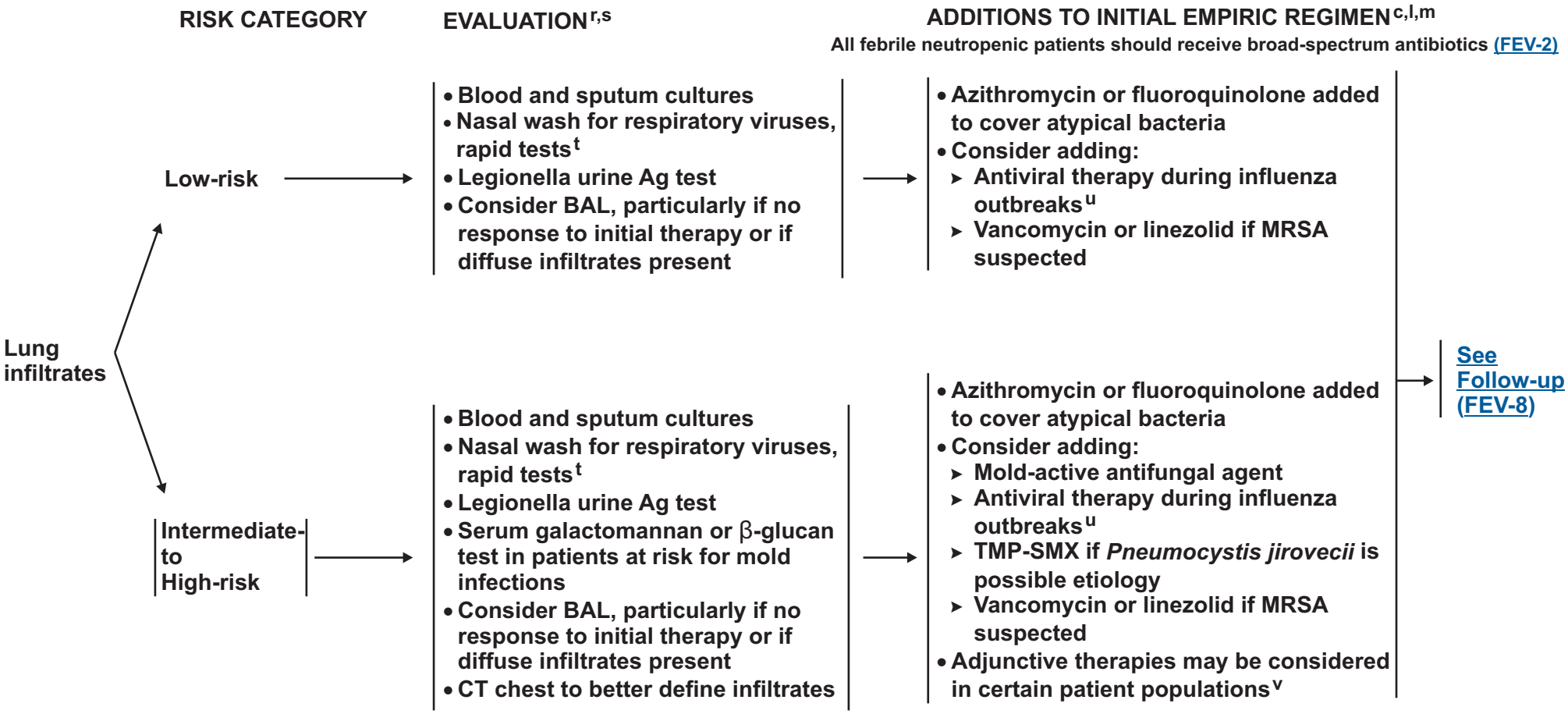

[c] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.
[l] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.
[m] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.
[r] Other diagnoses to consider include pulmonary edema, hemorrhage, and drug toxicities.
[s] Assess for healthcare acquired pneumonia and/or resistant pathogens.
[t] Rapid immunofluorescent viral antigen tests may be negative for H1N1 (swine flu).
[u] Antiviral susceptibility of influenza strains is variable and cannot be predicted based on prior influenza outbreaks. In cases of seasonal influenza and pandemic strains (eg H1N1), it is necessary to be familiar with susceptibility patterns and guidelines on appropriate antiviral treatment.
[v] See Adjuvant Therapies (FEV-F).

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INITIAL CLINICAL PRESENTATION (DAY 0)	EVALUATION	ADDITIONS TO INITIAL EMPIRIC REGIMEN[c,l,m] All febrile neutropenic patients should receive broad-spectrum antibiotics (FEV-2)
Cellulitis	Consider aspirate or biopsy for culture	Consider vancomycin[i]
Wound	Culture	Consider vancomycin[i]
Vesicular lesions	Aspiration or scraping for VZV or HSV direct fluorescent antibody (DFA)/herpes virus cultures	Consider acyclovir, famciclovir, or valacyclovir
Disseminated papules or other lesions	Aspiration or biopsy for bacterial, fungal, mycobacterial cultures and histopathology	• Consider vancomycin[i] • Consider mold-active antifungal therapy in high-risk patients
Urinary tract symptoms	• Urine culture • Urinalysis	No additional therapy until specific pathogen identified
Central nervous system symptoms	• Infectious disease (ID) consult • CT and/or MRI • Lumbar puncture (if possible) • Neurology consult	• Empiric therapy for presumed meningitis should include an anti-pseudomonal beta-lactam agent that readily enters CSF (eg, cefepime, ceftazidime, meropenem) plus vancomycin[i], plus ampicillin (to cover listeriosis). If meropenem is used, addition of ampicillin is unnecessary because meropenem is active against *Listeria*. • For encephalitis, add high-dose acyclovir 10 mg/kg/dose 3x/d) with hydration and monitor renal function

→ See Follow-up (FEV-8)

[c] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.
[i] See Appropriate Use of Vancomycin and Other Agents for Gram-positive Resistant Infections (FEV-D).
[l] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.
[m] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.

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PRINCIPLES OF DAILY FOLLOW-UP

- Daily site-specific H&P
- Daily review of laboratory tests and cultures: document clearance of bacteremia, fungemia with repeat blood cultures
- Evaluate for response to therapy and drug toxicity:
  - Fever trends
  - Signs and symptoms of infection
- Evaluation of drug toxicity including end-organ toxicity (LFTs and renal function tests at least 2x/wk)

→ Evaluate overall response to empiric therapy in 3-5 d[v] (72-120 h)

RESPONDING
- Decreasing fever trend
- Signs and symptoms of infection are stable or improving
- Patient is hemodynamically stable

→ See Follow-up Therapy (FEV-9)

NONRESPONDING
- Persistently or intermittently febrile
- Signs and symptoms of infection are not improving
- Patient may be hemodynamically unstable
- Persistent positive blood cultures

→ See Follow-up Therapy (FEV-11)

[v] See Adjunctive Therapies (FEV-F).

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FOLLOW-UP THERAPY FOR RESPONDING PATIENTS

- No change in initial empiric regimen
- If patients started on "appropriate" initial vancomycin,[i] continue course of therapy
- Initial antibiotic regimen should be continued at least until neutrophil count is ≥ 500 cells/mcL and increasing

SUGGESTED DURATION OF THERAPY FOR FEVER OF UNKNOWN ORIGIN

Documented infection
- Bacteremia
  - Simple (no tissue site)
  - Complex (tissue infection with bacteremia)
- Pneumonia
- Skin/soft tissue
- Sinus
- Fungal
- Viral

→ See Suggested Duration of Therapy for Documented Infection (FEV-10)

Fever of unknown origin

Neutrophils ≥ 500 cells/mcL → Discontinue therapy

Neutrophils < 500 cells/mcL → Continue current regimen until neutropenia resolves

[i] See Appropriate Use of Vancomycin and Other Agents for Gram-positive Resistant Infections (FEV-D).

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FOLLOW-UP THERAPY FOR RESPONDING PATIENTS

GENERAL GUIDELINES

SUGGESTED DURATION OF THERAPY FOR DOCUMENTED INFECTION[c,l,m]

These are general guidelines and may need to be revised for individual patients.

Documented infection →

- **Initial antibiotic regimen should generally be continued until neutrophil count is ≥ 500 cells/mcL and increasing**
- **Duration of antimicrobial therapy may be individualized based upon:**
  - **Neutrophil recovery**
  - **Rapidity of defervescence**
  - **Specific site of infection**
  - **Infecting pathogen**
  - **Patient's underlying illness**

→

- **Skin/soft tissue: 7-14 d**
- **Bloodstream infection (uncomplicated)**
  - **Gram-negative: 10-14 d**
  - **Gram-positive: 7-14 d**
  - ***S. aureus*: at least 2 weeks after first negative blood culture and normal transesophageal echocardiogram (TEE)[w]**
  - **Yeast: ≥ 2 wks after first negative blood culture**
  - **Consider catheter removal for bloodstream infections with *Candida, S. aureus*, *Pseudomonas aeruginosa*, *Corynebacterium jeikeium*, *Acinetobacter*, *Bacillus* organisms, atypical mycobacteria, yeasts, molds, vancomycin-resistant enterococci, and *Stenotrophomonas maltophilia***
- **Sinusitis: 10-21 d**
- **Catheter removal for septic phlebitis, tunnel infection, or port pocket infection**
- **Bacterial pneumonia: 10-21 d**
- **Fungal (mold and yeast):**
  - ***Candida*: minimum of 2 wks after first negative blood culture**
  - **Mold (eg, *Aspergillus*): minimum of 12 wks**
- **Viral:**
  - **HSV/VZV: 7-10 d (category 1); acyclovir, valacyclovir, or famciclovir (uncomplicated, localized disease to the skin)**
  - **Influenza: Oseltamivir is approved by FDA for 5 d based on data from ambulatory otherwise healthy individuals with intact immune systems; longer courses (eg, at least 10 d) and until resolution of symptoms should be considered in the highly immunocompromised[x]**

[c] See Antibacterial Agents (FEV-A) for dosing, spectrum, and specific comments/cautions.
[l] See Antifungal Agents (FEV-B) for dosing, spectrum, and specific comments/cautions.
[m] See Antiviral Agents (FEV-C) for dosing, spectrum, and specific comments/cautions.
[w] A TEE should be considered in all cases of *S. aureus* bacteremia. In patients with conditions that may increase the likelihood of complications (eg, neutropenia, thrombocytopenia, mucositis), a transthoracic echocardiogram (TTE) may be performed initially and, if negative, a TEE should be performed when safe. A TEE is more sensitive and preferred when compared with TTE.
[x] Some centers use higher dose (for example 150 mg).

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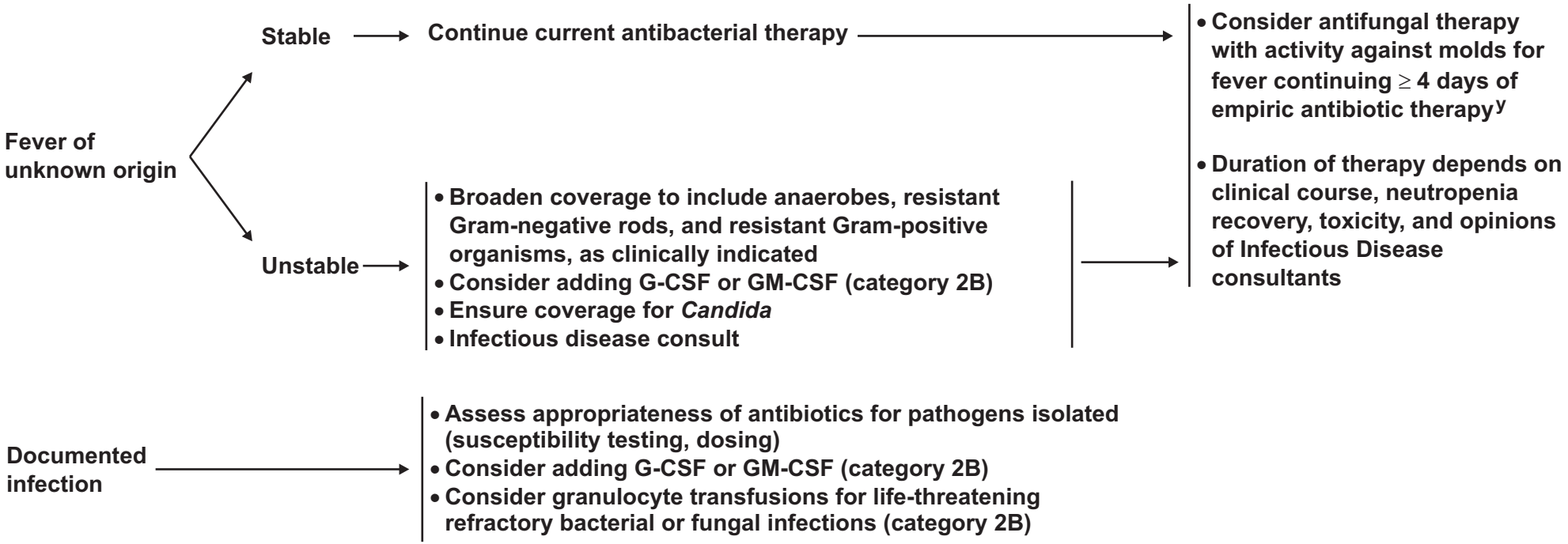
FOLLOW-UP THERAPY FOR NONRESPONDING PATIENTS

SUGGESTED DURATION OF THERAPY



[y]The timing to add empirical antifungal therapy varies with the risk of invasive mold infection but generally ranges between 4-7 d of neutropenic fever. In patients at high risk for mold infection (neutropenia > 10 d, allogeneic stem cell transplant recipients, high-dose corticosteroids), the panel recommends adding empirical antifungal therapy after 4 d unless patient is receiving prophylaxis directed against molds. See Discussion of antifungal prophylaxis versus empirical antifungal therapy.

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OUTPATIENT THERAPY FOR LOW-RISK PATIENTS

INDICATION

Patient determined to be in low-risk category on presentation with fever and neutropenia

- Outpatient status at time of development of fever
- No associated acute comorbid illness, independently indicating inpatient treatment or close observation
- Anticipated short duration of severe neutropenia (< 7 days)
- Good performance status (ECOG 0-1)
- Serum creatinine ≤ 2.0 mg/dL, liver functions ≤ 3x normal
  OR
- A score of 21 or greater on the MASCC Risk Index[j]

→

ASSESSMENT

- Careful examination
- Review lab results: no critical values
- Review social criteria for home therapy
  - Patient consents to home care
  - 24 h home caregiver available
  - Home telephone
  - Access to emergency facilities
  - Adequate home environment
  - Distance within approximately one hour of a medical center or treating physician's office
- Assess for oral antibiotic therapy
  - No nausea and vomiting
  - Able to tolerate oral medications
  - Not on prior fluoroquinolone prophylaxis

→

MANAGEMENT

Observation period (2-12 h) (category 2B) in order to:

- Confirm low-risk status and ensure stability of patient
- Observe and administer first dose of antibiotics and monitor for reaction
- Organize discharge plans to home and follow-up
- Patient education
- Telephone follow-up within 12-24 h

→ See Treatment and Follow-up (FEV-13)

[j]Risk categorization can predict outcome during the febrile episode, including complications/mortality. See Risk Assessment Resources (FEV-E).

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OUTPATIENT THERAPY FOR LOW-RISK PATIENTS

TREATMENT OPTIONS

- IV antibiotics at home
- Daily long-acting intravenous agent ± oral therapy
  - Home or office
- Oral therapy only[z]:
  - 500 mg every 8 h ciprofloxacin[aa] plus 500 mg every 8 h amoxicillin/clavulanate[x] (category 1)
  - Other oral regimens are less well-validated (eg, levofloxacin)

→

FOLLOW-UP

- Patient should be monitored daily[bb]
- Daily examination (clinic or home visit) for the first 72 h to assess response, toxicity, and compliance; if responding, then telephone follow-up daily thereafter.
- Specific reasons to return to clinic:
  - Any positive culture
  - New signs/symptoms reported by the patient
  - Persistent or recurrent fever at days 3-5
  - Inability to continue prescribed antibiotic regimen (ie, oral intolerance)
  - Office visit for infusion of IV antibiotics

[x] Use clindamycin for penicillin-allergic patients.
[z] Criteria for oral antibiotics: no nausea or vomiting, patient able to tolerate oral medications, and patient not on prior fluoroquinolone prophylaxis.
[aa] The fluoroquinolone chosen should be based on reliable Gram-negative bacillary activity, local antibacterial susceptibilities, and the use of quinolone prophylaxis of fever and neutropenia.
[bb] Provider should be individual (eg, MD, RN, PA, NP) who has expertise in the management of patients with neutropenia and fever.

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ANTIBACTERIAL AGENTS (References are on page 4)

GRAM-POSITIVE AGENTS[a]	DOSE	SPECTRUM	COMMENTS/PRECAUTIONS
Vancomycin	15 mg/kg IV every 12 h[b]	Gram-positive organisms with exception of VRE and a number of rare Gram-positive organisms	• Should not be considered as routine therapy for neutropenia and fever unless certain risk factors present (See FEV-D)
Linezolid	600 mg PO/IV every 12 h	Gram-positive organisms including VRE	• Hematologic toxicity may occur, thrombocytopenia most common (0.3% to 10%) • Serotonin syndrome rare, use cautiously with SSRI's[1] • Not for routine use in fever and neutropenia although does not impair neutrophil recovery • Treatment option for VRE and MRSA • Peripheral/optic neuropathy with long-term use • Not recommended for line infections
Daptomycin	4-6 mg/kg IV d[b,c]	• Gram-positive organisms • Has in vitro activity against VRE but is not FDA-approved for this indication	• Equivalent to standard antistaphylococcal agents for *Staphylococcus aureus* bacteremia at 6 mg/kg dose in non-neutropenic patients[2] • Weekly CPK to monitor for rhabdomyolysis • Not indicated for pneumonia due to inactivation by pulmonary surfactant • Not studied in patients with fever and neutropenia • Myositis is a potential toxicity
Dalfopristin/ Quinupristin	7.5 mg/kg IV every 8 h	Gram-positive organisms including most VRE (does not have activity against *Enterococcus faecalis*) or intolerance to vancomycin	• Use limited by myalgias/arthralgias (up to 47%) • Requires central venous access delivery • Avoid use due to toxicity although coverage is good • Musculoskeletal pain syndrome is a potential toxicity

[a] These drugs are not recommended as monotherapy for fever in the setting of neutropenia and should only be added for documented infection with resistant Gram-positive organisms or if certain risk factors are present. (See FEV-D)

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[b] Requires dose adjustment in patients with renal insufficiency.

[c] Limited published data suggest utilizing higher doses up to 10 mg/kg.

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ANTIBACTERIAL AGENTS (References are on page 4)

ANTI-PSEUDOMONAL AGENTS[e]	DOSE	SPECTRUM	COMMENTS/PRECAUTIONS
Imipenem/cilastatin sodium	500 mg IV every 6 h[b]	• Broad spectrum activity against most Gram-positive, Gram-negative and anaerobic organisms • Preferred against extended spectrum beta-lactamase (ESBL) and serious *Enterobacter* infections. • Carbapenem-resistant Gram-negative rod infections are an increasing problem at a number of centers	• Use for suspected intra-abdominal source • Meropenem is preferred over imipenem for suspected /proven CNS infection • Imipenem may lower seizure threshold in patients with CNS malignancies or infection or with renal insufficiency • Empiric therapy for neutropenic fever (category 1)
Meropenem	1 gram IV every 8 h[b] (2 g IV every 8 h for meningitis)		• Effective in nonsocomial pneumonia and intra-abdominal infections • Lack of clinical trial experience in neutropenic patients
Piperacillin/tazobactam	4.5 grams IV every 6 h[b]	• Broad spectrum activity against most Gram-positive, Gram-negative and anaerobic organisms	• Use for suspected intra-abdominal source • Not recommended for meningitis • May result in false positive galactomannan[3] • Empiric therapy for neutropenic fever (category 1)
Cefepime	2 grams IV every 8 h[b]	• Broad spectrum activity against most Gram-positive and Gram-negative organisms	• Use for suspected/proven CNS infection with susceptible organism • Increased frequency of resistance among Gram-negative rod isolates at some centers • Empiric therapy for neutropenic fever (category 1)
Ceftazidime	2 grams IV every 8 h[b]	• Relatively poor Gram-positive activity • Breakthrough streptococcal infections reported • Not active against most anaerobes and *Enterococcus spp.*	• Use for suspected/proven CNS infection with susceptible organism • Increased frequency of resistance among Gram-negative rod isolates at some centers • Empiric therapy for neutropenic fever based on resistance among certain Gram-negative rods (category 2B)

[b] Requires dose adjustment in patients with renal insufficiency.
[d] Local antibiograms should be considered.
[e] None of these agents are active against MRSA or VRE.

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ANTIBACTERIAL AGENTS (References are on page 4)

OTHER ANTIBACTERIAL AGENTS	DOSE	SPECTRUM	COMMENTS/CAUTIONS
Ciprofloxacin	500-750 mg PO every 12 hours or 400 mg IV every 8-12 h[b]	• Good activity against Gram-negative and atypical (e.g., *Legionella spp.*) organisms • Less active than "respiratory" fluoroquinolones against Gram-positive organisms • No activity against anaerobic organisms	• Avoid for empiric therapy if patient recently treated with fluoroquinolone prophylaxis • Increasing Gram-negative resistance in many centers • Oral antibiotic combination therapy in low-risk patients (with amoxicillin/clavulanate or clindamycin) • In combination with antipseudomonal penicillin in higher risk patients
Levofloxacin	500-750 mg oral or IV daily[b]	• Good activity against Gram-negative and atypical (e.g., *Legionella spp.*) organisms • Improved Gram-positive activity compared to ciprofloxacin • Limited activity against anaerobes • Prophylaxis in neutropenic patients[5,6]	• Prophylaxis may increase bacterial resistance and superinfection[7] • Limited studies as empirical therapy in patients with fever and neutropenia
Aminoglycosides • Gentamicin • Tobramycin • Amikacin	Dosing individualized with monitoring of levels[b]	• Activity primarily against Gram-negative organisms • Gentamicin is synergistic with beta-lactams against susceptible *S. aureus* and *Enterococcus* infections	• Nephrotoxicity and ototoxicity limit use • Combination therapy with anti-pseudomonal penicillin +/- beta-lactamase inhibitor or extended spectrum cephalosporin (see FEV-2)
Trimethoprim/sulfamethoxazole (TMP/SMX)	Single or double strength daily or Double strength 3 times per wk as prophylaxis for *P. jirovecii*		• Highly effective as prophylaxis against *P. jirovecii* in high risk patients (see INF-5)

[b]Requires dose adjustment in patients with renal insufficiency.

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ANTIBACTERIAL AGENTS REFERENCES

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ANTIFUNGAL AGENTS (References are on page 4)

AZOLES[a]	DOSE	SPECTRUM	COMMENTS/CAUTIONS
Fluconazole	In adults with normal renal function: 400 mg IV/PO daily	• Active against *Candida* • Active against dimorphic fungi (eg, histoplasmosis, coccidioidomycosis) and *C. neoformans*	• *Candida glabrata* is associated with variable resistance in vitro and *Candida krusei* is always resistant • Inactive against molds (eg, *Aspergillus* species, Zygomycetes)
Itraconazole	Oral 400 mg daily (aim for trough of > 0.25 mcg/mL after 7 d of therapy)	• Active against *Candida, Aspergillus* species and some of the rarer molds • Active against dimorphic fungi and *C. neoformans*	• Itraconazole has negative inotropic properties and is contraindicated in patients with significant cardiac systolic dysfunction
Voriconazole	IV 6 mg/kg every 12 h x 2 doses, then 4 mg/kg every 12 h; oral 200 mg PO BID (for invasive aspergillosis);[1] IV 6 mg/kg every 12 h x 2, then 3 mg/kg every 12 h for non-neutropenic patients with candidemia[2]	• Active against *Candida, Aspergillus* species and some of the rarer molds • Active against dimorphic fungi and *C. neoformans* • Standard of care as primary therapy for invasive aspergillosis (category 1)[1,3] • Effective in candidemia in non-neutropenic patients[2]	• Poor activity against Zygomycetes • IV formulation should be used with caution in patients with significant pre-existing renal dysfunction based on potential to worsen azotemia
Posaconazole	• Prophylaxis: 200 mg PO TID among high-risk patients (See INF-3) • Salvage therapy: 200 mg PO QID followed by 400 mg PO BID once infection has stabilized	• Effective as prophylaxis in neutropenic patients with myelodysplastic syndrome and acute myelogenous leukemia,[4] and in HSCT recipients with significant GVHD[5] • Active against *Candida*, *Aspergillus* sp, some Zygomycetes sp, and some of the rarer molds • Active against dimorphic fungi and *C. neoformans*	• Evaluated as salvage therapy (but not FDA-approved) in several invasive fungal diseases. • Data on posaconazole as primary therapy for invasive fungal infections are limited. • Should be administered with a full meal or liquid nutritional supplement. For patients who cannot eat a full meal or tolerate an oral nutritional supplement alternative antifungal therapy should be considered.

[a] Azoles inhibit fungal cell membrane synthesis and inhibit cytochrome P450 isoenzymes that may lead to impaired clearance of other drugs metabolized by this pathway. Fluconazole is a less potent inhibitor of cytochrome P450 isoenzymes than the mold-active azoles. Drug-drug interactions are common and need to be closely monitored (consult package inserts for details). Reversible liver enzyme abnormalities are observed.

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ANTIFUNGAL AGENTS (References are on page 4)

AMPHOTERICIN B FORMULATIONS[b]	DOSE	SPECTRUM	COMMENTS/CAUTIONS
Amphotericin B desoxycholate (AmB-D)	Varies on indication, generally 0.5 to 1.5 mg/kg/d	Broad spectrum of antifungal activity including *Candida*, *Aspergillus* sp (excluding *Aspergillus terreus*) Zygomycetes, rarer molds, *Cryptococcus neoformans*, and dimorphic fungi	• Substantial infusional and renal toxicity including electrolyte wasting • Saline loading may reduce nephrotoxicity • Infusional toxicity may be managed with anti-pyretics, an anti-histamine, and meperidine (for rigors)
Liposomal amphotericin B (L-AMB)	3 mg/kg/d IV was as effective as, but less toxic than, 10 mg/kg/d as initial therapy for invasive mold infections[6,c]		Reduced infusional and renal toxicity compared to AmB-D
Amphotericin B lipid complex (ABLC)	5 mg/kg/d IV for invasive mold infections		Reduced infusional and renal toxicity compared to AmB-D
Amphotericin B colloidal dispersion (ABCD)	5 mg/kg/d IV for invasive mold infections		Substantial infusional toxicity; other lipid formulations of amphotericin B are generally preferred

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[b] Broad spectrum of antifungal activity. Significant infusional and renal toxicity, less so with lipid formulations.
[c] The vast majority of subjects in this trial had invasive aspergillosis; optimal dosing of L-AMB for other mold infections (such as mucormycosis) is unclear.

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ANTIFUNGAL AGENTS (References are on page 4)

ECHINOCANDINS[d]	DOSE	SPECTRUM	COMMENTS/CAUTIONS
Caspofungin	• 70 mg IV x 1 dose, then 50 mg IV daily; some investigators use 70 mg IV daily as therapy for aspergillosis • 70 mg IV x 1 dose, followed by 35 mg IV daily for patients with moderate liver disease	Active against *Candida* and *Aspergillus* sp. Not reliable or effective against other fungal pathogens.	• Primary therapy for candidemia and invasive candidiasis (category 1)[7] • Salvage therapy for aspergillosis. Similar efficacy compared to AmB-D as primary therapy for candidemia and invasive candidiasis, but significantly less toxic[7] • 45% success rate as salvage therapy for invasive aspergillosis[8] • Similar efficacy, but less toxic compared with L-AMB as empirical therapy for persistent neutropenic fever[7] • Excellent safety profile.
Micafungin	100 mg/d IV for candidemia and 50 mg/d IV as prophylaxis		• Primary therapy for candidemia and invasive candidiasis (category 1) • Similar efficacy compared to caspofungin[9] and compared to L-AMB[10] as primary therapy for candidemia and invasive candidiasis • Superior efficacy compared to fluconazole as prophylaxis during neutropenia in HSCT recipients[11] • Excellent safety profile.
Anidulafungin	200 mg IV x 1 dose, then 100 mg/d IV		• Primary therapy for candidemia and invasive candidiasis (category 1) • Superior efficacy compared to fluconazole as primary therapy for candidemia and invasive candidiasis[12] • Excellent safety profile.

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[d] A number of centers use combination voriconazole and an echinocandin for invasive aspergillosis based on in vitro, animal, and limited clinical data.

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REFERENCES FOR ANTIFUNGAL AGENTS (page 4 of 4)

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ANTIVIRAL AGENTS (References are on page 4)[a]

AGENT	TREATMENT	SPECTRUM	COMMENTS/CAUTIONS
Acyclovir	Prophylaxis[b]: HSV (800-1600 mg PO BID [divided two to four times per day]; VZV in allogeneic HSCT recipients (800 mg PO BID)[1]; CMV in allogeneic HSCT recipients (800 mg PO QID)[c,2] Treatment: significant mucocutaneous HSV (5 mg/kg IV every 8H for 7-10 days); single dermatomal VZV (800 mg PO 5 times daily or 5 mg/kg IV every 8H for 7-10 days); disseminated HSV or VZV (10 mg/kg IV every 8H)[3]	HSV, VZV	Hydration to avoid crystal nephropathy with high dose
Valacyclovir	Prophylaxis[b]: HSV or VZV (500 mg PO BID or TID) CMV in allogeneic HSCT recipients (2gm PO QID)[c,4] Treatment: HSV or VZV (Valacyclovir 1 gm PO TID)[3]	HSV, VZV	
Famciclovir	Prophylaxis: HSV or VZV (250 mg PO BID) Treatment: HSV (250 mg PO TID) or VZV (500 mg PO TID)[5,6]	HSV, VZV	No data for oncologic related prophylaxis
Ganciclovir	Prophylaxis for CMV: 5-6 mg/kg IV every day for 5 days/week from engraftment until day 100 after HSCT[d,7] Pre-emptive therapy for CMV: 5 mg/kg every 12H for 2 weeks; if CMV remains detectable, treat with additional 2 weeks of ganciclovir 6 mg/kg daily 5 days per week. Therapy: CMV disease (5 mg/kg every 12H for 2 weeks followed by 5 to 6 mg/kg daily for at least an additional 2 - 4 weeks and resolution of all symptoms). Add IVIG for CMV pneumonia. Formulations and dosages of IVIG vary in different series; 400-500 mg/kg every other day for the first week is a reasonable regimen.	CMV, HSV, VZV	May cause bone marrow suppression
Valganciclovir	Prophylaxis: CMV (900 mg every day)[d] Pre-emptive therapy for CMV: 900 mg PO BID for 2 weeks; consider additional 900 mg PO daily for at least 7 days after a negative test	CMV	May cause bone marrow suppression

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[a] Requires dose adjustment in patients with renal insufficiency.

[b] Antiviral prophylaxis should be targeted to specific high-risk patients (see INF-4). In non-transplant high-risk patients, prophylaxis should be administered to patients seropostive for HSV or VZV (or with a history of chicken pox). In HSCT recipients, prophylaxis is only indicated if either the donor or recipient is seropositive for the virus in question. The indicated doses for antiviral agents are for adults with normal renal function; consult package insert for dose modification in pediatrics and in patients with renal impairment. Prophylactic antiviral doses may be higher than those routinely used in immunocompetent persons (for example, for recurrent cold sores); there is substantial variability in the prophylactic doses of acyclovir used in different clinical trials in patients with hematologic malignancies and HSCT recipients.

[c] High-dose acyclovir and valacyclovir have been used as prophylaxis for CMV. Because these agents have weak activity against CMV, a strategy of CMV surveillance and pre-emptive therapy with ganciclovir, valganciclovir, or foscarnet is required among patients at high risk for CMV disease.

[d] In general, the strategy of CMV surveillance testing by antigenemia or PCR followed by pre-emptive anti-CMV therapy for a positive result is favored over universal long-term prophylaxis in allogeneic HSCT patients.

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ANTIVIRAL AGENTS (References are on page 4)[a]

AGENT	TREATMENT	SPECTRUM	COMMENTS/CAUTIONS
Foscarnet	Prophylaxis for CMV: 60 mg/kg TID or 60 mg/kg IV every 12H for 7 days, followed by 90-120 mg/kg IV every day until day 100 after HSCT.[d,7,8] Pre-emptive therapy for CMV: 60 mg/kg every 12H for 2 weeks; if CMV remains detectable, treat with additional 2 - 4 weeks of foscarnet, 90 mg/kg daily 5 days per week. Therapy: Acyclovir-resistant HSV (40 mg/kg every 8H for 7-10 days); CMV disease (90 mg/kg every 12H for 2 weeks followed by 120 mg/kg daily for at least an additional 2 - 4 weeks and resolution of all symptoms). Add IVIG for CMV pneumonia.	HSV, VZV, CMV	Drug of choice for acyclovir resistant HSV and VZV and ganciclovir resistant CMV; nephrotoxic; monitor electrolytes
Cidofovir	Prophylaxis for CMV: Cidofovir 5 mg/kg IV every other week with probenecid 2 gm PO 3H before the dose, followed by 1 gm PO 2H after the dose and 1 gm PO 8H after the dose and IV hydration Treatment: Cidofovir 5 mg/kg IV every week for 2 weeks, followed by cidofovir 5 mg/kg every 2 weeks with probenecid 2 gm PO 3H before the dose, followed by 1 gm PO 2H after the dose and 1 gm PO 8H after the dose and IV hydration	CMV, HZV, VZV	Nephrotoxicity, ocular toxicity, bone marrow toxicity, hydration and probenecid required to reduce nephrotoxicity
Oseltamivir	Prophylaxis: 75 mg PO every day[e,9] Treatment: 75 mg BID	Influenza A & B	May cause nausea (improved when taken with food)
Zanamivir	Prophylaxis: 2 oral inhalations (5 mg/inhalation) daily Treatment: 2 oral inhalations (5 mg/inhalation) BID	Influenza A & B	Duration influenced by nature of exposure (ongoing vs. time limited); may cause bronchospasm
Amantadine		Influenza A	Not currently recommended secondary to resistance
Rimantadine		Influenza A	Not currently recommended secondary to resistance

[a] Requires dose adjustment in patients with renal insufficiency.

[d] In general, the strategy of CMV surveillance testing by antigenemia or PCR followed by pre-emptive anti-CMV therapy for a positive result is favored over universal long-term prophylaxis in allogeneic HSCT patients.

[e] Prophylaxis among highly immunocompromised persons during community and nosocomial outbreaks of influenza A should be considered.

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ANTIVIRAL AGENTS (References are on page 4)

AGENT	TREATMENT	SPECTRUM	COMMENTS/CAUTIONS
Pegylated Interferon-alpha (or peginterferon alfa-2a)	Treatment for HCV: Pegylated Interferon-alpha 1.5 mcg/kg (or peginterferon alfa-2a 180 mcg) SC weekly plus ribavirin orally (dosing based on weight: if less than 75 kg, 400 mg in the morning and 600 mg in the evening; if greater than 75 kg, 600 mg twice daily)	HCV	
Intravenous immune globulin (IVIG)	Doses of IVIG vary among different studies and different viral illnesses. A dose of 400 - 500 mg/kg administered daily for 5 days is common for parvovirus B19-associated disease.[10] For CMV and RSV disease, adjunctive IVIG (400mg/kg) every other day for 3 to 5 doses is commonly administered	RSV, Parvovirus B19, CMV	
Palivizumab	Prophylaxis: 15 mg/kg IM monthly during RSV season[f,11]	RSV	Data predominantly in pediatric population[f]
Ribavirin	Treatment for RSV disease[g]: (6 gm administered by continuous inhalation via SPAG-2 nebulizer every 12-18H daily for 7 days or 2g over 2 h TID); may be paired with IVIG (400 - 500 mg/kg every other day) or palivizumab[12]	RSV	
Lamivudine	100 mg PO every day	HBV	Concerns with resistant virus emerging when monotherapy utilized
Tenofovir DF	300 mg PO every day	HBV	Tenofovir DF is the preferred agent for chronic hepatitis B infection, but limited data in oncological populations. Adefovir and entacavir also have activity against hepatitis B.

[f]Palivizumab is an RSV-specific monoclonal antibody that has principally been evaluated in the pediatric population; there are inadequate data to judge efficacy in RSV disease in patients with hematologic malignancies and stem cell transplant recipients.

[g]Inhaled ribavirin is only FDA approved for hospitalized infants and young children with severe lower respiratory tract RSV disease. The experience in immunocompromised adults with RSV disease is limited, but should be considered given the potential morbidity and mortality associated with RSV infection. Ribvirin is teratogenic and precautions are required during administration (see Package insert).

Continued on next page

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

ANTIVIRAL AGENTS – REFERENCES

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APPROPRIATE USE OF VANCOMYCIN AND OTHER AGENTS FOR GRAM-POSITIVE RESISTANT INFECTIONS

- **Vancomycin should not be considered as a routine component of initial therapy for fever and neutropenia. Because of the emergence of vancomycin-resistant organisms, empiric vancomycin should be avoided except for serious infections associated with the following clinical situations:**
  - **Clinically apparent, serious, catheter-related infection**
  - **Blood culture positive for Gram-positive bacterium prior to final identification and susceptibility testing**
  - **Known colonization with penicillin/cephalosporin-resistant pneumococci or methicillin-resistant *Staphylococcus aureus***
  - **Hypotension or septic shock without an identified pathogen (ie, clinically unstable)**
  - **Soft tissue infection**
  - **Risk factors for viridans group streptoccocal, bacteremia (category 2B): severe mucositis (eg, associated with high-dose cytarabine) and prophylaxis with quinolones or TMP-SMX (see manuscript)[a]**
- **Vancomycin should be discontinued in 2-3 days if a resistant Gram-positive infection (eg, MRSA) is not identified.**
- **Linezolid, quinupristin/dalfopristin, and daptomycin may be used specifically for infections caused by documented vancomycin-resistant organisms (eg, VRE) or in patients for whom vancomycin is not an option. Vancomyocin or linezolid should be considered for ventilator associated MRSA pneumonia.**

(See FEV-A 1 of 4)

[a] Recent studies have shown that addition of vancomycin is likely to be unnecessary solely on the basis of neutropenic fever and mucositis when broad spectrum beta-lactam agents with activity against oral flora (eg, piperacillin/tazobactam or imipenem/cilastatin) are used.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

RISK ASSESSMENT RESOURCES

USING THE MASCC RISK-INDEX SCORE

- Using the visual analogue score, estimate the patient's burden of illness at the time of initial clinical evaluation. No signs or symptoms or mild signs or symptoms are scored as 5 points, moderate signs or symptoms are scored as 3 points. These are mutually exclusive. No points are scored for severe signs or symptoms or moribund.
- Based upon the patients age, past medical history, present clinical features and site of care (inpt/outpt when febrile episode occurred), score the other factors in the model and sum them.

BURDEN OF ILLNESS

How sick is the patient at presentation?

No signs or symptoms	Mild signs or symptoms	Moderate signs or symptoms	Severe signs or symptoms	Moribund

Estimate the burden of illness considering all comorbid conditions

MASCC RISK-INDEX SCORE/MODEL[1]

Characteristic	Weight
• Burden of illness	
▸ No or mild symptoms	5
▸ Moderate symptoms	3
• No hypotension	5
• No COPD	4
• Solid tumor or hemotologic malignancy with no previous fungal infection	4
• No dehydration	3
• Outpatient status	3
• Age <60 years	2

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Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

ADJUNCTIVE THERAPIES

Limited or anecdotal data are available to suggest that these interventions may be beneficial:

- **G-CSF or GM-CSF should be considered in neutropenic patients with serious infectious complications, such as the following (category 2B):**
  - **Pneumonia**
  - **Invasive fungal infection**
  - **Progressive infection (any type)**
- **Granulocyte transfusions (category 2B)**
  - **Invasive fungal infection**
  - **Gram-negative rod infection unresponsive to appropriate antimicrobial therapy**
- **Intravenous immunoglobulin**
  - **Should be used in combination with ganciclovir for CMV pneumonia**
  - **Consider IV IgG for patients with profound hypogammaglobulinemia (category 2B)**

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

Discussion

NCCN Categories of Evidence and Consensus

Category 1: The recommendation is based on high-level evidence (e.g. randomized controlled trials) and there is uniform NCCN consensus.

Category 2A: The recommendation is based on lower-level evidence and there is uniform NCCN consensus.

Category 2B: The recommendation is based on lower-level evidence and there is nonuniform NCCN consensus (but no major disagreement).

Category 3: The recommendation is based on any level of evidence but reflects major disagreement.

All recommendations are category 2A unless otherwise noted.

Overview

Infectious diseases are important causes of morbidity and mortality in patients with cancer. In certain instances, the malignancy itself can predispose patients to severe or recurrent infections. Neutropenia has been recognized for many decades as a major risk factor for the development of infections in cancer patients undergoing chemotherapy. Effective strategies to anticipate, prevent, and manage infectious complications in neutropenic cancer patients have led to improved outcomes.[1-12] Due to advances in antimicrobial therapy, it is now uncommon for patients with acute leukemia or those undergoing stem cell transplantation to die from infections during the neutropenic period.

Although neutropenia remains a key risk factor for infections, other immunocompromised states pose at least equal risk. Allogeneic hematopoietic stem cell transplant (HSCT) recipients with neutrophil recovery who require intensive immunosuppressive therapy for graft-versus-host disease (GVHD) are an example of non-neutropenic patients at great risk for common bacterial, viral, and opportunistic infections.[13-16] The spectrum of infectious diseases in allogeneic HSCT recipients with GVHD is distinct from neutropenia. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines ™) on Prevention and Treatment of Cancer-Related Infections discuss infections in neutropenic and immunocompromised non-neutropenic patients with cancer. Our scope also includes other highly immunocompromised patients with cancer (such as those receiving high-dose corticosteroids, purine analogues, or alemtuzumab).

We characterize the major categories of immunologic deficits in persons with cancer and the major pathogens to which they are susceptible. Specific guidelines are provided on the prevention, diagnosis and treatment of the major common and opportunistic infections that afflict patients with cancer. These NCCN Guidelines should be applied in conjunction with careful, individual patient evaluation and with an understanding of host factors that predispose patients to specific infectious diseases and with an understanding of antimicrobial susceptibility patterns.

The NCCN Guidelines on Prevention and Treatment of Cancer-Related Infections are divided into 4 sections. The first section discusses the major host factors that predispose patients to infectious diseases. The second section addresses management of neutropenic fever. The third section addresses site-specific infections (e.g., pneumonia, abdominal infections, catheter-associated infections) and focuses on patients who have neutropenia or who are otherwise significantly

immunocompromised (e.g., HSCT recipients). The fourth section addresses prevention of infectious complications, including immunization and targeted antimicrobial prophylaxis.

Host Factors That Predispose Patients to Infectious Complications

Immunodeficiencies Associated With Primary Malignancy

Certain malignancies are inherently associated with immune deficits. Patients with hematologic malignancies and myelodysplastic syndrome (MDS) may be leukopenic due to infiltration of the marrow with malignant cells or due to a dysfunctional marrow. Patients with chronic lymphocytic leukemia (CLL) frequently have hypogammaglobulinemia leading to increased susceptibility to encapsulated bacteria, principally *Streptococcus pneumoniae*.[17] Such patients may have recurrent sinopulmonary infections and septicemia. Patients with multiple myeloma are often functionally hypogammaglobulinemic; the total level of immunoglobulin production may be elevated, but the repertoire of antibody production is restricted. Savage et al [18] noted a biphasic pattern of infection among patients with multiple myeloma. Infections by *S.pneumoniae* and *Haemophilus influenzae* occurred early in the disease and in patients responding to chemotherapy, whereas infections by *Staphylococcus aureus* and Gram-negative pathogens occurred more commonly in advanced disease and during neutropenia.

Patients with advanced or refractory malignancy have a greater risk of infectious complications than those who respond to therapy. Refractory hematologic malignancies can be associated with marrow failure from the underlying disease itself and from multiple lines of prior immunosuppressive therapy. In patients with CLL, those who receive multiple chemotherapeutic regimens are at significantly increased risk for developing severe infections.[19] A retrospective study showed that nearly 90% of heavily pretreated patients (median 3 prior regimens; range, 1-8) with fludarabine-refractory CLL experienced serious infectious complications requiring hospitalization.[20] Pathogens responsible for the infections were bacterial, viral (e.g., herpes simplex virus [HSV], varicella zoster virus), fungal, and opportunistic pathogens, including *Pneumocystis carinii* (*Pneumocystis jiroveci*).[20] Solid tumors may predispose patients to infection because of anatomic factors. Tumors that overgrow their blood supply become necrotic, thus forming a nidus for infection. Endobronchial tumors may cause recurrent postobstructive pneumonias. Abdominal tumors may obstruct the genitourinary or hepatobiliary tracts, predisposing patients to pyelonephritis and cholangitis, respectively. Direct invasion through the colonic mucosa is associated with local abscess formation and sepsis by enteric flora. Patients undergoing surgery for malignancies may be at high risk for infectious complications as a result of the type of surgery (e.g., esophagectomy and hepatobiliary reconstruction are surgeries associated with a high risk for infection), extent of tumor burden, preoperative performance status, and previous surgery, chemotherapy, and radiation therapy. Patients with advanced malignancy are also commonly malnourished, which further increases the risk of infection.

Neutropenia

The absence of granulocytes; the disruption of the integumentary, mucosal, and mucociliary barriers; and the inherent microbial flora shifts that accompany severe illness and antimicrobial usage predispose the neutropenic patient to infection. The signs and symptoms of infection are often absent or muted in the absence of neutrophils, but fever remains an early, although nonspecific, sign.[7] Approximately 48% to 60% or more of the patients who become febrile have an established or occult infection.[21] Roughly 10% to 20% or more of patients with neutrophil counts less than 100/mcL will develop a

bloodstream infection.[9] Primary sites of infection are the alimentary tract (i.e., mouth, pharynx, esophagus, large and small bowel, and rectum), sinuses, lungs, and skin.

The pathogens responsible for initial infections early in the course of fever and neutropenia (F&N) are primarily bacteria, whereas antibiotic-resistant bacteria, yeast, other fungi, and viruses are common causes of subsequent infections.[22, 23] Coagulase-negative staphylococci, *S.aureus,* viridans group streptococci, and enterococci are the major Gram-positive pathogens. Coliforms (e.g., *Escherichia coli*, *Klebsiella, Enterobacter* species) and *Pseudomonas aeruginosa* are the most common Gram-negative infections complicating neutropenia.[22] Herpes simplex virus (HSV), respiratory syncytial virus (RSV), parainfluenza, and influenza A and B are also occasionally initial pathogens.[23] Infections due to *Candida* species may occur later in the course of neutropenia, particularly as a consequence of gastrointestinal (GI) mucositis. *Aspergillus* species and other filamentous fungi are an important cause of morbidity and mortality in patients with severe and prolonged neutropenia.[22, 24] Deaths resulting from infections identified at the onset of fever during neutropenia remain uncommon, and most infection-associated deaths result from subsequent infections during the course of neutropenia.

Studies from more than 4 decades ago have shown that as the neutrophil count decreases below 500/mcL (defined as *neutropenia*), the susceptibility to infection increases.[25] The frequency and severity of infection are inversely proportional to the neutrophil count; the risks of severe infection and bloodstream infection are greatest when the neutrophil count is less than 100/mcL. The rate of decline of the neutrophil count and the duration of neutropenia are also critical factors. These latter 2 aspects are a measure of bone marrow reserve and are highly correlated with severity of infection and clinical outcome.

Disruption of Mucosal Barriers

The mucosal linings of the GI, sinopulmonary, and genitourinary tracts constitute the first line of host defense against a variety of pathogens. Chemotherapy and radiation therapy impair mucosal immunity at several different levels. When the physical protective barrier conferred by the epithelial lining is compromised, local flora may invade. Neutropenia and loss of the epithelial cell anatomic barrier may predispose patients to typhlitis (neutropenic enterocolitis). Chemotherapy-related GI mucositis predisposes patients to blood stream infections by viridans group streptococci,[26-29] Gram-negative rods, and *Candida* species.[30, 31]

Splenectomy and Functional Asplenia

In the spleen, rapid antigen presentation occurs, which leads to the production of opsonizing antibodies by B-cells. The removal of non-opsonized bacteria protects against encapsulated bacteria to which the patient is not yet immune. Splenic irradiation results in functional asplenia, which predisposes patients to pneumococcal sepsis. Functional asplenia is also a late complication of severe GVHD.[32] Thus, in allogeneic HSCT recipients, fever in the late transplant period must be evaluated promptly (similar to patients with asplenia) because of the risk of overwhelming infection by encapsulated pathogens.

Asplenic patients are principally at risk for overwhelming sepsis by encapsulated bacteria. The most common pathogen is *S.pneumoniae*, but other pathogens include *H.influenzae* and *Neisseria meningitidis.* The Advisory Committee on Immunization Practices (ACIP) for the Centers for Disease Control and Prevention (CDC) recommends that asplenic persons be immunized with the pneumococcal polysaccharide and meningococcal vaccines.[33] The conjugated meningococcal vaccine (MCV4) is preferred in adults 55 years of age or younger, because it

confers longer lasting immunity than the polysaccharide vaccine. Immunization of adults with the pediatric *H.influenzae* type B (Hib) vaccine is considered optional because of lack of data on efficacy in older children and adults, although studies suggest good immunogenicity in immunocompromised patients. Immunization is ideally performed at least 2 weeks in advance of splenectomy. If this is not feasible, immunization is still advisable after splenectomy, because such patients are still capable of mounting a protective antibody response. One-time re-immunization with the pneumococcal vaccine is advised in asplenic persons 5 years after the time of initial vaccination. Re-vaccination with MCV4 after 5 years is recommended for functional asplenic patients who received MCV4 or MPSV4.[33] Penicillin prophylaxis is advised in asplenic patients to prevent pneumococcal disease.

Corticosteroids and Other Lymphotoxic Agents

High-dose corticosteroids have profound effects on the distribution and function of neutrophils, monocytes, and lymphocytes. In patients with cancer, corticosteroids are seldom the only immunosuppressive agents being administered, and it is therefore difficult to delineate the degree of impairment in host defense elicited by the corticosteroid regimen alone. The risk of infections is a function of the dose and duration of corticosteroids, co-existing immunodeficiencies (such as neutropenia and use of other immunosuppressive agents), and the status of the malignancy. Corticosteroids blunt fever and local signs of infection, such as peritonitis.

Lymphocyte-depleting agents increase the risk of common and opportunistic infectious diseases. Fludarabine is a fluorinated analogue of adenine that has been used in a variety of hematologic malignancies. Fludarabine is a lymphotoxic compound, primarily affecting CD4+ lymphocytes. In previously treated patients with CLL, fludarabine treatment (especially in combination with other immunosuppressive therapy) was associated with infections such as listeriosis, pneumocystosis (*Pneumocystis* pneumonia), mycobacterial infections, and opportunistic fungal and viral infections.[34] When used alone, purine analogs (e.g., fludarabine, clofarabine) are associated with an increased risk for infection; when combined with other immunosuppressive or cytotoxic agents, purine analogs are associated with an even higher risk for infection.[35] The combination of fludarabine and corticosteroids is more immunosuppressive than either agent alone.[36] Fludarabine plus prednisone results in a uniform depression of CD4+ cells that may persist for several months after completion of therapy.[37] In one series, 14 of 264 patients (5%) with CLL developed either *Pneumocystis jirovecii* (*P.jirovecii*) pneumonia (PCP) or listeriosis, and 3 cases occurred more than 1 year after therapy in patients who were in remission.[37]

Patients with hematologic malignancies and allogeneic HSCT recipients are increasingly being treated with novel monoclonal antibodies that cause a depletion of lymphocyte subsets. Alemtuzumab is a humanized monoclonal antibody that targets CD52, which is abundantly expressed on most normal and malignant B- and T-lymphocytes. This agent has been used most extensively in patients with CLL who have failed fludarabine therapy. Alemtuzumab has been associated with grade 3 or 4 neutropenia in about 40% of patients with previously untreated CLL and in 56%-78% of patients with fludarabine-refractory disease.[38-41] Alemtuzumab is also associated with prolonged and severe lymphopenia in most patients. Four weeks after initiation of alemtuzumab, the median CD4+ count was 0/mcL and 6 months after discontinuation, the count was 238/mcL in previously untreated patients .[38] The CD8+ cell counts also changed in a similar manner. In previously treated patients receiving alemtuzumab, CD4+ and CD8+

counts may not recover to baseline levels until more than 1 year after completion of therapy.[38] Infections pose a concern for morbidity and/or mortality in alemtuzumab recipients, particularly for patients with heavily pretreated, fludarabine-refractory disease.[20, 40, 42] Bacterial, viral, fungal, mycobacterial, and *P.jirovecii* infections have been reported with alemtuzumab.[40, 42, 43] Antiinfective prophylaxis against herpes viruses and PCP is recommended in patients receiving alemtuzumab treatment (see Discussion sections on Antiviral Prophylaxis and Preemptive Antiviral Therapy and Prophylaxis for *Pneumocystis jirovecii* Pneumonia).[38] Patients treated with alemtuzumab have increased susceptibility to cytomegalovirus (CMV) reactivation and disease.[38-40, 44-46] It is therefore recommended that surveillance for CMV reactivation is conducted routinely using polymerase chain reaction (PCR) or antigen-based methods in alemtuzumab recipients (see Discussion section on Antiviral Prophylaxis and Preemptive Antiviral Therapy: Cytomegalovirus). However, the Infectious Diseases Working Party (AGIHO) of the German Society for Hematology and Oncology (DGHO) does not recommend CMV surveillance in alemtuzumab recipients in the absence of large randomized controlled trials to substantiate this approach.[47]

Anti-CD20 monoclonal antibodies (e.g., rituximab, ofatumumab) are widely used in the treatment of patients with B-cell lymphoid malignancies. The use of these monoclonal antibodies has been associated with increased risks for hepatitis B virus (HBV) reactivation, which can lead to fulminant hepatitis, liver failure, and/or death.[38, 48-54] Antiviral prophylaxis is generally recommended for patients who test positive for HBV surface antigen (see Discussion section below for Prevention of Infectious Disease >> Antiviral prophylaxis and preemptive antiviral therapy >> Hepatitis B virus). In addition, the use of anti-CD20 monoclonal antibodies in patients with B-cell malignancies has been associated with rare instances of progressive multifocal encephalopathy (PML).[38, 48] PML is a demyelinating disease of the CNS resulting from reactivation of the John Cunningham (JC) virus, and occurs in severely immunocompromised individuals. Though rare, PML is most often fatal. In reports of PML potentially associated with rituximab treatment in patients with B-cell malignancies, rituximab was typically given in combination with chemotherapy regimens or patients had received prior immunosuppressive regimens.[55-62] Moreover, patients who developed PML often presented with low CD4+ counts or abnormal (low) CD4+/CD8+ ratio,[55, 57, 60, 62] which points to a critical role of T-cell immunity in suppressing reactivation of the JC virus.

Hematopoietic Stem Cell Transplantation

Autologous HSCT recipients generally have fewer infectious complications than allogeneic transplant recipients. Most infections in autologous HSCT recipients occur during neutropenia or within the first few months after transplantation before reconstitution of cellular immunity. However, CD34+ cell enrichment of autografts leads to a substantial reduction in T-cells, natural killer cells, and monocytes, compared with unmanipulated autografts, which delays immune reconstitution.[63] Recipients of CD34+ cell-enriched autografts appear to be at a similar level of risk as allogeneic HSCT recipients for CMV and other opportunistic infections.[63] Severe or ulcerative mucositis, which develops as a result of myeloablative high-dose therapy administered prior to HSCT, is associated with the occurrence of bacteremia in autologous HSCT recipients.[64-66] Recently, a multicenter prospective study evaluated the potential role of G-CSF responsiveness in predicting the occurrence of infections in patients with hematologic malignancies undergoing high-dose therapy and autologous HSCT.[67] Responsiveness to G-CSF was determined by the administration of a single dose of G-CSF after completion of high-dose therapy (but prior to

HSCT), and measuring the induced leukocyte peak 12-14 hours after the G-CSF dose. G-CSF responsiveness showed a significant inverse correlation with incidences of febrile neutropenia and infections (i.e., higher responsiveness associated with lower infection rates), and was shown to be the only independent predictor of infections based on multivariate analysis.[67]

The spectrum of pathogens to which allogeneic HSCT recipients are most susceptible follows a time line corresponding to the predominant immune defects. In the first month after HSCT, neutropenia is the principal host defense defect, which predisposes patients to bacterial, fungal, and viral infections. After myeloid engraftment, qualitative dysfunction of phagocytes persists due to corticosteroid and other immunosuppressive agents. The risk of infection by opportunistic viruses and filamentous fungi (molds) during this period is strongly associated with the severity of GVHD and with the requirement for potent immunosuppressive regimens.

Defects in cell-mediated immunity persist for several months even in uncomplicated allogeneic HSCT recipients, predisposing them to common bacterial and viral infections and to multiple opportunistic infections (e.g., candidiasis, invasive mold infections, *P.jirovecii*, *Cryptococcus neoformans*, dimorphic fungal infections [such as, histoplasmosis and coccidioidomycosis], HSV, CMV, herpes zoster, Epstein-Barr virus-associated lymphoproliferative disease, community respiratory viruses, legionellosis, listeriosis, nocardiosis, toxoplasmosis, and mycobacterial diseases). Whereas mature and cooperative T- and B-cell functions are usually reconstituted by 1 to 2 years after engraftment, chronic GVHD is associated with persistently depressed cell-mediated and humoral immunity.

Defective reconstitution of humoral immunity is a major factor contributing to increased infection susceptibility in the late transplant period. Winston et al[68] noted a high frequency of pneumococcal infections between 7 and 36 months after transplantation, associated with serum opsonic deficiency for *S.pneumoniae*. Kulkarni et al[69] reported that pneumococcal sepsis occurred a median of 10 months after transplant (range, 3 to 187 months) and was significantly more frequent in patients with chronic GVHD.

Guidelines from the CDC recommend that allogeneic HSCT recipients with severe hypogammaglobulinemia (IgG < 400 mg/dL) and with recurrent infections receive intravenous immunoglobulin (IVIG) prophylaxis; IVIG is not recommended in other patient groups or in autologous HSCT recipients routinely.[16] The CDC has published guidelines on vaccination of HSCT recipients and household members to prevent infections following transplantation.[16]

Allografts from human leukocyte antigen (HLA)–matched unrelated donors, partially mismatched related donors, and cord blood are associated with a higher risk of GVHD. T-cell depletion delays immune reconstitution and, consequently, carries a greater risk of infectious complications, most notably opportunistic viral[70] and fungal[71, 72] pathogens. Cord blood transplant recipients may have a higher risk of infections than other allograft recipients during the early transplant period because of slower myeloid engraftment.

Management of Neutropenic Patients With Fever

The definitions of F&N in these NCCN clinical guidelines are consistent with those developed by the Infectious Diseases Society of America (IDSA) and the U.S. Food and Drug Administration (FDA) for evaluating antimicrobial therapy for F&N.[4] *Fever* is defined as a single temperature 38.3°C or more orally or 38.0°C or more over 1 hour in the absence of

an obvious cause. Although uncommon, a patient with neutropenia and signs or symptoms of infection (i.e., abdominal pain, severe mucositis, perirectal pain) without fever should be considered to have an active infection. The concomitant administration of corticosteroids may also blunt the fever response and any localizing signs of infection. The NCCN Guidelines define *neutropenia* as either 1) an absolute neutrophil count (ANC) less than 500/mcL, or 2) an ANC less than 1000/mcL and a predicted decline to 500/mcL or less over the next 48 hours.

Initial Evaluation

The initial evaluation should focus on determining the potential sites and causative organisms of infection and on assessing the patient's risk of developing an infection-related complication. A site-specific history and physical examination should be performed promptly, cultures should be obtained, and empiric antibiotics started soon after the time of presentation (see Guidelines section on Clinical Presentation/Initial Evaluation of Fever and Neutropenia). The common sites of infection for patients with F&N (such as the alimentary tract, groin, skin, lungs, sinus, ears, perivagina, perirectum, and intravascular access device sites) should be thoroughly assessed. Other important historical features to consider include major comorbid illness, medications, time since last chemotherapy administration, recent antibiotic therapy, and exposure to infections from household members (see Guidelines section on Initial Evaluation of Fever and Neutropenia).

Initial laboratory/radiology evaluation should include a complete blood count with differential analysis and blood chemistry tests to assess liver function (e.g., total bilirubin, albumin, ALT, AST) and renal function (e.g., blood urea nitrogen, creatinine, electrolytes) (see Guidelines section on Clinical Presentation/Initial Evaluation of Fever and Neutropenia). Oxygen saturation and urinalysis should be considered, depending on symptoms. Chest radiographs should be done for all patients with respiratory signs or symptoms; however, radiographic findings may be absent in neutropenic patients with pulmonary infection.[73]

Cultures

Culture specimens should be collected during or immediately after completing the examination. Two blood samples should be cultured. When obtaining blood cultures, there are 3 options: 1) one set can be obtained peripherally and one can be obtained from a central venous catheter (if present); 2) both sets can be obtained peripherally; or 3) both sets can be obtained through the catheter (see Guidelines section on Microbiologic Evaluation). The positive predictive value of a catheter culture is less than a peripheral culture. The approach of obtaining blood for culture from both the central catheter and peripherally may help determine whether the venous access device (VAD) is the source of bloodstream infection based on the differential time to positivity.[74] However, some experts recommend that only blood from the VAD needs to be obtained for culture, without the requirement for a peripheral vein blood culture.[74] A meta-analysis has shown little clinical use for two-site culturing in patients with cancer who have a VAD, and poor patient acceptance of peripheral venipunctures when a VAD is in place.[75] The panel consensus is that the volume of blood for culture is the most important aspect of blood culturing; in addition, the panel recommends obtaining one peripheral and one catheter culture for distinguishing between cateher-related infections and those from secondary sources.

In the absence of lesions or clinical signs and symptoms, routine cultures of the anterior nares, oropharynx, urine, stool, and rectum are rarely helpful. Diarrheal stools felt to be infectious should be tested for the presence of *Clostridium difficile*.[76] In patients with diarrhea, consider

screening for enteric pathogen including rotavirus and norovirus in winter months and during outbreaks. Symptoms of urinary tract infection should be evaluated with a urinalysis and culture. Vascular access site inflammation or drainage should be cultured. Biopsy with microbiologic and pathologic evaluation should be considered for new or undiagnosed skin lesions (see Guidelines section on Microbiologic Evaluation). Viral cultures of vesicular or ulcerated mucosal or cutaneous lesions may identify HSV infections. In patients with symptoms of respiratory viral infection, viral cultures and rapid viral antigen testing of the nasopharyngeal secretions can be useful during local outbreaks of such infections.[77, 78] However, note that rapid immunofluorescent viral antigen tests may be negative for H1N1 (swine flu).

Initial Empiric Antibiotic Therapy

The foundation of infection management is to administer empiric antibiotics in patients with F&N. This approach is necessary because currently available diagnostic tests are not sufficiently rapid, sensitive, or specific to identify or exclude microbial causes of fever from other noninfectious causes. All neutropenic patients should be treated empirically with broad spectrum antibiotics promptly at the first sign of infection (i.e., fever). This is done to avoid the mortality associated with a delay in treatment in those patients who have a serious infection.[4, 79] Many highly effective antibiotic regimens are available, and those that are recommended are supported by randomized clinical trials.

Selection of initial therapy should consider the following:

- The patient's infection risk assessment;
- The antimicrobial susceptibilities of pathogens isolated locally;
- The most common potentially infecting organisms, including antibiotic-resistant pathogens, such as extended spectrum beta-lactamase–producing Gram-negative rods, vancomycin-resistant enterococcus (VRE), and colonization with or previous infection with methicillin-resistant *S.aureus* (MRSA);
- The potential sites of infection;
- The importance of a broad spectrum bactericidal antibiotic regimen that includes antipseudomonal coverage;
- Clinical instability (e.g., hypotension, organ dysfunction);
- Drug allergy;
- Recent antibiotic use (including prophylaxis).

Recommended Approaches

The panel considers each of the following three approaches to initial empiric management of febrile neutropenia to be appropriate based on the results of large, randomized controlled clinical trials (see Guidelines section on Initial Therapy for Fever and Neutropenia).[4, 7, 79]

The first approach is intravenous (IV) antibiotic monotherapy (all category 1 except where noted) with either imipenem/cilastatin, meropenem, piperacillin/tazobactam, or an extended-spectrum antipseudomonal cephalosporin (cefepime or ceftazidime [category 2B]).[2, 80-83] Local institutional bacterial susceptibilities should be considered when selecting empiric antibiotic therapy. At hospitals where infections by antibiotic resistant bacteria (e.g., MRSA or drug-resistant Gram-negative rods) are commonly observed, policies on initial empirical therapy of neutropenic fever may need to be tailored accordingly.

A meta-analysis of randomized trials involving cefepime reported that cefepime was associated with increased all-cause mortality when used for empiric therapy for neutropenic fever, although no increase in infection-related mortality was noted.[84, 85] A subsequent meta-analysis by the FDA, using additional data beyond what was used in the Yahav

study, did not find a statistically significant increase in mortality for cefepime-treated patients compared with controls. Thus, the FDA concluded that cefepime remains appropriate therapy for its approved indications.[86, 87]

The second approach to initial empirical therapy is IV antibiotic combination therapy using 3 options (see Guidelines section on Initial Therapy for Fever and Neutropenia): (1) an aminoglycoside plus an antipseudomonal penicillin (with or without a beta-lactamase inhibitor) (category 1); (2) ciprofloxacin plus an antipseudomonal penicillin (category 1);[88] or (3) an aminoglycoside plus an extended-spectrum antipseudomonal cephalosporin (ceftazidime or cefepime).[88-90] The use of vancomycin, linezolid, daptomycin, or quinupristin/dalfopristin is not routinely recommended. Although published studies exist regarding the use of some of these agents in neutropenic patients, the panel strongly recommends that these agents not be used routinely as initial empirical therapy because of concerns for resistance and breakthrough infections.

Aminoglycoside use carries the inherent risk of renal and otic toxicity. Avoiding these toxicities requires careful monitoring and necessitates frequent reassessment, but once-daily aminoglycoside dosing is associated with less renal toxicity than shorter interval dosing.[91] Once-daily aminoglycoside dosing should probably not be used for treating meningitis or endocarditis based on inadequate clinical data.

For patients at high risk for *Pseudomonas* infections (such as, history of previous *Pseudomonas* infections or presence of ecthyma gangrenosum), initial combination therapy with the most active antipseudomonal agents available in the local setting should be considered.

The third approach to initial empirical therapy for fever and neutropenia is oral antibiotic combination therapy for low risk patients (see Guidelines section on Initial Therapy for Fever and Neutropenia). Ciprofloxacin plus amoxicillin/clavulanate is recommended (category 1), with the option of ciprofloxacin plus clindamycin for patients allergic to penicillin. Fluoroquinolone regimens should not be administered in patients receiving antimicrobial prophylaxis with a fluoroquinolone.

The addition of IV vancomycin for specific indications either to IV monotherapy or to combination therapy (see Discussion section below on Empiric Addition of Vancomycin) may be considered. Support for the judicious use of vancomycin has developed because of the increased frequency of beta-lactam–resistant Gram-positive infections caused by MRSA, most coagulase-negative staphylococci, penicillin-resistant viridans group streptococci and enterococci, and *Corynebacterium jeikeium.* Vancomycin should be reserved for specific indications and should not be considered as a routine component of initial therapy for F&N.

Empiric Addition of Vancomycin

Considerable debate has occurred about the use of empiric vancomycin in patients with F&N, as the uncontrolled use of vancomycin has facilitated the dissemination of vancomycin-resistant organisms, especially enterococci.[92, 93] The clinical concern is that a portion of infections caused by Gram-positive pathogens can be fulminant and lead to rapid death in patients who are not treated promptly with appropriate antibiotics. However, a large, prospective, randomized trial from the European Organization for Research and Treatment of Cancer failed to show true clinical advantages for empiric vancomycin in adults.[94] This study reported that empiric vancomycin decreased the number of days the patients had fever but did not improve survival. The study also showed that empiric vancomycin was

associated with an increased incidence of nephrotoxicity and hepatotoxicity.[94] A prospective randomized trial of F&N in children has reported benefit for empiric vancomycin[95]; however, another randomized study in children failed to show a benefit for the addition of vancomycin.[96]

In addition to the occurrence of vancomycin-resistant enterococci (VRE), there are other vancomycin-resistant pathogens of note. Reports of vancomycin-resistant and vancomycin-intermediate sensitive *S.aureus* are currently rare but are of key concern, and they underscore the need for judicious vancomycin use.[97-99] The increase in vancomycin resistance has been associated with use of vancomycin among hospitalized patients. The NCCN Guidelines panel advises practitioners to adopt the recommendation of the Hospital Infection Control Practices Advisory Committee (HICPAC) of the CDC for preventing the spread of vancomycin resistance.[100, 101] Because of the increased risk of vancomycin-resistant organisms, empiric vancomycin use should be considered only in patients at high risk for serious Gram-positive infection, and should not be considered as a routine component of initial therapy for F&N. Vancomycin should be considered in the following clinical situations (see Guidelines section on Appropriate Use of Vancomycin and Other Agents for Gram-Positive Infections):

- Clinically apparent, serious IV catheter-related infection (to cover coagulase-negative staphylococcal isolates, which are usually beta-lactam antibiotic-resistant and MRSA)[102, 103];
- Blood cultures positive for Gram-positive bacteria before final identification and susceptibility testing;
- Known colonization with penicillin/cephalosporin–resistant pneumococci or MRSA;
- Clinical instability (e.g., hypotension or shock), pending the results of cultures[104, 105];
- Soft tissue infection (particularly in regions where MRSA infection is common)[106];
- Risk factors for viridans group streptococcal bacteremia (category 2B): severe mucositis (e.g., associated with high-dose cytarabine) and prophylaxis with quinolones or TMP/SMX.

If empiric vancomycin is initiated in any of these situations, its use should be reassessed within 2 to 3 days of initiation. If a resistant Gram-positive pathogen is not identified, the panel recommends discontinuing vancomycin. Recent authoritative guidelines have been published on dosing and therapeutic monitoring of vancomycin.[107]

In patients with acute leukemia receiving mucotoxic regimens, prophylaxis with ciprofloxacin and TMP/SMX have been associated with an increased risk of viridans group streptococcal infections.[108-110] The broad spectrum, Gram-negative bacillary coverage and limited Gram-positive pathogen activity of these drugs likely predispose to GI colonization and subsequent infection with such organisms.[111, 112] It is unknown whether prophylaxis with newer generation fluoroquinolones (e.g., levofloxacin), which have increased activity against Gram-positive bacteria compared to ciprofloxacin, will increase the risk of breakthrough viridans group streptococcal infections.

Although bloodstream infections by viridans group streptococci resistant to all beta-lactams are observed in patients with cancer, cefepime, imipenem/cilastatin, meropenem, and piperacillin-tazobactam have more reliable activity than ceftazidime against viridans group streptococci.[113] Addition of vancomycin produced no benefit compared to placebo with regard to defervescence, episodes of Gram-positive bacteremia, or use of empiric antifungal therapy in patients with

hematologic malignancies with neutropenic fever of unknown etiology that persisted for 48 to 60 hours after initial empiric piperacillin-tazobactam.[114, 115] A smaller randomized, placebo-controlled study did not show any advantage after adding teicoplanin (a glycopeptide antibiotic similar to vancomycin) in patients with neutropenic fever that persisted after 3 to 4 days of empiric imipenem/cilastatin.[116] In patients with neutropenic fever and severe mucositis who are receiving imipenem/cilastatin, meropenem, or piperacillin/tazobactam (i.e., antibiotics with activity against oral flora), it does not appear that the addition of vancomycin is advantageous. Thus, the NCCN Guidelines panel strongly recommends that vancomycin should not be routinely added to an empiric regimen solely based on persistent neutropenic fever of unknown etiology (see Guidelines section on Appropriate Use of Vancomycin and Other Agents for Gram-Positive Infections).

Agents With Broad Spectrum Activity Against Gram-Positive Pathogens

Linezolid, daptomycin, and quinupristin/dalfopristin are active against the majority of Gram-positive organisms, including beta-lactam-resistant and vancomycin-resistant pathogens.[117-121] The panel recommends that the use of these drugs be limited to specific situations involving infections caused by documented vancomycin-resistant organisms, or for patients in whom vancomycin is not an option. Although studies have been published in patients with neutropenia, the NCCN Guidelines panel strongly recommends that these agents not be used as routine empiric therapy for neutropenic fever because of concerns about emergence of resistance and toxicity.

Resistance of Gram-positive organisms to linezolid is infrequent, but this agent needs to be used cautiously in patients with compromised bone marrow function because of the marrow toxicity associated with long-term use of linezolid. Thrombocytopenia is most common (0.3% to 10%) and increases with the duration of use. In neutropenic patients with cancer, myeloid recovery does not seem to be delayed with short courses of linezolid[122, 123]; however, experience with long durations of therapy (e.g., more than 14 days) is limited in cancer patients. Vancomycin or linezolid should be used for treatment of MRSA pneumonia in ventilated patients.[124-127] The FDA issued an alert about linezolid indicating that it is not approved for treatment of catheter-related infections, catheter-site infections, or Gram-negative infections.[128] In an open-label randomized study, patients treated with linezolid had a higher chance of death compared with those receiving vancomycin, oxacillin, or dicloxacillin for intravascular catheter-related infections with 1) Gram-negative agents alone; 2) both Gram-positive and Gram-negative organisms; or 3) no infection. No mortality difference by treatment was found among those who had Gram-positive infections alone.[128]

Daptomycin is effective against most Gram-positive pathogens, but it should not be used for treatment of pneumonia, because it is inactivated by pulmonary surfactant.[129, 130] Daptomycin is indicated for the treatment of complicated skin and skin structure infections caused by susceptible strains of certain Gram-positive microorganisms.[131-133] A randomized study showed similar efficacy of daptomycin compared with vancomycin or anti-staphylococcal beta-lactams as therapy for *S.aureus* bacteremia and endocarditis.[134]

Quinupristin/dalfopristin is active against *S.aureus* (including MRSA) and *Enterococcus faecium* (including vancomycin-resistant strains) but is inactive against *Enterococcus faecalis*. Use of quinupristin/dalfopristin has been limited because of the high frequency of substantial musculoskeletal symptoms.[135]

Optimal therapy for VRE infections is not well defined. Linezolid, quinupristin-dalfopristin (active against *E. faecium*, but not *E. faecalis*),

and daptomycin have been used in VRE bloodstream infections in patients with cancer with variable success rates.[123, 135, 136] Removal of an infected catheter should always be strongly considered. In the absence of more definitive data, therapy with one of these agents is advised for VRE bacteremia.

Tigecycline has activity against clinically relevant resistant Gram-positive (including VRE and MRSA) and the majority of Gram-negative pathogens but is not active against *P.aeruginosa*.[137] It is effective in complicated skin and skin structure infections, intraabdominal infections, and community-acquired bacterial pneumonia in non-neutropenic patients.[137] Tigecycline has not been evaluated in clinical trials in patients with cancer and specifically should not be used as single-agent therapy in neutropenic patients given its lack of anti-pseudomonal activity. The combination of tigecycline and an antipseudomonal drug may be considered in patients with cancer with refractory or multi-drug resistant infections.[138]

Telavancin, a lipoglycopeptide antibiotic, and ceftaroline, a broad spectrum cephalosporin antibiotic, have both recently been approved for the treatment of complicated skin and skin structure infections caused by Gram-positive pathogen, including MRSA.[139, 140] However, there are no directive data on their use in the oncologic setting. Other glycopeptide antibiotics (e.g., dalbavancin, oritavancin) are in clinical development.

Initial Empiric Therapy for Patients Who Are Clinically Unstable

Sepsis is suggested by signs of clinical instability including hypotension, tachypnea, new or worsening tachycardia, mental status changes, decreased urine output, and organ dysfunction. Initial therapy for sepsis should broadly cover pathogens that are likely to cause sepsis while minimizing the potential for inadequate treatment.[104] Unlike the stable patient with neutropenic fever, modifying antibiotics based on culture data may not be possible for the patient with sepsis if the initial regimen does not provide adequate coverage. The antibiotic regimen should be modified, if necessary, after culture results and susceptibility are known.

The initial empiric regimen for the neutropenic patient with clinical instability may include a broad spectrum beta-lactam (e.g., imipenem/cilastatin, meropenem, or piperacillin-tazobactam) plus an aminoglycoside and vancomycin. Addition of fluconazole or an echinocandin should be strongly considered in patients not receiving antifungal prophylaxis. Local susceptibility patterns and recent antibiotic use should be taken into account when devising the antibiotic regimen.[104] At hospitals where infections by antibiotic resistant bacteria (e.g., MRSA or drug-resistant Gram-negative rods) are commonly observed, policies on initial empirical therapy of neutropenic fever may need to be tailored accordingly. Some experts also suggest that patients who have a history of *P.aeruginosa* colonization or of invasive disease should receive combination therapy with an antipseudomonal beta-lactam plus an aminoglycoside or ciprofloxacin.

For cases of septic shock, rapid interventions are needed. Fluid resuscitation, oxygen, invasive hemodynamic monitoring, and vasopressor agents may be required. Stress doses of hydrocortisone (IV 50 mg every 6 hours with or without fludrocortisone oral 50 mcg daily) have been associated with decreased mortality in patients with septic shock and with insufficient adrenal reserve.[141-145] Stress-dose corticosteroids are recommended for patients with septic shock who require vasopressor support.[104, 146, 147] High-dose corticosteroids have not shown any benefit in the setting of septic shock or severe sepsis, and may be associated with increased risks for secondary infections.[148-151]

In patients with severe sepsis, drotrecogin alfa, a recombinant human activated protein C (APC), is an approved agent indicated for reducing mortality in those at highest risk of death (APACHE II score, 25 or more); however, this agent is not beneficial in lower risk patients or in pediatric patients.[104, 152-155]Bleeding is the most common serious complication associated with drotrecogin alfa[154]; a study in neutropenic/thrombocytopenic patients was stopped early due, in part, to bleeding complications. The data are currently inadequate to make a recommendation about the efficacy or safety of this agent in neutropenic patients, or more generally, in patients receiving treatment for cancer.

Prognostic Factors in Patients With Bacteremia

Elting and colleagues have developed a classification system for bacteremias in febrile neutropenic patients based on size and presence of associated tissue involvement.[156] This classification system is based on an analysis of studies from the 1970s to 1990s. Complex bacteremias are associated with the lung, liver and spleen, kidney, colon, bone and joints, veins and heart, meninges, soft tissues with necrosis, or skin/soft tissue/wound/cellulitis greater than 5 cm. Simple bacteremias are associated with less tissue involvement (bacteruria, otitis, pharyngitis, soft tissue <5 cm). Complex infections associated with bacteremia decrease survival and, thus, have prognostic significance. At 21 days, 20% of patients with complex infections were dead compared to only 5% of patients with simple bacteremias (P<0.0001). Profoundly neutropenic patients with simple bacteremias had a much higher response rate to antibiotics (94% versus 70%, P<0.0001) compared to patients with complex bacteremias. Response to the initial antibiotic regimen and ultimate outcome were decreased in patients with leukemia (who presented with shock or patients with serum albumin <3.5 g/dL). The median time to defervescence for patients with simple bacteremias was 50% of that observed for patients with complex bacteremias (2.5 versus 5.3 days, P<0.0001).[156] Based on these and other studies, clinical criteria can be used to stratify patients with bacteremia into high- and low-risk strata shortly after the onset of the febrile neutropenic episode. These criteria in one combination or another have been used to select patients for risk-adjusted clinical trials of empiric antibiotic therapy.[3, 5, 6, 8, 12, 157-162]

Empiric Antifungal Therapy in Persistent Neutropenic Fever

Empiric antifungal therapy for persistent febrile neutropenia unresponsive to broad spectrum antibacterial agents is used, because neutropenic patients are known to be at risk for invasive fungal infections, and because clinical examination and collection of cultures are not sufficiently sensitive for early detection of those infections.[14, 163-166] Traditionally, empiric antifungal therapy is initiated after 4-7 days of empiric antibiotic therapy for F&N, in patients who have remained febrile or have recrudescent fever (see Guidelines section on Follow-up Therapy for Nonresponding Patients >> Fever of Unknown Origin). The concept of using empiric antifungal therapy was established in the 1970s and 1980s when about 20% of patients being treated for acute leukemia or undergoing HSCT would develop an invasive fungal infection due to *Candida* or *Aspergillus* species by day 20 of neutropenia.[167] The toxicity of amphotericin B limited its use as routine prophylaxis, which would entail exposing more patients to a toxic drug over a prolonged period than does empiric therapy. With the widespread use of fluconazole prophylaxis in the 1990s among high-risk patients with acute leukemia and in HSCT recipients, the incidence of invasive candidiasis in these patients decreased substantially, although breakthrough candidemia by fluconazole-resistant strains occurred.[72, 168] Empiric antifungal therapy for neutropenic fever principally involved switching from fluconazole to amphotericin B to

broaden the antifungal spectrum to include molds such as *Aspergillus*. Subsequently, liposomal amphotericin B (L-AMB) proved to be safer than and as effective as conventional amphotericin B for empiric antifungal therapy.[169]

Based on the toxicity of amphotericin B products and the availability of safer and equally effective alternative agents, amphotericin B products were considered a category 2B recommendation for prophylaxis and empirical antifungal therapy for persistent or recurrent neutropenic fever of unknown etiology. In cases where there is a stronger clinical suspicion of mold infection than neutropenic fever alone (e.g., a new pulmonary nodule in a patient with fever and prolonged neutropenia), then use of an amphotericin B formulation (or a mold-active azole or an echinocandin) should be considered pending additional diagnostic evaluation. In general, lipid formulations of amphotericin B are preferred over the conventional formulation, because they are less toxic.[170] This recommendation is stronger in patients with risk factors for acute renal failure, such as pre-existing renal disease, HSCT recipients, and co-administration of nephrotoxic agents.[171-173]

Fluconazole has been used successfully as empiric therapy for neutropenic fever[174, 175] in patients not receiving prophylaxis but is limited by lack of activity against molds. Intravenous followed by oral itraconazole solution was as effective as, but less toxic than, conventional amphotericin B when used as empiric therapy in an open, randomized study[176]; these results led to FDA approval of oral itraconazole solution for this indication. Intravenous itraconazole is no longer available in the United States .[177] Itraconazole in the capsule formulation has erratic oral bioavailability and is therefore not suitable as empiric antifungal therapy. Itraconazole has negative inotropic effects and is contraindicated in patients with evidence of ventricular dysfunction or a history of congestive heart failure.[178]

Voriconazole was compared with liposomal amphotericin B (L-AMB) in an open, randomized study of empiric antifungal therapy (N=837 patients, 72% with hematologic malignancies).[179] The overall success rates for preventing invasive fungal infections were 26% with voriconazole and 31% with L-AMB. Empiric voriconazole was associated with fewer breakthrough fungal infections (1.9% versus 5.0%; *P*=0.02), with the greatest protective benefit occurring in pre-specified high-risk patients (relapsed acute leukemia and allogeneic HSCT). Because the noninferiority of voriconazole versus L-AMB was not demonstrated in this study based on prespecified criteria, voriconazole did not receive FDA approval for use as empiric therapy.[164, 180] Voriconazole is an option (category 2B) for empiric therapy in patients at high risk for invasive mold infection.

Echinocandins are active against *Candida* and *Aspergillus* species but have unreliable activity against most other opportunistic fungi. Caspofungin was compared with L-AMB as empiric therapy for fungal infections in a randomized double-blind study in patients with persistent fever and neutropenia (N=1095).[181] The overall success rates were 34% in both caspofungin and in L-AMB recipients. The proportion of patients who survived at least 7 days after therapy was greater in the caspofungin group (92.6% versus 89.2%, *P*=0.05). The rates of breakthrough fungal infections and resolution of fever during neutropenia were similar in the 2 groups. Among patients with a baseline invasive fungal infection, success rate was higher with caspofungin versus L-AMB (52% vs 26%; *P*=0.04) and mortality rate was lower with caspofungin (11% vs 44% with L-AMB).[181] Drug-related toxicities and premature withdrawals because of drug-related adverse events were significantly lower in caspofungin recipients. This study supports caspofungin as an option for empiric antifungal therapy. Caspofungin is approved for use as empirical treatment of presumed

fungal infection in patients with fever and neutropenia.[182] The other echinocandins, anidulafungin and micafungin, have not been studied specifically for empiric antifungal therapy; however, some panel members would consider them to likely be effective, based on the data for caspofungin.

It is unclear whether patients who are already receiving mold-active prophylaxis should subsequently receive empiric antifungal therapy with an additional or different antifungal solely based on persistent neutropenic fever.[183] One approach has been to evaluate such patients with a high resolution computed tomography (CT) scan of the chest, in search of lesions suspicious for invasive fungal disease. CT scanning in this setting has not been validated but it is a reasonable approach, along with careful physical examination and blood cultures, in an effort to identify a source of persistent unexplained fever in the neutropenic patient. Laboratory markers (such as serum galactomannan and beta-glucan) have important limitations, including false-negative results in some patients already receiving prophylactic or empiric antifungals.[184, 185] A meta-analysis showed the sensitivity of the galactomannan test for proven aspergillosis to be only 70% among patients with hematologic malignancies and 82% among stem cell transplant recipients..[186] However, these antigen-based assays have a high negative predictive value in the absence of mold-active antifungal therapy.

In patients undergoing chemotherapy for acute leukemias and receiving only yeast-active prophylaxis with fluconazole, 3%-4% developed invasive fungal infections despite prophylaxis.[187, 188] Empiric antifungal therapy with anti-mold activity would be expected to benefit these few patients without incurring greater risk of toxicity.

Pre-emptive antifungal therapy uses characteristic changes in chest or sinus CT scans, laboratory markers, or both to trigger modification of the antifungal regimen, rather than providing empiric antifungals to all persistently febrile neutropenic patients. Maertens and colleagues[189] evaluated the strategy of fluconazole prophylaxis in high-risk neutropenic patients followed by switching to L-AMB based on such pre-specified triggers, including serially positive serum galactomannan tests, a bronchoalveolar lavage (BAL) showing mold, and/or suggestive chest CT in patients with persistent fever or with signs of invasive fungal infection. Directed antifungal therapy was given to 7.7% (9/117) of patients rather than up to one third of patients who might have received it on the basis of fever alone. This approach detected all but 1 of 22 invasive fungal infections; the missed case involved disseminated zygomycosis.[189] In a randomized trial of patients with neutropenic fever, a preemptive strategy was associated with an increased incidence of probable or proven invasive fungal infections (9% vs 3% in empirically treated group; $P<0.05$), although without an increase in overall mortality and decreased the cost of antifungal drugs compared to empirical therapy.[190] Taken together, the panel considers the evidence supporting pre-emptive antifungal therapy to be too preliminary to support its routine use.

Follow-up of Patients With Neutropenic Fever

Daily evaluation by a health care professional who is experienced in treating patients with F&N is essential. The daily examination should focus on a site-specific assessment, and an infectious disease consultation should be considered for all complicated cases or progressive infections (see Guidelines section on Principles of Daily Follow-up). Time to defervescence ranges from 2 to 7 days (median, 5 days) for febrile cancer patients with neutropenia who receive appropriate initial antibiotic therapy.[191] This rate of fever response should be considered when assessing the need to adjust initial antibiotics; random additions or changes for persistent fever are

discouraged in the absence of additional clinical or microbiologic evidence. The expected slow defervescence of fever also complicates decisions regarding the need for repeat blood cultures. Although some experts recommend daily blood cultures until the patient becomes afebrile, increasing evidence suggests that daily blood cultures are unnecessary in stable neutropenic patients with persistent fever of unknown etiology.[192]

Current bacterial blood culture systems (such as the BACTEC™ continuous-monitoring culture system) can detect 90% to 100% of bacterial bloodstream pathogens within 48 hours of culture. For this reason, ordering additional cultures routinely before obtaining the results from the initial series is discouraged. Daily review of previously obtained cultures is critical, and the panel recommends documenting clearance of bloodstream bacterial or fungal infections with repeat blood cultures.

Evaluation of Response and Duration of Therapy

The duration of antimicrobial therapy, in general, is dictated by the 1) underlying site of infection; 2) causative organism(s); and 3) the patient's clinical condition, response to treatment and neutrophil recovery. It is generally recommended that antibiotics be continued until the ANC is ≥500 cells/mcL in cases of fever of unknown etiology (see Guidelines section on Follow-up Therapy for Responding Patients >> Suggested Duration of Therapy for Fever of Unknown Origin). Documented infections are usually treated according to the site, pathogen, and at least until ANC recovery. The panel is limited by a lack of high-level evidence to formulate consensus about duration of treatment for all situations; however, general recommendations are given.

Patients With Documented Infection Sites or Pathogens

Most experts recommend continuing antimicrobial therapy for documented infections at least until a patient's ANC recovers to ≥500/mcL, but also recommend using a defined course of therapy appropriate for the specific infection. Thus, the duration of antimicrobial therapy may be longer than the duration of neutropenia in these patients (see Guidelines section on Follow-up Therapy for Responding Patients >> Suggested Duration of Therapy for Documented Infection). For example, most uncomplicated skin and soft tissue infections can be treated with 7 to 14 days of therapy. For most uncomplicated bacterial bloodstream infections, 7 to 14 days of therapy is usually adequate, with longer durations (10-14 days) recommended for Gram-negative bacteremias. A longer duration (10-21 days) of treatment is also usually indicated for infections of the lungs or sinuses .[156] Complex intra-abdominal infections, such as typhlitis, should be treated until all evidence of infection has resolved, and the patient has recovered from neutropenia. Invasive mold infections (e.g., aspergillosis) generally require a minimum of 12 weeks of treatment.

For all *S.aureus* bloodstream infections, a transesophageal echocardiogram (TEE) is recommended to determine the absence or presence of heart valve vegetations, and thus, to help define the duration of therapy as short (2 weeks after first negative blood culture) or long (4 to 6 weeks).[103, 193-196] A TEE is more sensitive and preferred when compared with a transthoracic echocardiogram (TTE).[103, 193, 195, 197] In patients with conditions that may increase the likelihood of complications (e.g., neutropenia, thrombocytopenia, mucositis), a TTE may be performed initially and, if negative, a TEE should be performed when safe. If a TEE is not feasible, a minimum 4-week course of IV antibiotics should be considered for *S.aureus* bloodstream infections.

The duration of treatment for HSV (uncomplicated, localized disease to the skin) and varicella zoster virus (VZV; uncomplicated, localized disease to a single dermatome) infections is typically 7 to 10 days.[198-200] Life-threatening infections, such as invasive fungi or CMV, require individualized courses of therapy that are often prolonged. The duration of anti-infective therapy may need to be extended if further chemotherapy is required while treating a significant infection. This may occur with infections that complicate leukemia or lymphoma treatments in which multiple cycles of intensive chemotherapy are required.

Patients with documented infections who become afebrile after the initiation of the empiric antibiotic regimen and who are at low risk for complications associated with infection may be candidates for outpatient antibiotic therapy. The regimen, whether oral or IV, should be appropriate for neutropenic fever and have activity against the specific infection.

Severe or Refractory Infections

Patients with documented infection sites or pathogens who do not respond to initial antimicrobial therapy pose a difficult management challenge and are at increased risk of infection-associated morbidity and mortality. The panel strongly recommends that an infectious disease expert be consulted for all such patients (see Guidelines section on Follow-up Therapy for Nonresponding Patients >> Documented Infection). The lack of response may suggest an infection with a pathogen resistant to the antimicrobial therapy being used, inadequate serum or tissue levels of the antibiotic(s), infection at a vascular site (i.e., catheter or “closed space” infection), or emergence of a second infection. Some documented infections fail to respond to appropriate therapy because of associated profound neutropenia. If possible, treatment should be optimized using broad spectrum antibiotic combinations that minimize other organ toxicity.

Both the American Society of Clinical Oncology[201] and the NCCN have guidelines for the use of prophylactic colony-stimulating factors (CSF) in neutropenic patients (see NCCN Myeloid Growth Factors Guidelines). It is not clear whether these agents are useful as adjunctive therapy for established infectious events. Although the data supporting their use are limited, adjunctive therapy with granulocyte colony-stimulating factor (G-CSF) or granulocyte-macrophage colony-stimulating factor (GM-CSF) should be considered (category 2B) in neutropenic patients with serious infectious complications such as pneumonia, invasive fungal infections, or any type of progressive infection (see Guidelines section on Adjunctive Therapies). Granulocyte transfusions may be considered (category 2B) in neutropenic patients with serious infectious complications, such as invasive fungal infections or gram-negative rod infection unresponsive to appropriate antimicrobial therapy (see Guidelines section on Follow-up Therapy for Nonresponding Patients >> Documented Infection; and section on Adjunctive Therapies). The panel notes that the benefit versus toxicity balance associated with granulocyte transfusions has not been established.

Patients With Persistent Neutropenia and Fever of Unknown Etiology

A critical component of treating patients with fever of unknown etiology is daily clinical evaluation. Careful, daily, site-specific examinations should be performed by a health care professional who has experience and expertise in managing neutropenia and fever. Reassessment should include a review of all previous cultures and radiographs. If patients receive vancomycin as part of their initial empiric therapy, but they do not have a pathogen recovered or a site of infection identified justifying such treatment, then vancomycin should be discontinued.

Patients with fever of unknown origin who become afebrile soon after starting empiric therapy may have empiric antibiotics discontinued with

ANC recovery (≥ 500/mcL) as long as the neutrophil count is likely to continue to increase (patients are often receiving a growth factor). This recommendation assumes that the patient is clinically well and afebrile for at least 24 hours before antibiotic discontinuation. Patients who become afebrile but remain persistently neutropenic (ANC <500 /mcL) should receive a more prolonged course of antibiotic therapy until the neutropenia resolves (see Guidelines section on Follow-up Therapy for Responding Patients). Lower risk patients can also be switched to oral antibiotics until their neutropenia resolves (i.e., 500 mg ciprofloxacin every 8 hours plus 500 mg of amoxicillin/potassium clavulanate every 8 hours). Patients with recurrent fever should be reassessed promptly to determine the need for a change in their antibiotic regimen or for addition of antifungal therapy.

Patients with a fever persisting beyond 4 days of initial antimicrobial therapy and with an unidentified source of infection should undergo reassessment of their antimicrobial therapy. The need for a change in therapy should be based on the patient's clinical status and likelihood of imminent bone marrow recovery.

The clinically stable patient with persistent fever of unknown etiology may be safely watched without altering the initial antimicrobial therapy. Modifications of initial empiric antibiotic therapy should be based on specific new clinical findings and/or new microbiologic results; fever alone should not prompt changes in antimicrobial therapy. The major exception is the initiation of empiric antifungal therapy in patients who have persistent or recurrent fever after 4 to 7 days of empiric antibacterial therapy and who are not receiving mold-active prophylaxis. (see Guidelines section on Follow-up Therapy for Nonresponding Patients: Fever of Unknown Origin >> Stable; and earlier Discussion section on Empiric Antifungal Therapy in Persistent Neutropenic Fever).

Most experts advise continuing empiric antibiotic therapy until the absolute neutrophil count recovers.

Although fever resolution may be slow during neutropenia, persistent fever may result from a noninfectious etiology, such as drug-induced fever. Persistent fever may also represent an inadequately treated infectious process, such as a nonbacterial infection (fungal or viral), a bacterial infection that is resistant to empiric antibiotics, a venous access or closed space infection, or inadequate antimicrobial serum levels. It is important to recognize that documented deep tissue infections may take longer than fever of unknown etiology to respond to antimicrobial therapy. In these cases, daily assessment of clinical improvement or failure depends on radiographic, culture and clinical examination data, and on the fever trends. Unusual infections (e.g., toxoplasmosis) may complicate neutropenia, particularly if immunosuppressive agents (e.g., high-dose corticosteroids) are also used. The panel strongly recommends an infectious disease consultation for these patients.

Development of Clinical Instability While Receiving Antibacterial Therapy

It is essential to recognize the early signs of breakthrough infections after the initiation of antibacterial therapy. Although persistent neutropenic fever alone is not an indication to modify the antibacterial regimen, signs of breakthrough infection should prompt additional evaluation and consideration to modify therapy.

New findings suggestive of sepsis (e.g., hypotension, tachycardia, mental status changes, organ dysfunction) require the following: 1) repeat physical examination to identify a source of infection; 2) repeat blood cultures; 3) consideration of radiologic studies; and 4) empiric modification of antimicrobial therapy pending culture results.[104]

Information about the previous use of antibiotics and local sensitivity patterns of Gram-negative pathogens should guide empiric changes. Empiric addition of vancomycin is warranted in the unstable patient. In patients receiving ceftazidime, the possibility of breakthrough infections (either from extended spectrum beta-lactamase–producing or from cephalosporinase-producing Gram-negative rods) should be considered and switching to imipenem/cilastatin or meropenem is appropriate pending culture results. *Stenotrophomonas maltophilia* or carbapenem-resistant *P.aeruginosa* may cause breakthrough sepsis in patients receiving imipenem/cilastatin or meropenem; consider empiric modification to a regimen containing piperacillin-tazobactam, an aminoglycoside, and TMP/SMX. In patients not receiving a systemic antifungal agent, addition of fluconazole or an echinocandin should be strongly considered for possible candidemia. The antibiotic regimen should then be tailored based on culture and radiologic results.

Outpatient Management of Patients With Neutropenic Fever

Initial Evaluation of Risk

Patients with neutropenia may be categorized into either a high- or low-risk group using criteria that are derived either from validated clinical prediction rules based on risk models or from clinical trials eligibility criteria.[8, 10-12, 157, 162, 202] Risk assessment attempts to predict the probability that a neutropenic patient will experience serious complications during a febrile episode; such assessment also helps to determine whether the patient who is at low risk for serious complications could safely receive treatment outside of the hospital and receive initial empiric therapy with oral antibiotics.

Prospective trials have indicated that febrile neutropenic patients can be initially evaluated in the hospital, ambulatory clinic, or home and then treated effectively with broad spectrum IV, sequential IV /oral, or oral therapy.[159, 160, 162] Only centers with the necessary infrastructure should treat low-risk patients in an outpatient setting, preferably in an investigational context.

Risk assessment should be performed as part of the initial evaluation (see Guidelines section on Initial Risk Assessment for Febrile Neutropenic Patients). A widely used and recently validated prediction rule to assess risk was developed by the Multinational Association of Supportive Care in Cancer (MASCC). The MASCC risk index is derived from a model that includes weighted scores based on burden of illness (extent of febrile neutropenia), evidence of clinical instability or comorbid conditions (hypotension, COPD, dehydration), history of prior fungal infections, site of medical care (inpatient, outpatient) and age (cut off of 60 years); patients with MASCC risk index scores <21 are considered at high risk for developing infectious complications (see Guidelines section on Risk Assessment Resources).[203-206] It is also acceptable to employ risk assessment criteria that have been identified in large clinical trials to distinguish between patients at low and high risk for complications during the course of neutropenia.

The MASCC prediction rule does not consider the duration of neutropenia to be a deciding factor that influences the clinical course during the febrile episode[205]; however, the panel acknowledges that the duration of anticipated neutropenia may be helpful in risk assessment. A patient with severe neutropenia (ANC ≤100/mcL) anticipated to last ≥7 days may be considered at high risk, regardless of the MASCC risk index score or other risk factors listed in the Guidelines. This recommendation is also in agreement with those of the recently updated IDSA guidelines on the management of neutropenic patients with cancer.[22]

Duration of Neutropenia and Risk

For decades, clinicians have regarded depth and duration of neutropenia as critical determinants of a patient's risk for infection. Once the relationship between the ANC and incidence of infections was demonstrated, the importance of increased neutrophil counts on outcomes was evident. In the original study by Bodey et al, the fatality rate was highest (80%) among patients who initially started with neutrophil counts less than 100/mcL that did not change during the first week of infection compared to the lower rate (27%) seen in patients who started out with neutrophil counts less than 1000/mcL, which then rose to greater than 1000/mcL.[25] Subsequently, clinical trials have reported that response rates to antibiotic regimens are highly influenced by trends in the neutrophil count during febrile episodes. In one study, the overall response rate was 73% if the initial neutrophil count increased compared to 43% if it decreased or remained unchanged (P<0.0001). The response rate in patients who were initially profoundly neutropenic (i.e., ANC <100/mcL) but who recovered from neutropenia was 67%, compared to only 32% in patients who remained profoundly neutropenic (P<0.0001).

In 1988, Rubin et al examined the influence of the duration of neutropenia on the response to empiric antimicrobial therapy in patients with fever of undetermined origin.[207] Patients with less than 7 days of neutropenia had response rates to initial antimicrobial therapy of 95%, compared to only 32% in patients with more than 14 days of neutropenia (P<0.001); however, intermediate durations between 7 and 14 days had response rates of 79%.[207]

Bone marrow recovery is an important factor that influences outcome during the febrile neutropenic episode. Delayed bone marrow recovery might be anticipated in certain patient subsets (e.g., those who have received multiple cycles of myelosuppressive chemotherapy; HSCT recipients; patients with known bone marrow metastases; or patients who have received radiation therapy to the pelvis, spine, or long bones). Most patients with solid tumors have neutropenia lasting less than 7 days and are at much lower risk. Several studies have demonstrated the ability of clinicians to predict a patient's anticipated duration of neutropenia. In prospective studies of patients identified as being at low risk for morbidity and mortality from febrile neutropenia, the expected duration of neutropenia was used as an eligibility criteria; clinicians were correctly able to identify patients with an expected short duration of neutropenia (e.g., less than 7-10 days) in more than 80% of the cases.[3, 159, 160] The duration of neutropenia can be one of several factors in selecting patients for outpatient management of neutropenic fever.

Evaluation of Patients for Outpatient Therapy for Neutropenic Fever

Outpatient therapy has become a common practice in low-risk patients with neutropenic fever. Several single-center clinical trials generally support the shift in care for low-risk patients to the outpatient setting; the hospital is not necessarily a safer place for low-risk patients, given the documented hazards of hospitalization.[208, 209] However, not all centers are equipped to attempt such outpatient treatment, and some patients with fever are not appropriate candidates. Early success with this type of therapy has been predicated on the ability to accurately determine an individual patient's risk of developing complications associated with infection and on the presence of an adequate infrastructure for treatment and monitoring.

Once a patient's level of risk has been identified, it can then be used to determine the appropriate site of care and route of administration of broad spectrum antibiotics. The panel recommends that all high-risk patients receive hospital care with broad spectrum IV therapy (see

Guidelines on Initial Risk Assessment for Febrile Neutropenic Patients). Low-risk patients may be treated in the hospital with oral or IV antibiotics, in an ambulatory clinic, or at home if adequate follow-up care can be provided (i.e., 24 hours per day, 7 days per week). Outpatient therapy should be considered only for low-risk patients who consent to home care, have a telephone, have access to emergency facilities, have an adequate and supportive home environment, and are within 1-hour travel time of a medical center or physician's office. Outpatient therapy requires a period of early assessment and an observation period of 2 to 12 hours (category 2B) (see Guidelines section on Outpatient Therapy for Low-Risk Patients). The assessment requires a careful examination, review of laboratory results, review of social criteria for home therapy (as described above), and assessment of whether oral antibiotics are feasible. The observation period is used to confirm that the patient is at low risk and ensure clinical stability of the patient, to administer the first dose of antibiotics and monitor for any reactions, , to organize discharge plans for home and follow-up care, and to provide patient education. A telephone follow-up should be performed within 12 to 24 hours. This assessment and observation can be performed during a short hospital stay or in an ambulatory facility or office staffed with qualified health care professionals. Providers who perform the early assessment and follow-up should be well trained (e.g., a physician, nurse, physician assistant, and/or nurse practitioner) and should have experience and expertise in managing patients with F&N.

Outpatient Regimens

Outpatient antimicrobial treatment may consist of broad spectrum IV antibiotics given at home or in the clinic, or an oral regimen for carefully selected patients.[210] For selected low-risk patients, the combination of ciprofloxacin with amoxicillin/clavulanate (both at 500 mg every 8 hours) is considered the oral regimen of choice based on well-designed randomized trials (category 1) (see Guidelines section on Outpatient Therapy for Low-Risk Patients: Treatment Options). Although some of these trials were performed in an inpatient setting, they provide evidence of the efficacy of the oral combination compared with standard IV therapy in the low-risk population.[5, 157, 211] Ciprofloxacin plus clindamycin is an acceptable alternative for penicillin-allergic patients.[8, 22] However, ciprofloxacin monotherapy is not considered by the panel to be an adequate broad spectrum agent because of the suboptimal coverage for Gram-positive organisms and potential for serious breakthrough infections caused by viridans group streptococci.[111] Nonetheless, several small studies have used high-dose oral ciprofloxacin alone in low-risk patients with F&N.[1, 212, 213]

Ofloxacin was safe in low-risk patients with neutropenic fever in a randomized trial; an early death in a non-hospitalized patient in this trial underscores the need for close monitoring.[159] Presumably, levofloxacin (which is the L-isomer of ofloxacin) would be equally effective. Many oncologists (50%) are using levofloxacin as empiric therapy for low-risk patients with febrile neutropenia.[214] A preliminary study suggested that moxifloxacin (a newer generation quinolone) may also be safe in low risk patients with neutropenic fever.[215]

The panel feels that outpatient therapy with a fluoroquinolone should be based on reliable Gram-negative bacillary activity of the antibiotic that includes *P.aeruginosa* and local antibacterial susceptibilities. Ciprofloxacin plus amoxicillin/clavulanate (or ciprofloxacin plus clindamycin in penicillin-allergic patients) is the standard oral outpatient antibiotic regimen for low-risk patients with neutropenic fever. There is also evidence supporting quinolone monotherapy in this setting, but the panel feels that additional studies are required before such an approach can be routinely recommended. These recommendations for quinolone-based outpatient regimens for neutropenic fever only apply

to low-risk patients who have not received a quinolone as prophylaxis. Additionally, in order for a low-risk patient to receive oral antibiotics, the patient should not present with nausea or vomiting, and must be able to tolerate oral medications. Intravenous therapy may also be used for outpatient treatment of low-risk patients with F&N with treatment given either in the home or day clinic setting. Several IV outpatient regimens for low-risk patients have been studied in nonrandomized or small open trials, including IV ceftazidime, imipenem/cilastatin, and aztreonam plus clindamycin.[8, 84, 157, 160, 162, 216]

Once-daily ceftriaxone has been used for empiric antibiotic therapy in a few noncomparative studies in centers where *Pseudomonas* is not a common pathogen.[158] However, most *P.aeruginosa* isolates are resistant to ceftriaxone. Although ceftriaxone combined with a once-daily aminoglycoside is a convenient regimen for outpatient IV administration, an aminoglycoside without an antipseudomonal beta-lactam may not be effective against *P.aeruginosa*, which remains an infrequent but potentially lethal pathogen. Therefore, the panel cannot recommend ceftriaxone (with or without an aminoglycoside) as empiric therapy for neutropenic fever. If this regimen is used, it should be restricted to low-risk patients at centers where *P.aeruginosa* infection is uncommon. In addition to antimicrobial spectrum, other factors to consider in the choice of an outpatient regimen include stability of the reconstituted drugs, ability to manage IV infusions, and VADs.

Follow-Up of Outpatients With Fever and Neutropenia

Follow-up management can be performed at the patient's home or in the physician's office or clinic. The panel recommends that patients be assessed daily while febrile, although some experts feel that less frequent follow-up may be appropriate after fever defervescence (see Guidelines section on Outpatient Therapy for Low-Risk Patients: Follow-up). For the first 72 hours from initiation of empirical therapy, the patient should be assessed daily at home or at the clinic for treatment response, signs of toxicity, and treatment compliance. If the patient is responding to the treatment regimen, then daily follow-up by telephone is sufficient. A return to the clinic is recommended for any positive culture, for persistent or recurrent fever at 3-5 days, if serious subsequent infections or adverse events develop, or if the patient is unable to continue the prescribed antibiotic regimen (e.g., because of intolerance to the oral regimen).

Site-Specific Evaluation and Treatment of Infectious Diseases

The NCCN Guidelines provide recommendations for site-specific evaluation and therapy for infections of the mouth and esophagus, sinuses, liver, abdomen, rectum, vascular access sites, lungs, skin/soft tissue, urinary tract, and central nervous system (CNS). This section is tailored to patients with neutropenia or those who are otherwise significantly immunocompromised (e.g., HSCT recipients).

Mouth and Esophageal Infections

The mouth and esophagus are common sites of infection in patients with F&N. This site predilection occurs because of the propensity of the mouth and alimentary tract mucosa to be disrupted by cytotoxic therapy, which can cause mucositis. Unfortunately, the characteristics of this disruption are not etiology specific, and important viral and fungal pathogens often can be distinguished only by microbiologic culture. Empiric antibiotic therapy must consider the endogenous anaerobic flora and the shift in oral flora, which occurs with serious illness or antibiotic use. The increased frequency of HSV reactivation and severity of these infections in cancer patients are well known and preventable. The incidence of HSV reactivation in immunocompromised patients may approach 50% to 75%, but it is nearly zero in those who

receive prophylaxis with appropriate antiviral agents.[217] HSV infections are associated with more extensive mucosal damage, increased secondary infections, and significantly prolonged healing time. Baglin et al reported that patients with F&N who experienced concomitant HSV reactivation and were treated with appropriate antiviral therapy had a significant decrease in the number of days with fever.[218] Ulcerations of the oral mucosa may be due to HSV infections or fungal sources; a culture should be obtained to determine the pathogenic organism, and addition of antiviral or systemic antifungal therapy should be considered, pending results. Vesicular lesions are most often caused by herpes virus infections and should be treated with antivirals pending culture (or other diagnostic assays) results (see Guidelines section on Initial Clinical Presentation: Mouth/Mucosal Membrane).

Systemic or topical antifungal agents can be used to treat thrush. Because of the risk of candidemia, systemic antifungal therapy is advised in neutropenic patients. Fluconazole is recommended as first-line therapy for thrush (see Guidelines section on Initial Clinical Presentation: Mouth/Mucosal Membrane). If patients do not respond, the dose of fluconazole can be increased up to 800 mg daily (in adults with normal renal function).[219] Although cross-resistance among azoles may occur, oral voriconazole, itraconazole, or posaconazole are reasonable oral options for thrush that is refractory to fluconazole. Echinocandins (such as, caspofungin, micafungin, or anidulafungin) can be used for patients with azole-refractory mucosal candidiasis. Amphotericin B formulations are also effective but are limited by toxicity.

Thrush along with retrosternal burning, chronic nausea, or odynophagia should raise suspicion for *Candida* esophagitis. However, *Candida* esophagitis may occur in the absence of oral thrush, especially in patients receiving oral topical antifungal agents. Definitive diagnosis of esophageal candidiasis is made by endoscopy. Empiric systemic antifungal therapy is often used to treat presumed *Candida* esophagitis.

The presence of thrush favors esophageal candidiasis in patients with symptoms compatible with esophagitis, although the symptoms of HSV and *Candida* esophagitis are similar. Other causes of esophagitis (e.g., radiation esophagitis, GVHD of the esophagus or stomach) also produce similar symptoms. A trial of fluconazole and acyclovir (5 mg/kg IV every 8 hours in patients with normal renal function) should be considered in neutropenic patients and other highly immunocompromised persons with symptoms that suggest esophagitis. CMV esophagitis is a rare complication of chemotherapy-induced neutropenia and is most commonly observed in allogeneic HSCT recipients with GVHD. Negative CMV surveillance results from antigenemia or PCR studies would make CMV disease very unlikely. Ganciclovir or foscarnet may be considered for patients at high risk for CMV disease with symptoms suggestive of esophagitis.

For patients with esophagitis who do not respond to empiric therapy with these agents, careful upper endoscopy with platelet support (if required) may be considered to obtain cultures. Tissue biopsies are the gold standard of diagnosis of invasive esophageal infections. However, endoscopy and biopsy may be associated with complications in patients who are profoundly neutropenic and/or thrombocytopenic; therefore, the procedure should be performed with caution. Radiographic procedures, such as barium studies, are insensitive and add little clinically significant information; therefore, these procedures are not recommended.

Sinus or Nasal Infections

The sinuses are a common site of bacterial infection. Patients with severe and prolonged neutropenia (e.g., more than 10 days) and

allogeneic HSCT recipients with GVHD are particularly susceptible to invasive mold infections. Cytotoxic therapy disrupts the natural cleansing mechanisms in the nasal passages and increases colonization. A preceding chronic infection may also become active in the setting of neutropenia. Sinusitis during the early neutropenic period (less than 7 days) is principally caused by respiratory and Gram-negative bacterial pathogens. In patients with longer duration neutropenia or in patients receiving concomitant high-dose corticosteroid therapy, invasive mold infections are an important concern.

Initial symptoms of sinusitis may be mild. A high-resolution CT scan of the sinuses is the radiographic procedure of choice to evaluate patients with pain or tenderness of the sinuses, nasal erosions, unilateral facial swelling, unilateral eye tearing, or epistaxis. A magnetic resonance image (MRI) that includes evaluation of the orbit and cavernous sinuses is useful to evaluate proptosis of the eye or cranial nerve abnormalities (see Guidelines section on Initial Clinical Presentation: Sinus/Nasal). Bony erosion on CT scan suggests invasive fungal disease. Ear, nose, and throat (ENT) and ophthalmologic examinations should be performed for symptomatic patients with abnormalities on CT scan, with biopsy and culture of any abnormal tissues. Broad spectrum coverage for aerobes and anaerobes is appropriate for neutropenic and otherwise highly immunocompromised patients with sinus infections. Vancomycin (or another anti-Gram-positive agent) should be added for periorbital cellulitis, which is frequently caused by *S.aureus*.

Sinus endoscopy with biopsy and culture are often required to definitively establish the diagnosis and should be pursued aggressively in patients at high risk for mold infection. Invasive fungal sinusitis in patients with hematologic malignancies and with prolonged neutropenia is principally caused by *Aspergillus* species (*A.flavus* and *A.fumigatus*) and Zygomycetes. In a case-control study of invasive aspergillosis and zygomycosis in patients with acute leukemia and in allogeneic HSCT recipients, fungal sinusitis and use of voriconazole each favored a diagnosis of zygomycosis.[220] A lipid formulation of amphotericin B should be used for suspected or confirmed invasive sinus mold infection, pending definitive histology and culture results. Posaconazole can be considered for salvage therapy or for intolerance to amphotericin B formulations; posaconazole is not approved by the FDA as either primary or salvage therapy for invasive fungal infections. Voriconazole (category 1) is the drug of choice for invasive aspergillosis.[221-223] Urgent debridement of necrotic tissue should be performed, when feasible.[223]

Abdominal, Rectal, and Liver Infections

Most infections in the abdomen, rectum, or liver are discovered because of a combination of clinical signs and symptoms (e.g., abdominal pain, perirectal pain, and diarrhea) and of biochemical abnormalities (e.g., abnormal liver function tests). These infections are usually diagnosed and managed based on the radiologic, GI, and surgical expertise of the treating oncology center. Improved imaging techniques (including ultrasonography, CT scans, MRI, and radionuclide and endoscopic procedures) have decreased the need for surgical intervention. The choice of diagnostic studies should be based on the clinical presentation and on relative clinical benefit.

Antimicrobial therapy for GI infections must take into account the high likelihood of polymicrobial pathogens and the presence of the endogenous anaerobic GI flora. Acceptable therapeutic options in this setting include monotherapy with a carbapenem (imipenem/cilastatin, meropenem, doripenem, or ertapenem), piperacillin/tazobactam, or pairing ceftriaxone with metronidazole. In neutropenic patients, the antibiotic regimen should have antipseudomonal activity. Percutaneous

aspiration and drainage should be performed, if feasible, for suspicious infected collections. Cholangitis may complicate obstructive tumors or previous hepatobiliary surgery. If cholangitis is suspected (patients have fever with or without abdominal tenderness and liver enzyme abnormalities compatible with obstruction), a CT scan should be performed to evaluate for biliary tract dilatation and for abscess or infected collections. An endoscopic cholangiogram is useful to document the level of obstruction; if present, endoscopic stent placement may resolve the obstruction, which is a key component in managing cholangitis.

The GI tract and central venous catheters are the principal portals of entry of systemic candidiasis. *Candida* species are frequently components of the colonic flora in normal adults. Patients are susceptible to candidal bloodstream infection because of the mucosal damage induced with cytotoxic therapy and neutropenia. Breaches in the GI tract after anastomotic leaks also predispose patients to candidal peritonitis and bloodstream infections,[224] and antifungal prophylaxis (e.g., with fluconazole) should be considered.

Clostridium difficile Colitis

Clostridium difficile colitis is principally a complication of antibiotic therapy and hospitalization, but it is also a complication of neutropenia, occurring in about 7% of patients.[225] Diarrhea should be evaluated with at least 2 stool *C.difficile* toxin screens. The rate and severity of *C.difficile* colitis in the United States may be increasing, partly because of the emergence of a more virulent strain of *C.difficile.* Multi-institutional outbreaks of *C.difficile* colitis have been reported that were associated with high morbidity and mortality; these outbreaks were caused by a distinct strain with variations in toxin genes and with resistance to fluoroquinolones.[226, 227] Early reports suggested that metronidazole cured over 90% of cases of *C.difficile* colitis, and the rate of recurrence was low.[228, 229] However, Musher et al[230] reported that among patients (N=207) treated with metronidazole for *C.difficile* colitis, only 50% were cured and had no recurrence of disease. The panel recommends initial oral metronidazole for *C.difficile* colitis that is not severe.[231-233] IV metronidazole should be used in patients who cannot be treated with oral agents.

Oral vancomycin is not advised as routine initial therapy for *C.difficile* colitis because of the risk of selection for VRE and because of the substantial expense. However, oral vancomycin should be considered for more complicated cases, such as those associated with severe diarrhea, dehydration, clinical instability, significant co-morbidities, or recurrent or refractory *C.difficile* colitis. Efforts should be made to deliver vancomycin by the nasogastric route in patients with severe *C.difficile* colitis.[231, 234] Limited data suggest that IV metronidazole may be useful in this setting, and it is best used as an adjunct to oral vancomycin.[235, 236] Intravenous vancomycin is of no value in this setting because of inadequate luminal levels. Recently, a multicenter, double-blind randomized trial was conducted to evaluate the efficacy and safety of oral fidaxomicin versus oral vancomycin in patients with *C.difficile* infection (N=629).[237] The primary end point of this study was clinical cure, defined as the resolution of diarrhea and requiring no further therapy following completion of study treatment. The clinical cure rate with fidaxomicin was noninferior to vancomycin (88.2% vs 85.8%) in the modified intent-to-treat analysis.[237] The frequency and severity of adverse events were similar between treatment arms. In addition, fidaxomicin was associated with a significantly decreased recurrence rate compared with vancomycin (15.4% vs 25.3%; *P*=0.005) and a significantly higher rate of resolution of diarrhea without recurrence (74.6% vs 64.1%; *P*=0.006).[237] A decrease in recurrence of *C. difficile* diarrhea was not observed in the treatment of the current

epidemic strain, NAP1/BI/027. The investigators postulate that the improved duration of infection resolution with fidaxomicin may be due to its preservation of normal intestinal anaerobic flora, which may help to prevent the reemergence of *C.difficile*.[237] Fidaxomicin was recently approved by the US FDA for the treatment of *C.difficile*-associated diarrhea.

Subtotal colectomy, diverting ileostomy, or colostomy may be required in cases involving toxic dilatation or perforation of the colon. Newer therapies—including the oral agents rifaximin and nitazoxanide—are under investigation.[232, 238] Multiple recurrences of *C.difficile* are a challenging problem in the cancer patient and may respond to a prolonged, tapering oral vancomycin dose over several weeks.[239]

Enterocolitis

Neutropenic enterocolitis is a serious, potentially life-threatening disease characterized by fever, diarrhea, and abdominal pain.[240, 241] When it occurs in the cecum, it is commonly referred to as typhlitis. The cecum is more vulnerable because of its size and shape, but any or the entire colon may be involved. CT scanning is the diagnostic study of choice and usually demonstrates thickening of the bowel wall. This illness has frequently been associated with acute leukemia, neutropenia, and intensive cytotoxic therapy. The differential diagnosis for this syndrome includes *C.difficile* colitis, CMV enteritis (most common in allogeneic HSCT recipients), and GI tract GVHD. Bloodstream infections and sepsis (frequently polymicrobial), bowel perforation, and hemorrhage may occur. The natural history of typhlitis is quite variable, but all patients should be assessed for *C.difficile* infection and should be treated with bowel rest and broad spectrum antibiotics, including coverage for *C.difficile*, aerobic pathogens, and anaerobic pathogens. Parenteral nutrition should be considered if clinical signs and symptoms do not resolve promptly. Approximately 5% of patients with typhlitis develop complications requiring surgical intervention (e.g., perforation, uncontrolled sepsis or rectal bleeding).[242] Consequently, the panel recommends that surgical and other subspecialty consultations be obtained early in the course of treatment.

Vascular Access Device Infections

VAD infections are common as a consequence of the ubiquity of VADs in patients undergoing intensive or cyclic chemotherapy. The risk of infection varies with the device used (long-term implanted catheters versus short-term central catheters), duration of placement, and extent of the patient's immunosuppression. Short-term central catheters coated with the antimicrobial agent chlorhexidine and silver sulfadiazine (CHSS) have been shown to significantly decrease the incidence of both catheter colonization and catheter-related bloodstream infections compared with standard (non-coated) catheters[243, 244]; however, this benefit with CHSS coating was not observed in the setting of patients with hematologic malignancies requiring longer use of central catheters (e.g., duration of catheterization 20 days).[245] In subsequent studies that evaluated the use of CHSS-coated short-term catheters compared with controls, CHSS-coated catheters significantly decreased the incidence of colonization but showed no difference in terms of incidence of catheter-related bloodstream infections.[246-248] The use of short-term catheters coated with minocycline and rifampin has been shown to significantly decrease risks for catheter colonization and bloodstream infections compared with controls or with CHSS-coated catheters.[249, 250] However, conflicting results were reported by another study in which minocycline- and rifampin-coated catheters reduced the risk for coagulase-negative staphylococci colonization whereas they increased the risk for colonization with *Candida* spp; moreover, no significant difference was noted in the incidence of catheter-related bloodstream infections compared with controls.[251] Only limited data are available on

the use of long-term catheters coated with minocycline and rifampin. In a prospective, randomized, double-blind study in patients with cancer requiring long-term catheterization (mean duration of catheterization 63-66 days), a significant risk reduction in catheter-related bloodstream infections was observed with the coated catheter (1.6% vs 8%; relative risk for uncoated vs coated =1.8; 95% CI, 1.4-2.3; *P*=0.003).[252] The recently published guidelines for the prevention of catheter-related infections (based on a interdisciplinary working group involving the IDSA and CDC) recommend the use of catheters impregnated with CHSS or minocycline/rifampin in patients requiring catheterization for >5 days, if the rate of catheter-related bloodstream infections do not decrease despite implementation of comprehensive prevention measures at the local institution.[253] A meta-analysis of prospective, randomized studies showed that use of a vancomycin lock solution in patients being treated with long-term central VADs reduced the risk of bloodstream infection.[254] The panel does not currently endorse this practice due to concerns over the emergence of bacterial resistance if this approach were widely employed. The IDSA has published guidelines on the diagnosis and management of intravascular catheter-related infections.[103]

VAD infections are categorized as entry or exit site infections versus tunnel or port pocket infections or septic phlebitis (see Guidelines section on Initial Clinical Presentation: Vascular Access Devices). The majority of these infections are caused by Gram-positive pathogens, with coagulase-negative staphylococci recovered most frequently.[103] Accordingly, IV vancomycin is recommended for those infections that are serious and clinically obvious.

Most VAD exit site infections can be treated effectively with appropriate antimicrobial therapy without the need for catheter removal. If clinical signs of catheter infection are present, a skin swab for culture from the exit site and blood cultures should be obtained. In a patient with neutropenic fever and clinical signs of a VAD-associated infection, an appropriate initial regimen would consist of an agent recommended for neutropenic fever (see Guidelines section on Initial Therapy for Fever and Neuropenia) and vancomycin. Linezolid is not advised as routine therapy for catheter-related infections nor is it FDA-approved for this indication.[128] For a clinically apparent, serious, catheter-related infection (such as a tunnel or port pocket infection, or septic phlebitis), catheter removal should be performed immediately.

Determining the role of the catheter in bloodstream infections is frequently difficult if local catheter inflammation is not evident. The differential time to positivity (DTP) method is a useful diagnostic tool for detecting VAD infections. Early positivity of central venous blood cultures predicts catheter-related bacteremia and may be used to avoid unnecessary catheter removal in critically ill patients. It was shown that a DTP of 120 minutes or more (between centrally and peripherally drawn blood cultures) is highly sensitive and specific for diagnosing catheter-related bacteremia.[128, 255-259] However, these studies were only performed in patients with removable catheters, not implanted catheters (e.g., Hickman or Mediport) that are frequently used in patients undergoing cancer treatment.

Most catheter-associated bloodstream infections respond to antimicrobial therapy alone without catheter removal, but immediate catheter removal is advisable for patients with bloodstream infections caused by fungi (yeasts or molds) or nontuberculosis mycobacteria (e.g., *Mycobacterium chelonae*, *Mycobacterium abscessus*, *Mycobacterium fortuitum*).[103] Bloodstream infections caused by *Bacillus* organisms, *Candida, S.aureus, Acinetobacter*, *C.jeikeium*, *P.aeruginosa*, *S.maltophilia,* and vancomycin-resistant enterococci may be difficult to eradicate with antimicrobial therapy alone; therefore,

catheter removal should be considered as part of initial therapy (see Guidelines section on Follow-up Therapy for Responding Patients: Suggested Duration of Therapy for Documented Infection). In patients with mucositis, the bowel is likely to be the portal of entry for bloodstream infection by GI flora such as *Candida* spp. and enterococci. DTP may be useful to distinguish whether bloodstream infection by these organisms is catheter-related and to guide whether catheter removal should be performed. If not removed initially, catheter removal is advised for known or suspected VAD-associated bloodstream infections if the organism is recovered from blood obtained 48 hours after initiation of appropriate antibiotic therapy. In patients with VAD infection and clinical instability, removal of the infected catheter should be performed immediately.

In all patients with *S.aureus* bloodstream infection, a TEE is recommended to evaluate for endocarditis (see Guidelines section on Follow-up Therapy for Responding Patients: Suggested Duration of Therapy for Documented Infection).[103] Removal of the catheter should be considered to avoid a persistent nidus of infection that may predispose patients to recurrent bacteremia.

The panel recognizes that certain conditions may preclude the ability to immediately replace IV catheters, such as limited options for IV access and thrombocytopenia refractory to platelet products. Administering antibiotics through each lumen of the involved catheter has been suggested to avoid treatment failure caused by microbial sequestration. Some experts believe supplemental urokinase infusions can be helpful in patients with catheter-related infections.[260] However, the panel believes data are insufficient to recommend either of these approaches.

Lung Infections

Pulmonary infiltrates pose a difficult diagnostic challenge in patients with cancer. Noninfectious causes of pulmonary infiltrates include congestive heart failure, pulmonary edema, hemorrhage, infarction, drug-induced pneumonitis, radiation injury, tumor, bronchiolitis obliterans, and acute respiratory distress syndrome. Common processes can have atypical radiographic appearances, and 2 or more pulmonary processes can exist simultaneously. A careful history should include the time course of respiratory symptoms, sick contacts (e.g., community respiratory viral infections, tuberculosis), recent hospitalization, travel, exposure to animals, and exposure to droplets from water distribution systems (*Legionella*). Community outbreaks of specific pathogens (e.g., influenza, pertussis) should be considered in the differential diagnosis and should guide initial therapy.

Community-Acquired Pneumonia in the Absence of Neutropenia and Immunosuppressive Therapy

The diagnostic evaluation and initial therapy for community-acquired pneumonia must consider host factors and previous use of antibiotics. The IDSA has published guidelines on community-acquired pneumonia.[261] If feasible, sputum and blood cultures should be collected before starting therapy. In patients who are not neutropenic, not receiving immunosuppressive therapy, and not requiring hospital admission (based on a validated pneumonia severity index), therapy includes either 1) a respiratory fluoroquinolone (levofloxacin 750 mg/day, moxifloxacin, or gemifloxacin); or 2) a beta-lactam (e.g., high-dose amoxicillin or amoxicillin-clavulanate) plus a macrolide (e.g., azithromycin).[261] These regimens will treat most of the common community-acquired pathogens, including “atypical” pneumonia (*Chlamydia, Mycoplasma*, and *Legionella* species).

In patients requiring hospital admission, monotherapy with a respiratory fluoroquinolone or combination therapy with a macrolide plus either ceftriaxone, cefotaxime, or ertapenem is recommended. Ertapenem has Gram-positive, Gram-negative (excluding *P.aeruginosa* and *Acinetobacter* species), and anaerobic activity useful for suspected aspiration or postobstructive pneumonia. In patients with severe community-acquired pneumonia (e.g., who require admission to an intensive care unit), the panel advises broad spectrum coverage with an antipseudomonal beta-lactam plus either a respiratory fluoroquinolone or azithromycin. In patients with previous MRSA infection or known colonization with MRSA, addition of vancomycin or linezolid should be considered for pneumonia requiring hospitalization (see Guidelines section on Lung Infiltrates: Additions to Initial Empiric Regimen).[261] A nasopharyngeal wash for respiratory viruses and initiation of empiric antiviral therapy should be considered during the winter, early spring, and during community outbreaks of influenza. Note that rapid immunofluorescent viral antigen tests may be negative for H1N1 (swine flu). A parapneumonic effusion should be aspirated and submitted for Gram stain, bacterial culture, protein, lactate dehydrogenase, and pH.

Community respiratory viral infections (such as, influenza, RSV, adenovirus, rhinoviruses, metapneumoviruses) have a seasonal pattern (generally November through April); however, parainfluenza viral infections can occur throughout the year. During the influenza season, consider empiric antiviral therapy for patients within 48 hours after symptoms develop that are suggestive of influenza (such as, high fever, coryza, myalgia, and dry cough), especially during community outbreaks. Both the IDSA (2007) and current CDC guidelines (2011) recommend antiviral treatment with the neuraminidase inhibitors oseltamivir or zanamivir, which are active against both influenza A and B viruses.[261, 262] Both agents are approved by the FDA for the treatment of influenza within 48 hours of symptomatic onset; the indicated duration of treatment is 5 days.[263, 264] However, longer courses of treatment (e.g., 10 days) and until resolution of symptoms should be considered in immunocompromised patients; some centers have used higher doses (e.g., 150 mg BID) of oseltamivir in such patients, with mixed results (see Guidelines section on Follow-up Therapy for Responding Patients >> Suggested Duration of Therapy for Documented Infections). Pandemic influenza does not have a predictable seasonal pattern, and may spread in the community concurrently with a seasonal influenza strain. Antiviral susceptibility of influenza strains is variable and cannot be predicted based on previous influenza outbreaks. In cases of seasonal influenza and pandemic strains, it is necessary to be familiar with susceptibility patterns and guidelines on appropriate antiviral treatment .[265]

Hospital-Acquired Pneumonia

Guidelines on the management of adults with hospital-acquired pneumonia from the American Thoracic Society (ATS) emphasize that the time of onset of pneumonia is an important risk factor for specific pathogens that may be resistant to antibiotics.[266] Early-onset hospital-acquired pneumonia (occurring within the first 4 days of hospitalization) is likely to be caused by antibiotic-sensitive bacteria and usually carries a better prognosis. However, patients with cancer may be at risk for acquisition of antibiotic-resistant bacteria based on prior hospitalizations, prior antibiotic use, and impaired immune status regardless of when pneumonia begins in the course of the current hospitalization. The ATS guidelines define the following as risk factors for multi-drug resistant pathogens in patients with health-care-associated pneumonia: received antibiotics in the preceding 90 days; hospitalization for 2 days or more in the preceding 90 days; resident in nursing home or extended care facility; chronic dialysis within 30 days;

home wound care; and family member with a multi-drug resistant pathogen.[266] Late-onset hospital-acquired pneumonia (occurring after 5 days or more of hospitalization) is more likely caused by multidrug-resistant pathogens, and is associated with greater morbidity and mortality.

The population of multidrug resistant bacteria (notably, MRSA and antibiotic-resistant Gram-negative pathogens) varies among different hospitals and geographic distributions. Therefore, the selection of initial therapy for hospital-acquired pneumonia requires knowledge of the local patterns of antibiotic susceptibility. For example, at some centers, a high frequency of extended spectrum beta lactamase-producing Gram-negative bacterial infections may make a carbapenem the drug of choice as initial therapy for pneumonia. At other centers, carbapenem-resistant Gram-negative infections are an increasing problem, and an alternative class of antibiotics may be preferred based on prior local susceptibility results.[267]

In patients with late-onset hospital-associated pneumonia or risk factors for multi-drug resistant pathogens regardless of when pneumonia developed in relation to hospitalization, a broad-spectrum antibiotic regimen is recommended. An antipseudomonal beta-lactam (e.g., ceftazidime, cefepime, imipenem/cilastatin, meropenem, doripenem, or piperacillin/tazobactam) plus an antipseudomonal fluoroquinolone (e.g., ciprofloxacin or levofloxacin) or aminoglycoside, plus either linezolid or vancomycin (to cover MRSA) is a reasonable initial regimen (aim for vancomycin trough level of 15-20 mcg/mL).[266] If *Legionella* is suspected, a quinolone (ciprofloxacin or levofloxacin) should be used instead of an aminoglycoside. The antibiotic regimen should be subsequently tailored based on culture results.

Pulmonary Infiltrates in Neutropenic Patients

In patients with neutropenia for less than7 days, pulmonary infections are likely to be caused by Enterobacteriaceae (e.g., *E.coli, Klebsiella* sp.), *P.aeruginosa*, *S.aureus*, and pathogens encountered in non-immunocompromised persons (as previously described). Because of the neutropenia, consolidation and sputum production may be absent.[268] Blood cultures, a chest radiograph, and, if possible, a sputum sample for Gram stain and culture should be obtained. In suspected acute bacterial pneumonia, appropriate empiric antibiotic therapy must be initiated promptly and the response must be closely monitored in an inpatient setting. The therapeutic regimen depends on several variables, including recent use of antibiotics, community or nosocomial pneumonia, and the local antibiotic sensitivity data.

If community-acquired pneumonia is suspected (i.e., pneumonia present before admission or developing within 3 to 4 days of hospitalization), addition of a macrolide or fluoroquinolone to an antipseudomonal beta-lactam is warranted to treat atypical pathogens. For nosocomial pneumonia, therapy with an antipseudomonal beta-lactam is advised, and addition of an aminoglycoside or fluoroquinolone should be considered. For cases of nosocomial pneumonia in which hospital-acquired legionellosis is suspected, empiric addition of a macrolide or fluoroquinolone is also warranted. Vancomycin or linezolid should be added for pneumonia in patients colonized with MRSA and for nosocomial pneumonia at centers in which MRSA is common. Community respiratory viruses should also be considered, especially during winter months. Respiratory syncytial virus, parainfluenza, and influenza are significant pathogens during neutropenia in patients receiving chemotherapy for acute leukemia and in HSCT recipients.

If clinical improvement occurs within 48 to 72 hours of therapy, no further diagnostic measures are necessary; antibiotic therapy should be

continued until neutropenia resolves and for at least 10 to 21 days. Once neutropenia resolves, an appropriate oral antibiotic regimen can be administered for the remainder of the course.

In cases of refractory pneumonia, bacterial infection resistant to the initial antibiotic regimen and nonbacterial pathogens should be considered, particularly filamentous fungi.[268] A CT scan of the chest is useful in defining the location and morphology of the lesions, and in guiding diagnostic procedures. A “halo sign” in a persistently febrile neutropenic patient is highly suggestive of invasive aspergillosis[269]; however, angioinvasive infections including other filamentous fungi and *P.aeruginosa* may produce similar findings.

A new or progressive infiltrate developing in patients with prolonged neutropenia (e.g., more than 10 days) receiving broad spectrum antibacterial agents suggests invasive aspergillosis or infection with other molds.[268] Consider adding voriconazole or a lipid formulation of amphotericin B while waiting for diagnostic results. Empiric modification of the antibacterial regimen based on the predominant local hospital pathogens (e.g., MRSA, antibiotic-resistant Gram-negative bacteria) is also warranted in patients with a rapidly progressive pneumonia.

Pulmonary Infiltrates in Patients With Impaired Cellular Immunity

Patients with impaired cellular immunity are at increased risk for common bacterial infections and opportunistic infections, including fungi (*Aspergillus* and other filamentous fungi, *Cryptococcus neoformans*, dimorphic fungi), *Legionella*, *P.jirovecii, M.tuberculosis*, nontuberculous mycobacteria, *Nocardia* species, and viral pathogens.

In patients with clinical and radiographic findings suggestive of acute bacterial pneumonia (e.g., acute onset fever, respiratory symptoms, and a focal infiltrate), the diagnosis and management are similar to that for neutropenic patients. An antipseudomonal beta-lactam plus either a respiratory quinolone or azithromycin is a reasonable initial regimen in patients with pneumonia requiring hospitalization. In allogeneic HSCT recipients with GVHD not receiving mold-active prophylaxis, addition of a mold-active drug (e.g., voriconazole) should be considered. Particularly among the most highly immunocompromised patients (e.g., significant GVHD), the differential diagnosis is very broad, and an initial empiric regimen cannot have activity against all possible pathogens. It is critical to establish a definitive diagnosis in patients with negative diagnostic results who are deteriorating clinically after a 2 to 3 day trial of broad spectrum antibiotics.

Diffuse infiltrates have a broad differential diagnosis,[268] including PCP, viral infections, hemorrhage, and drug-induced pneumonitis. A diagnosis of PCP should be considered in patients with significantly impaired cellular immunity not receiving PCP prophylaxis who present with diffuse pulmonary infiltrates. BAL is the standard approach for diagnosing PCP. In patients with substantial respiratory disease (e.g., labored breathing, requiring supplemental oxygen), empiric therapy should be initiated before BAL. Pending BAL results, an initial regimen can include a respiratory fluoroquinolone against community-acquired pathogens and TMP-SMX (TMP component: 5 mg/kg every 8 hours) against possible PCP. In patients with suspected PCP and with room air PaO_2 of 75 torr or less, corticosteroids (initially prednisone 40 mg twice daily, then tapered) should be added based on studies of patients with AIDS–associated PCP.[270]

Patients at the highest risk for CMV pneumonia include allogeneic HSCT recipients in the post-engraftment setting (particularly those receiving immunosuppressive therapy for GVHD) and patients receiving treatment with alemtuzumab. Negative results from CMV surveillance testing (antigenemia or peripheral blood PCR) make CMV pneumonia

very unlikely. CMV pneumonia is uncommonly observed in non-transplanted patients receiving immunosuppressive chemotherapy for leukemia.[271] Community respiratory viruses can cause severe pulmonary infection in neutropenic patients and in non-neutropenic patients with impaired cellular immunity. Noninfectious etiologies must also be considered, as previously stated. BAL is sensitive in diagnosing bacterial and viral pneumonia and PCP, and is often the initial invasive diagnostic procedure (see Discussion section below for Invasive Diagnostic Procedures for Pulmonary Infiltrates).

Non-Invasive Diagnosis of Pneumonia

In patients with suspected pneumonia, routine sputum and blood cultures should be obtained, ideally before antibiotics are initiated or modified. Sputum cultures for *Legionella* species are sensitive if obtained before initiating antibiotics; however, specific culture conditions are required. Legionellosis can also be diagnosed based on urine antigen testing, which only detects *Legionella pneumophila* type I, the cause of most (but not all) cases of *Legionella* pneumonia.[261] A nasopharyngeal wash is useful to diagnose community respiratory viral infections. The rapid test for influenza A and B may be performed using a throat or nasopharyngeal swab. Rapid antigen detection methods can provide a diagnosis within hours; however, if results are negative, shell vial culture takes about 5 days.

Fungal pneumonia is suggested by the following: host factors predisposing the patient to invasive aspergillosis; appropriate symptoms or signs of infection; a compatible pulmonary lesion; and a positive serum galactomannan or beta-glucan assay. Host factors indicative of high risk for invasive aspergillosis include neutropenia for more than 10 days, receipt of an allogeneic HSCT, prolonged use of high-dose systemic corticosteroids, or treatment with T-cell suppressants. The galactomannan assay is specific for invasive aspergillosis,[184, 272] whereas the beta-glucan assay detects aspergillosis and other invasive fungal infections (including invasive candidiasis, PCP, and fusariosis).[273-275] Zygomycosis yields negative serum galactomannan or beta-glucan test results.

Antigen-based detection systems have advantages and limitations. A meta-analysis showed that the galactomannan assay had a sensitivity of 70% and specificity of 89% for proven invasive aspergillosis, and that the accuracy of the test varied.[186] The lack of consistent results likely relates to different cut-off values for a positive result, differences in patient populations, and possibly use of mold-active prophylaxis. Several variables can affect the performance of the galactomannan assay,[276, 277] which may account for the different results. The sensitivity of the assay is significantly reduced by concomitant mold-active antifungal agents.[185, 278] False-positive results may be more common in children and in allogeneic HSCT recipients.[279] Moreover, concomitant piperacillin/tazobactam causes false-positive galactomannan results.[280, 281] False-positive beta-glucan results have also been reported in patients with surgical packing who are receiving immunoglobulin therapy and in patients receiving IV amoxicillin-clavulanate.[282, 283] Despite these limitations, a patient at high risk for invasive aspergillosis (e.g., prolonged neutropenia or allogeneic HSCT recipient) with clinical and radiological findings (e.g., a new pulmonary nodule of 1 cm or greater or infiltrate) compatible with invasive aspergillosis and with a positive serum galactomannan is likely to have invasive aspergillosis, and a mold-active agent (voriconazole is preferred) should be added.

The assay for serum or urine Histoplasma antigen is a sensitive and specific test in patients with disseminated histoplasmosis (histoplasmosis is endemic in the central United States). Coccidioidomycosis is endemic in the southwestern United States. Disseminated coccidioidomycosis can be diagnosed based on

appropriate symptoms and signs of infection and on positive serum titers. As previously discussed, BAL is the diagnostic gold standard for PCP. In a small series, sputum induction with hypertonic saline was diagnostic of PCP in non–HIV-infected patients in about 60% of cases.[284] A BAL should be performed if sputum induction is attempted, and the results are negative.

Invasive Diagnostic Procedures for Pulmonary Infiltrates

Invasive diagnostic procedures may be required in the following situations: 1) the clinical course does not suggest an acute bacterial process; 2) the patient has not responded to initial antibiotic therapy and/or; 3) noninvasive testing yields negative results. BAL has a high diagnostic yield in alveolar infiltrates, such as pneumonia caused by *P.jirovecii*, *M.tuberculosis,* and respiratory viruses. The sensitivity of BAL for focal lesions (such as nodules) is variable. In lesions more than 2 cm, the sensitivity of BAL ranges from 50% to 80%; however, in smaller lesions, the diagnostic yield is usually about 15%.[285] Quantitative cultures from BAL or from a protected brush catheter may increase the specificity in the diagnosis of bacterial pneumonia as distinguished from upper airway colonization in ventilated patients.

BAL cultures only detect about 50% of cases; therefore, it is relatively insensitive for diagnosing aspergillosis.[286] Galactomannan detection in BAL fluid appears to be more sensitive than serum detection[287, 288] and can be used to support a diagnosis of probable aspergillosis.[289] In patients with focal peripheral lesions, percutaneous biopsy may increase the diagnostic yield; however, in thrombocytopenic patients, the risk of bleeding may be unacceptably high. The microbiologic evaluation should take into account the clinical manifestations and nature of immunocompromise. In the highly immunocompromised (e.g., those receiving chemotherapy for acute leukemia, HSCT recipients), the following studies on BAL and lung biopsies should be considered: culture and stains for bacteria, fungi, *Legionella*, mycobacteria, *Nocardia*, HSV, CMV, community respiratory viruses (both rapid antigen and shell vial culture), and cytology or immunofluorescent studies for *P.jirovecii*. In a patient with compatible host factors and radiologic findings, a positive galactomannan result from BAL is also indicative of probable invasive aspergillosis.[289]

For nondiagnostic BAL or percutaneous lung biopsy results, a thoracoscopic lung biopsy should be considered if an adequate platelet count is achievable. The thoracoscopic approach has less morbidity than an open lung biopsy and generally provides adequate tissue samples for diagnosis of most infectious and noninfectious etiologies. This invasive procedure may identify the causative pathogen or the presence of a noninfectious etiology (e.g., treatment-associated lung toxicity, hemorrhage, or bronchiolitis obliterans–organizing pneumonia [BOOP]), which may allow one to eliminate potentially toxic or unnecessary antimicrobial therapies. Thoracoscopic and open lung biopsies sometimes do not provide a definitive diagnosis, either due to sampling error or nonspecific pathologic findings.

Skin and Soft Tissue Infections

The evaluation and recommended empiric therapy for skin and soft tissue infections in neutropenic patients are discussed in this NCCN Guidelines. When evaluating the potential for a skin/soft tissue infection, careful examination of all line sites and perineal areas are essential. Antimicrobial therapy should be tailored to the probable organism(s): Staphylococci and streptococci for catheter-associated processes, and Gram-negative and anaerobic organisms for perineal processes, respectively. Vancomycin may be considered for cellulitis, disseminated papules/lesions, and wound infections (see Guidelines section on Initial Clinical Presentation >> Cellulitis, Wound, or Disseminated Papules or Other Lesions >> Additions to Initial Empiric

Regimens). Acyclovir, famciclovir, or valacyclovir should be considered for vesicular lesions after appropriate diagnostic tests (scraping base of vesicle for HSV or VZV, direct fluorescent antibody tests, herpesvirus culture) have been performed.

Skin lesions can be manifestations of systemic infection. Ecthyma gangrenosum is the most characteristic skin lesion associated with systemic *P.aeruginosa* infection.[290] Similar lesions can be caused by *S.aureus*, enteric Gram-negative bacilli infection, and filamentous fungi (including *Aspergillus*, Zygomycetes, and *Fusarium* species). A rapidly progressive deep soft tissue infection with gas formation suggests clostridial myonecrosis (or polymicrobial necrotizing fascitis).[291] Broad spectrum antibiotics and surgical debridement may be life saving if initiated early. Hematogenously disseminated candidiasis with skin involvement manifests as fever and erythematous cutaneous papules; blood cultures are expected to be positive for *Candida* species.

In the highly immunocompromised patient with cancer, the differential diagnosis of skin lesions is often broad and includes noninfectious etiologies such as drug reactions, Sweet's syndrome, erythema multiforme leukemia cutis, and (in the case of allogeneic HSCT recipients) GVHD. Biopsy of skin lesions for histology and culture is recommended. In allogeneic HSCT recipients, the differential diagnosis of infectious etiologies is particularly broad, and cultures from skin biopsies for bacteria, fungi, viruses, and mycobacteria should be considered when infection is suspected.

Central Nervous System Infections

CNS infections in patients with cancer can be divided into surgical and nonsurgical complications. The IDSA has published guidelines on the management of bacterial meningitis.[292] The most common organisms infecting intraventricular devices are coagulase-negative staphylococci, *S.aureus,* and *Propionibacterium acnes*. Enterobacteriaceae and *P.aeruginosa* account for only 10% of these infections. Coagulase-negative staphylococci and *P.acnes* usually cause indolent late postoperative infections. Therapy with systemic antibiotics and removal of the entire device are the most effective approaches to eradicate infection. Use of parenteral and intraventricular instillation of antibiotics without removal of the device may not be effective, and recrudescence of infection is common. Antibiotic therapy should be tailored to the specific pathogen isolated from cerebrospinal fluid. In an acutely ill patient with suspected meningitis related to previous neurosurgery, empiric therapy can include parenteral vancomycin (which has activity against *Staphylococcus*, *Streptococcus*, and *Propionibacterium* species; dose 15 mg/kg every 8 to 12 hours to maintain serum trough concentration of 15-20 mcg/mL) in combination with ceftazidime (2 g every 8 hours), cefepime (2 g every 8 hours), or meropenem (2 g every 8 hours) (which have activity against Enterobacteriaceae and *P.aeruginosa*); these doses apply to adults with normal renal function.[292]

CNS infections unrelated to neurosurgery are relatively uncommon in patients with cancer. Initial evaluation generally involves a head CT scan to rule out intracranial bleeding and a lumbar puncture (assuming there are no contraindications). Cerebrospinal fluid studies should be tailored to specific host factors, epidemiologic exposures (e.g., travel history), and clinical presentation. At a minimum, cell counts with differential, glucose and protein levels, Gram stain and bacterial culture, cryptococcal antigen and fungal culture on cerebrospinal fluid should be obtained. Noninfectious causes of meningitis include nonsteroidal anti-inflammatory agents, TMP/SMX, carcinomatous meningitis, and serum sickness (e.g., associated with anti-lymphocyte immunoglobulin preparations).

Empiric therapy for presumed meningitis should include an anti-pseudomonal beta-lactam agent that readily enters the CSF (e.g., cefepime, ceftazidime, meropenem) plus vancomycin plus ampicillin (to cover listeriosis) (see Guidelines section on Initial Clinical Presentation >> Central Nervous System Symptoms >> Additions to Initial Empiric Regimen). If meropenem is used, addition of ampicillin is unnecessary because meropenem is active against *Listeria*. This regimen has activity against the common causes of bacterial meningitis, including penicillin-resistant pneumococci and listeriosis. In patients at risk for *P.aeruginosa* meningitis (e.g., neutropenia, neurosurgery within the past 2 months, allogeneic HSCT, history of *P.aeruginosa* infection), use of cefepime (2 g every 8 hours in adults with normal renal function) or meropenem (2 g every 8 hours in adults with normal renal function) instead of ceftriaxone in the initial empiric regimen is advised. The antibiotic regimen should be tailored based on culture results.

The use of dexamethasone as adjuvant therapy in the management of bacterial meningitis has been evaluated in a number of studies, although conflicting results have been reported. In an earlier systematic review of published data in patients with acute bacterial meningitis, adjuvant therapy with corticosteroids was associated with significantly lower risks for mortality (relative risk [RR]=0.76; 95% CI, 0.59-0.98), severe hearing loss (RR=0.36, 95% CI, 0.22-0.60), and long-term neurological sequelae (RR=0.66; 95% CI, 0.44-0.99).[293] These outcomes mainly reflected the pediatric population, as only limited data were available for adults. In a prospective randomized double-blind study involving adult patients with acute bacterial meningitis (N=301), adjuvant dexamethasone compared with placebo significantly reduced the risks for unfavorable outcomes (defined as score 1-4 on the Glasgow Outcome Scale)(RR=0.59; 95% CI, 0.37-0.94; *P*=0.03) and mortality (RR=0.48; 95% CI, 0.24-0.98; *P*=0.04); this benefit was observed in patients with pneumococcal meningitis.[294] In a more recent prospective, randomized double-blinded study in adults and adolescents with suspected or confirmed bacterial meningitis (N=435), adjuvant dexamethasone significantly reduced the risks for death at 1 month (RR=0.43; 95% CI, 0.20-0.94) and death or disability at 6 months (RR=0.56; 95% CI, 0.32-0.98) in patients with confirmed cases of bacterial meningitis, but not for those with suspected cases.[295] Other recent prospective randomized studies in pediatric patients appear to conflict with the findings from the earlier systematic review. In these studies that evaluated the use of adjuvant dexamethasone, glycerol, or both, in children treated with ceftriaxone for bacterial meningitis, adjuvant dexamethasone alone was not associated with significant reductions in risks for death, deafness/hearing loss, or severe neurological sequelae.[296, 297] Moreover, in a recent meta-analysis of data from a large number of patients (N=2029), dexamethasone was not found to be associated with significant reductions in death or neurological sequelae, although a statistically significant reduction in hearing loss was observed among surviving patients.[298] The IDSA guidelines (2004) for the management of bacterial meningitis support the incorporation of adjuvant dexamethasone in pediatric patients with *H.influenzae* type B meningitis and in adult patients with pneumococcal meningitis.[292] In patients with suspected encephalitis (fever, mental status changes, cerebrospinal fluid pleocytosis), IV acyclovir (10 mg/kg every 8 hours in patients with normal renal function) should be considered as empiric therapy for HSV in addition to an appropriate antibacterial regimen.[299] An MRI and the following cerebrospinal fluid studies should be performed: 1) cell count with differential; 2) glucose and protein levels; 3) Gram stain and culture for bacteria; 4) Cryptococcal antigen and fungal culture; and 5) PCR for HSV. PCR for West Nile virus and other arboviruses should be considered in patients with exposure to endemic areas. Culture and PCR for tuberculosis

should be considered in patients with known or suspected exposure to tuberculosis (e.g., residence in an endemic area, shelter, or prison; previous positive PPD [purified protein derivative]). In patients with severe impairment of cellular immunity (e.g., allogeneic HSCT recipients, advanced AIDS), additional cerebrospinal fluid studies should be considered (such as PCR for CMV, VZV, human herpes virus–6 type B [HHV-6B], and toxoplasmosis). For cases of HHV-6B-associated encephalitis in severely immunocompromised patients such as those who have received an allogeneic transplant, treatment is recommended, however, the optimal therapy is not known (with either foscarnet or ganciclovir).[299] Cytology to evaluate for CNS malignancy as a cause of meningitis or encephalitis should also be considered.

Brain abscesses usually manifest with headache, focal neurologic findings, or seizures. An MRI typically shows single or multiple lesions with edema and ring enhancement.[300] Bacterial abscesses in non-immunocompromised patients are typically caused by dental flora. In patients with prolonged neutropenia and in allogeneic HSCT recipients, CNS aspergillosis must be considered. A chest CT showing a new nodule or infiltrate and a positive serum galactomannan result in this setting are highly suggestive of pulmonary aspergillosis with CNS dissemination. In patients with impaired cellular immunity, other causes of CNS abscesses include toxoplasmosis, nocardiosis, cryptococcosis, and mycobacterial infections. Noninfectious etiologies in patients with impaired cellular immunity include CNS malignancies (such as secondary lymphomas) and Epstein-Barr virus (EBV)–associated post-transplantation lymphoproliferative disorder (PTLD). Given the broad differential diagnosis of new CNS lesions in highly immuno-compromised patients, a brain biopsy is strongly recommended (if feasible) with material submitted for histology and culture. Cultures and stains should include bacteria, fungi, mycobacteria, and *Nocardia* species.

In non-immunocompromised patients with a bacterial brain abscess, initial therapy with ceftriaxone (2 g every 12 hours in adults) plus metronidazole (7.5 mg/kg every 6 hours in adults with normal renal function) is advised.[22, 300, 301] In patients with prolonged neutropenia without corticosteroids or lymphocyte-depleting agents, a reasonable initial regimen consists of combination cefepime, metronidazole, and voriconazole (IV 6 mg/kg every 12 hours for 2 doses followed by 4 mg/kg every 12 hours); however, IV voriconazole (but not the oral formulation) may worsen renal disease in patients with significant pre-existing renal impairment. Voriconazole (as well as itraconazole and posaconazole) has important drug-drug interactions with certain antiseizure agents (e.g., phenytoin); therefore, the voriconazole package insert should be reviewed to guide dosing of these agents.[302] In allogeneic HSCT recipients and other patients with severe T-cell impairment, addition of high-dose TMP/SMX (trimethoprim component: 5 mg/kg every 8 hours) should be considered to cover toxoplasmosis and nocardiosis, pending a definitive diagnosis. An Infectious Diseases consultation is advised in all cases of suspected or documented CNS infections.

Therapy for Invasive Fungal Infections

Invasive Candidiasis

Candida species are the fourth most common cause of nosocomial bloodstream infections in the United States.[303, 304] The crude mortality of candidemia ranges from 20% to 40%.[304, 305] This variable mortality rate reflects the presence of serious comorbidities (such as malignancy, neutropenia), patient population (adult versus pediatric), and illness requiring prolonged periods in the intensive care unit. *Candida albicans* is the most common *Candida* species isolated from the blood.[304] The

proportion of non-albicans *Candida* species varies among different centers, but accounts for approximately 50% of blood stream isolates.

A randomized study comparing IV fluconazole (400 mg daily) with amphotericin B as therapy for candidemia in non-neutropenic patients found both regimens equally effective, but fluconazole had less toxicity.[306] In a subsequent study of non-neutropenic patients with candidemia, combination therapy with a higher dose of fluconazole (800 mg daily) and amphotericin B led to improved clearance of candidemia compared with fluconazole alone, but the combination regimen was associated with significantly more nephrotoxicity and with no survival benefit.[219] Voriconazole was equally effective as, but less nephrotoxic than, a strategy of amphotericin B followed by fluconazole in non-neutropenic patients with invasive candidiasis.[307] In trials of "invasive candidiasis," most patients had candidemia, but those with deep organ involvement (e.g., peritoneal, hepatic, or renal candidiasis) without positive blood cultures were also eligible for enrollment.

Four phase III randomized trials have been performed evaluating echinocandins as initial therapy for invasive candidiasis.[308-311]When caspofungin was compared with conventional amphotericin B, there was a trend for a higher favorable response (defined as resolution of clinical symptoms and culture-confirmed eradication) rate in the caspofungin arm (73% vs 62%) in the modified intent-to-treat analysis.[309] Among patients who met prespecified criteria for evaluation (those who met eligibility criteria and received at least 5 days of study drug), caspofungin resulted in significantly higher success rate compared with amphotericin B (81% vs 65%; 95.6% CI, 1.1-29.7; *P*=0.03). Caspofungin was less toxic than amphotericin B. Micafungin was shown to be as effective as liposomal amphotericin B for invasive candidiasis, with fewer treatment-related adverse events (including those that led to treatment discontinuation) occurring with micafungin.[308] Anidulafungin was not inferior to fluconazole as therapy for invasive candidiasis and was possibly more efficacious.[311] At the end of IV therapy, successful outcomes (based on both clinical and microbiologic responses; primary endpoint) was achieved in a higher proportion of patients treated with anidulafungin compared with fluconazole (76% vs 60%; 95% CI, 3.9-27.0; *P*=0.01), though a center effect was observed in this study. Finally, caspofungin and micafungin were shown to be equally safe and efficacious as treatment for invasive candidiasis.[310]

The IDSA has published detailed updated guidelines for the management of candidiasis.[312] Fluconazole (loading dose of 800 mg [12 mg/kg], then 400 mg [6 mg/kg] daily) or an echinocandin (caspofungin: loading dose of 70 mg, then 50 mg daily; micafungin: 100 mg daily; anidulafungin: loading dose of 200 mg, then 100 mg daily) is recommended as initial therapy for most non-neutropenic adult patients. An echinocandin is preferred in critically ill patients. Transition from an echinocandin to fluconazole is recommended for patients who have isolates that are likely to be susceptible to fluconazole (e.g., *Candida albicans*), who are clinically stable, and who have not had recent azole exposure.[312] Fluconazole-resistant *Candida* isolates are frequently cross-resistant to other azoles[313]; therefore, if candidemia occurs in a patient with recent azole exposure, a switch in class (e.g., to an echinocandin) is recommended. *Candida krusei* is generally resistant to fluconazole. *Candida glabrata* strains can have variable sensitivity to azoles; an echinocandin is therefore the preferred therapy,[312] and transition to fluconazole or voriconazole can be considered if azole susceptibility is documented. Echinocandins have reduced sensitivity to *Candida parapsilosis* compared to other candidal strains; fluconazole is recommended in this setting.[312]

The IDSA recommends an echinocandin as initial therapy for candidemia in most neutropenic patients.[312] The NCCN Guidelines panel agrees with this recommendation, but notes that because studies evaluating echinocandins have included very small numbers of neutropenic patients, the optimal therapy for invasive candidiasis in this population is not definitive. Given the availability of safer alternatives, the panel does not recommend amphotericin B products routinely for candidemia, although such agents may be considered in unusual complicated cases, such as meningitis and endocarditis.

Invasive Aspergillosis

Voriconazole is the recommended agent as primary therapy for invasive aspergillosis (see Guidelines section on Antifungal Agents). In an open-label, multicenter randomized trial of primary therapy for invasive aspergillosis, voriconazole resulted in significantly higher success rate (successful outcome included complete and partial responses) compared with amphotericin B (53% vs 32%; 95% CI, 10.4-32.9) and was associated with improved survival rate at 12 weeks (71% vs 58%; hazard ratio=0.59; 95% CI, 0.40-0.88).[222] Success rates were similar for the 2 treatment arms in the subgroup of patients with neutropenia (51% with voriconazole vs 32% with amphotericin B). In a retrospective analysis of 86 patients with CNS aspergillosis treated with voriconazole either as primary or salvage therapy, 35% had a complete or partial response.[314] This success rate compares favorably to previous series in which the frequency of successful responses to amphotericin B in CNS aspergillosis was almost nil.[315] Based on the strength of this database, the NCCN Guidelines panel recommends voriconazole as first-line therapy for invasive aspergillosis, which is consistent with IDSA recommedations.[223]

There can be considerable inter-individual variability in voriconazole exposure, and the utility of monitoring drug levels is controversial.[316, 317] Studies with a few patients have noted a relationship between low plasma voriconazole levels and treatment failure,[318] and between high voriconazole levels and toxicity.[319, 320] Voriconazole blood levels of at least 1 to 2 mcg/mL are thought to be required for efficacy. Obtaining a serum voriconazole level should be considered in cases of breakthrough or refractory fungal disease or drug toxicity.

It is not clear what the optimal therapy is for breakthrough invasive aspergillosis in patients receiving mold-active prophylaxis. Breakthrough invasive aspergillosis in a patient receiving oral posaconazole prophylaxis may be caused by inadequate oral bioavailability due to mucositis or poor oral intake, or possibly resistance. Some experts would advise changing to a different class of antifungals (such as a lipid formulation of amphotericin B, with or without an echinocandin). Others would use IV voriconazole with or without an echinocandin.

Lipid formulations of amphotericin B have at least comparable efficacy and reduced renal toxicity compared to conventional amphotericin B deoxycholate. Some investigators have persuasively argued that lipid formulations should be considered suitable replacements for amphotericin B for primary therapy for many invasive fungal infections.[170] Amphotericin B colloidal dispersion (ABCD) was equally effective as, but less nephrotoxic than, amphotericin B as primary therapy for invasive aspergillosis.[321] Amphotericin B lipid complex (ABLC) was shown to be safe and efficacious as therapy for invasive aspergillosis based on an analysis of a registry database.[322]

A randomized study compared liposomal amphotericin B (L-AMB) at either 3 or 10 mg/kg per day for 14 days, followed by 3 mg/kg per day as therapy for invasive mold infections.[323] Response rate (both complete and partial responses) after completion of treatment with the

3 mg/kg/day and 10 mg/kg/day dose groups was similar (50% vs 46%); the 12-week survival rate was 72% and 59%, respectively (95% CI, -0.2-26%). The high-dose group was associated with significantly higher incidences of nephrotoxicity and hypokalemia, which suggested that the 3 mg/kg/day dosing was more optimal in this patient population.[323] Because 97% of enrolled patients had invasive aspergillosis, this study does not permit conclusions about optimal L-AMB dosing in patients with other mold infections (such as zygomycosis).

Echinocandins have not been evaluated as initial monotherapy for invasive aspergillosis in clinical trials. Caspofungin as salvage therapy in patients with invasive aspergillosis led to a favorable response in 37 (45%) of 83 patients.[324] It might be possible to use combination antifungal therapy pairing an echinocandin with either an amphotericin B preparation or an azole with activity against *Aspergillus* species. The rationale is that echinocandins target a unique site (the beta-glucan constituent of the fungal cell wall), which is distinct from the polyenes and azoles that target the fungal cell membrane. The combination of an echinocandin with an azole or amphotericin B has shown neutral to synergistic activity in vitro. Enhanced efficacy of combination regimens pairing an echinocandin with either an azole or an amphotericin B formulation was observed in some animal models of invasive aspergillosis[325-328] but not in others.[329-331]

In small retrospective series, the combination of caspofungin and liposomal amphotericin B as salvage therapy led to a favorable outcome in approximately 40% to 60% of patients with invasive aspergillosis, although these series included cases of “possible” or “probable” aspergillosis.[332, 333] Marr et al reported a significant improvement in 3-month survival rate with voriconazole plus caspofungin compared with voriconazole alone in a small retrospective analysis (N=47) of salvage therapy for invasive aspergillosis.[334] This database study, although encouraging, involved small numbers of patients and the 2 groups of patients evaluated were noncontemporaneous; therefore, other host and infection-related factors may have influenced the outcome. A noncomparative study of caspofungin combined with other mold-active drugs as salvage therapy for invasive aspergillosis reported a success rate of 49% (25/51) at 12 weeks after initiation of combination therapy,[335] which was similar to caspofungin monotherapy.[324] In an open-label study of invasive aspergillosis, micafungin combined with other antifungals led to a successful response in 29% (5/17) and 35% (60/174) of the primary and salvage treatment groups, respectively.[336] These results did not appear favorable to response rates observed with micafungin alone (50% and 41% in primary and salvage treatment groups, respectively); however, the patient numbers in the micafungin monotherapy arms was too small to permit comparisons. In addition, the initial micafungin dose (75 mg/day) used in this study was low by current standards.

Although combination antifungal therapy is commonly used as treatment for invasive aspergillosis, the clinical evidence is inadequate to make conclusions about whether any combination regimen is more effective than voriconazole alone, the current gold standard. A randomized, prospective study comparing voriconazole versus voriconazole plus anidulafungin as primary therapy for invasive aspergillosis is underway.

Posaconazole has shown activity as salvage therapy against a broad spectrum of invasive fungal infections.[337-340] In an open-label study in patients with invasive aspergillosis refractory to or who had intolerance to standard antifungal therapy (N=107), 42% had a complete or partial response with posaconazole.[341] Posaconazole is approved in the European Union for treatment of invasive aspergillosis and certain other invasive fungal infections refractory to standard antifungal agents. In

the U.S., posaconazole is approved by the FDA for prophylaxis of invasive *Aspergillus* and *Candida* infections, but is not indicated as primary or salvage therapy for invasive fungal disease.[342]

Zygomycosis and Other Invasive Mold Infections

The frequency of zygomycosis (also referred to as "mucormycosis") has increased at some centers in the setting of more frequent voriconazole usage.[220, 343, 344] In a case-control study of invasive aspergillosis and zygomycosis in patients with acute leukemia and allogeneic HSCT recipients, use of voriconazole and presence of fungal sinusitis each favored a diagnosis of zygomycosis.[220] However, some transplant centers reported an increased frequency of zygomycosis that pre-dated the availability of voriconazole,[345, 346] a finding that likely reflects a greater proportion of patients with severe host defense impairment. Zygomycosis typically manifests as rhinocerebral or pulmonary disease. Histopathology showing broad aseptate or hyposeptate hyphae with 90-degree branching is suggestive of zygomycosis, although culture is required for confirmation.

No randomized studies have been performed for treatment of zygomycosis and other uncommon invasive mold infections. Recommendations for therapy are based on a limited number of patients from retrospective analyses, data registries, and open-label trials for salvage therapy. Treatment of zygomycosis involves amphotericin B (a lipid formulation is advised over amphotericin B deoxycholate to reduce the chance of nephrotoxicity) plus early and aggressive surgical debridement, when feasible. A gap in knowledge exists regarding optimal dosing of lipid formulations of amphotericin B for invasive non-*Aspergillus* mold infections; an initial dose of 5 mg/kg/day is commonly used. Posaconazole, a second generation antifungal azole with activity against most of the zygomycetes, has shown promising results as salvage therapy in zygomycosis refractory to or intolerant of amphotericin B formulations.[337, 347] Although not approved by the U.S. FDA for this indication, posaconazole can be considered as maintenance therapy for zygomycosis following control of infection with an amphotericin B formulation and/or surgical debridement. Posaconazole has not been evaluated as primary therapy for invasive fungal diseases in clinical trials.

Fusarium species[348-350] and *Scedosporium* species have emerged as important causes of invasive fungal infections–related mortality in leukemia and in allogeneic HSCT recipients at some centers.[346, 351, 352] The likelihood of infection by a *Fusarium* species is substantially increased by the presence of disseminated cutaneous lesions and isolation of a mold from blood culture.[348] Therapy for invasive fusariosis generally involves voriconazole,[353] posaconazole,[340] or a lipid formulation of amphotericin B[354]. *Scedosporium* species are resistant to amphotericin B; therapy generally involves itraconazole, voriconazole, or posaconazole.[355, 356] An Infectious Diseases consultation is advised in all cases of invasive mold infections, particularly for cases involving uncommon and resistant molds.

Early Diagnosis of Invasive Mold Infections

Invasive fungal pathogens have increased and remain a major concern. CT scanning of the chest may facilitate early detection of aspergillosis and other filamentous fungi.[357, 358] A CT scan may show peripheral or subpleural nodules inapparent on plain chest radiographs. The "halo sign" is a characteristic, but not pathognomonic, early chest CT feature of angioinvasive organisms.[269] The hazy alveolar infiltrates surrounding the central nodule or region of consolidation appear to correspond to regions of hemorrhage and are highly suggestive of invasive mold disease, aspergillosis being the most common. The panel recommends a chest CT scan in patients with 10 to 14 days of neutropenia and with persistent or recurrent fever of unknown origin that is unresponsive to

empiric antibacterial agents. A chest CT scan may be considered earlier in patients with multiple prior cycles of potently cytotoxic chemotherapy and in patients receiving systemic corticosteroid therapy.

Studies differ regarding whether serum galactomannan is a useful surveillance tool in asymptomatic patients at high risk for mold infections and in patients with persistent neutropenic fever of unknown etiology. In one study, prospective serial monitoring of galactomannan antigenemia in allogeneic HSCT recipients yielded positive and negative predictive values of 94.4% and 98.8%, respectively, and antigenemia preceded radiographic findings by more than 1 week in 80% of cases of invasive aspergillosis.[359] In another study, the sensitivity was only 64.5% in cases of definite invasive aspergillosis.[279] The positive predictive value (PPV) was poor when serum galactomannan was used as a surveillance tool in patients with persistent neutropenic fever (PPV=7.1%) and in HSCT (mostly autologous) recipients (PPV=10%); the negative predictive value was 100% in both groups.[279]

Odabasi et al evaluated the beta-glucan assay as an early diagnostic marker for invasive fungal infections in patients with acute leukemia or MDS receiving antifungal prophylaxis.[273] At least one serum sample was positive at a median of 10 days before the clinical diagnosis in all patients with a proven or probable invasive fungal infection, including candidiasis, fusariosis, trichosporonosis, and aspergillosis. The negative predictive value was 100%, and the specificity of the test was 90% for a single positive test result and at least 96% for 2 or more sequential positive results.[273] The experience of the beta-glucan assay in HSCT recipients is limited and requires additional study.

Although valuable as diagnostic adjuncts to support a diagnosis of a probable invasive aspergillosis in patients with compatible host factors, clinical findings, and radiologic findings[360] (see Guidelines section on Lung Infiltrates: Evaluation), the value of these laboratory markers as surveillance tools for invasive fungal infections is controversial. Use of surveillance markers as a trigger for additional diagnostic evaluation or to modify antifungal therapy is at an exploratory level,[189] and more research is required. Currently, the evidence is inadequate to recommend any of these methods as a surveillance tool in asymptomatic immunocompromised patients or in patients with neutropenic fever alone.

Prevention of Infectious Diseases

Infection prophylaxis in cancer patients generally involves broad spectrum antimicrobial therapy directed against the most common infecting pathogens (including bacterial, viral, and fungal) in high-risk patients.

Antibacterial Prophylaxis During Neutropenia

Patients with cancer and chemotherapy-induced neutropenia are at risk for severe bacterial infections. Fluoroquinolones are the most commonly used prophylactic antibacterial agents in adults with chemotherapy-induced neutropenia. In a meta-analysis that evaluated 18 trials (N=1408) in which fluoroquinolones were compared to either placebo or TMP/SMX, fluoroquinolone prophylaxis significantly reduced the incidence of Gram-negative infections by about 80% compared with those without prophylaxis (relative risk=0.21; 95% CI, 0.12-0.37), leading to an overall reduction in total infections.[361] The reduction in fever was small, and in blinded trials, was not significant. Fluoroquinolone prophylaxis did not affect infection-related mortality rates in this meta-analysis. Moreover, the rate of Gram-positive infections and fungal infections was not significantly affected by fluoroquinolone prophylaxis.[361] This is an important consideration given

the occurrence of an increased rate of Gram-positive infections in some trials of fluoroquinolone prophylaxis.[362] Viridans group streptococcal bacteremia breakthroughs have been associated with ciprofloxacin prophylaxis,[26, 110] which poses a concern given the potential for substantial morbidity and mortality associated with this pathogen in neutropenic patients.

The potential benefit of antibacterial prophylaxis was evaluated in a single-center randomized study in patients undergoing high-dose therapy followed by autologous HSCT (N=157).[363] Patients were randomized to receive prophylaxis (with 500 mg oral ciprofloxacin twice daily and 1000 mg IV vancomycin once daily) or no prophylaxis; all patients received antifungal prophylaxis with fluconazole. Empirical therapy (comprising amikacin, ceftazidime and full-dose vancomycin) was initiated when neutropenic fever developed. The use of antibacterial prophylaxis significantly reduced the incidences of neutropenic fever (56% vs 91%; $P<0.001$) and bacteremia (6% vs 35%; $P=0.005$) compared with no prophylaxis, but at the expense of decreased responses to first-line empirical therapy (66% vs 84%; $P=0.025$).[363] Among the patients who received prophylaxis and developed neutropenic fever, 34% required second-line therapy that included a carbapenem, suggesting that these patients developed infections resistant to the prophylactic regimen. Duration of hospitalization and overall survival rates were similar between study arms. These results led the study investigators to conclude that routine antibacterial prophylaxis was not recommended in patients undergoing high-dose therapy and autologous HSCT.[363] It should be noted, however, that the prophylactic regimen in this study included vancomycin (albeit at a lower dose), which is not supported by the panel for use as either antimicrobial prophylaxis or initial empirical therapy for fever and neutropenia. This view is in agreement with the published guidelines of the IDSA.[22]

Studies have provided additional insight into the benefits and limitations of prophylaxis among neutropenic patients with varying degrees of risk for serious infectious complications. Gafter-Gvili et al conducted a meta-analysis of 95 randomized controlled trials comparing antibiotic prophylaxis with either placebo or no intervention or with another antibiotic in afebrile neutropenic patients.[364] Antibiotic prophylaxis significantly decreased the risk for all-cause death when compared with placebo or no treatment (relative risk=0.67; 95% CI, 0.55-0.81); significant risk reductions were also observed for infection-related mortality, fever, clinically and microbiologically document infections, Gram-positive and Gram-negative infections, and bacteremia. Similar results were obtained when the analysis was restricted to prophylaxis with fluoroquinolones. Fluoroquinolone prophylaxis significantly reduced the risk for all-cause mortality (relative risk=0.52; 95% CI, 0.35-0.77), as well as all of the secondary measures indicated above.[364] Most of the trials involved hospitalized patients with hematologic malignancies, and data were inadequate to assess the relationship between duration and degree of neutropenia and relative risk of mortality. No significant increase was observed in fluoroquinolone-resistant bacterial infections, although the length of observation may have been too short to detect the emergence of resistant bacteria.[364] The panel recognizes the substantial limitations associated with meta-analyses. However, the panel believes that the benefit of prophylaxis in patients with hematologic malignancies on overall survival outweighs detriments related to adverse effects and development of resistance.

Two large randomized, placebo-controlled studies showed the benefit of levofloxacin prophylaxis in neutropenic patients at different levels of

risk of infectious complications.[365, 366] Levofloxacin has similar activity against Gram-negative pathogens compared to ciprofloxacin and ofloxacin; however, levofloxacin has improved activity against certain Gram-positive pathogens, including streptococci. Bucaneve et al evaluated levofloxacin prophylaxis in adult patients with cancer in whom chemotherapy-induced neutropenia (less than 1000 neutrophils/mcL) was expected to occur for more than 7 days. This protocol intentionally excluded patients anticipated to have a short duration of neutropenia who would generally be candidates for outpatient management of neutropenic fever. Levofloxacin recipients had a lower rate of microbiologically documented infections, bacteremias, and single-agent Gram-negative bacteremias than did placebo recipients.[365] The effects of prophylaxis were also similar between patients with acute leukemia and those with solid tumors or lymphoma. Mortality and tolerability were similar in the 2 groups.[365]

Cullen et al evaluated levofloxacin prophylaxis after chemotherapy for solid tumors and lymphomas for patients anticipated to have brief durations of neutropenia and typically categorized as low risk.[366] The primary outcome was the incidence of clinically documented febrile episodes (temperature more than 38°C) attributed to infection. Secondary outcomes included the incidence of all probable infections, severe infections, and hospitalization. A total of 1565 patients underwent randomization, 87% with solid tumors and 13% with lymphoma. During the entire chemotherapy course, 10.8% of levofloxacin recipients had at least one febrile episode compared with 15.2% of placebo recipients (P=0.01).[366] Hospitalization was required for the treatment of infection (suspected and documented) in 15.7% of patients in the levofloxacin group and 21.6% of patients in the placebo group (P=0.004). The incidence of severe infections, infection-related mortality, and overall mortality were similar in both groups.[366]

Thus, the main advantage of levofloxacin prophylaxis in intermediate and higher risk patients with chemotherapy-induced neutropenia was a reduction in clinically significant bacterial infections, including Gram-negative rod bacteremia.[365] In contrast, the main advantage of prophylaxis in lower risk neutropenic patients was a small, but statistically significant, reduction in fever and hospitalization for neutropenic fever.[366] Neither study conducted a systematic long-term evaluation of antimicrobial resistance. The NCCN Guidelines panel considers that reduction in the incidence of significant infections is a more clinically meaningful endpoint than reduction in the incidence of neutropenic fever. Using the primary endpoint of prevention of neutropenic fever in the study by Cullen et al, [366] 1000 hypothetical low-risk patients would have to receive prophylaxis during each cycle of chemotherapy-induced neutropenia to benefit only 44 patients.

An important consideration for low-risk patients with short durations of neutropenia is whether fluoroquinolone prophylaxis is of greater benefit than the option of outpatient fluoroquinolone treatment for F&N, should it occur. Both the NCCN Guidelines panel and IDSA[22] recommend oral fluoroquinolone-based regimens as outpatient empiric therapy for neutropenic fever in adults who meet criteria for low risk of complications. Use of fluoroquinolone prophylaxis may preclude their later use as empiric therapy for neutropenic fever in the same patient. The modest difference in rates of hospitalization for suspected infection in levofloxacin compared to placebo recipients (15.7% vs 21.6%, respectively) in the study by Cullen et al[366] may be offset by exclusion of outpatient oral empiric therapy in patients receiving fluoroquinolone prophylaxis. To target antibacterial use, Cullen et al have recently suggested more limited prophylaxis using levofloxacin only on cycle 1 of myelosuppressive cancer chemotherapy and on subsequent cycles after a fever in cycle 1.[367]

The decision whether to use antibacterial prophylaxis and the selection of the specific agent requires a balance between expected benefit and risk. The concept of risk applies to immediate adverse effects of the drug (e.g., rash, GI intolerance), the potential for selection for resistant pathogens that can harm the individual receiving prophylaxis, and the risk of resistant organisms to a specific population of patients (e.g., those being treated at a cancer center). The link between fluoroquinolone use and severe *C.difficile* as well as MRSA infections provides an additional cautionary note regarding excess use of fluoroquinolones.[226, 227, 368, 369]

The panel advises that fluoroquinolone prophylaxis (levofloxacin is preferred) be considered in patients with expected duration of neutropenia (ANC less than 1000/mcL) for more than 7 days. This is in agreement with the recommendations of the recent IDSA guidelines for the use of antimicrobial agents in neutropenic patients with cancer.[22] Trimethoprim-sulfamethoxazole should be used in patients at risk for *P.jirovecii* (formerly *P.carinii*) such as patients with childhood acute lymphoblastic leukemia (see Discussion section on Prophylaxis against *P.jirovecii*). Among patients with neutropenia who are at lower risk of infectious complications (a category that includes most patients with solid tumor malignancies), the main benefit of antibacterial prophylaxis relates to a reduction in fever rather than in documented infections. In patients with neutropenia expected to last less than 7 days who are not receiving immunosuppressive regimens (e.g., systemic corticosteroids), the panel suggests no antibiotic prophylaxis.[22]

Prophylaxis Against Pneumococcal Infection

Prophylaxis against pneumococcal infection is advised in allogeneic HSCT recipients.

Patients undergoing allogeneic HSCT are at increased risk for pneumococcal sepsis due to functional asplenia and impaired B-cell immunity. Pneumococcal sepsis is most common in the late transplant period, between 3 months to years after HSCT.[69, 370] Immunosuppressive therapy for GVHD delays reconstitution of B-cell immunity and significantly increases the risk of post-transplant pneumococcal sepsis.[69, 371]

The NCCN Guidelines panel advises that penicillin prophylaxis be initiated at 3 months after HSCT and be continued until at least 1 year after transplant. Prophylaxis should be continued in patients with chronic GVHD until immunosuppressive therapy has been discontinued. Post-transplant pneumococcal infection is generally community-acquired, and the frequency of resistance to antibiotics reflects regional antibiotic susceptibility patterns. In some areas, as many as 35% of pneumococcal isolates have intermediate- or high-level resistance to penicillin,[372] and cross-resistance to other classes of antibiotics is common. Breakthrough pneumococcal sepsis in HSCT recipients receiving penicillin prophylaxis is well described.[373] Thus, in areas with a significant frequency of penicillin-resistant pneumococcal isolates, alternative agents should be considered based on local susceptibility patterns. Daily TMP/SMX used as prophylaxis for PCP is likely to be protective against pneumococcal disease. Vaccination with the polysaccharide pneumococcal vaccine is also strongly recommended at 1 year after cessation of immunosuppression in HSCT patients with revaccination after 5 years.

Antifungal Prophylaxis

Antifungal prophylaxis should not be used routinely in all patients with neutropenia. The rationale for antifungal prophylaxis is to prevent fungal infections in a targeted group of high-risk patients, especially those with longer durations of neutropenia or with GVHD after

allogeneic HSCT.[22] In neutropenic allogeneic HSCT recipients, 2 double-blind, placebo-controlled trials have shown that prophylactic fluconazole controlled yeast colonization and also decreased the rate of mucosal candidiasis and invasive *Candida* infections.[374, 375] A decrease in mortality was noted in the study by Slavin et al, in which most of the patients were allograft recipients.[375] Fluconazole conferred significant long-term improvement in survival, possibly by decreasing *Candida* antigen-induced GI tract GVHD.[168]

Fluconazole prophylaxis decreased fungal colonization, invasive infection, and fungal infection-related mortality in nontransplant patients with leukemia and in autologous bone marrow transplant recipients in a placebo-controlled trial.[187] However, only 30% of the patients received growth factors, and the median duration of neutropenia was 14 to 16 days. The benefit of fluconazole prophylaxis was greatest in autologous transplant recipients not receiving colony-stimulating growth factor support and in patients with leukemia receiving mucotoxic regimens consisting of cytarabine plus anthracycline.[187] Therefore, no antifungal prophylaxis can be considered (category 2B) in autologous HSCT recipients who receive growth factor support and who do not have significant mucositis (see Guidelines section on Overall Infection Risk in Cancer Patients >> Antifungal Prophylaxis). Other studies of nontransplant patients with acute leukemia showed no significant benefit of fluconazole in preventing invasive fungal infections, reducing mortality, or reducing the requirement for amphotericin B.[188, 376]

The panel recognizes that strong evidence exists for the use of fluconazole as prophylaxis in neutropenic allogeneic HSCT recipients (category 1). However, fluconazole use can predispose to colonization and bloodstream infection by fluconazole-resistant *Candida* strains.[72, 377]

Low-dose amphotericin B product and itraconazole have also been studied in high-risk patients and have been shown to provide protection against invasive molds, although they have provided no survival benefit in randomized studies with fluconazole.[378-380] Itraconazole, however, may be associated with hepatic toxicity and GI intolerance.[379] Itraconazole is contraindicated in patients with a decreased cardiac ejection fraction or a history of congestive heart failure based on its negative inotropic properties. It can also increase cyclophosphamide metabolites, which in turn are associated with hyperbilirubinemia and nephrotoxicity during the early transplant period.[381] This finding reinforces a note of caution about itraconazole (and by extension, voriconazole and posaconazole), a potent inhibitor of the cytochrome P450 3A4 isoenzyme, with regard to potential serious drug-drug interactions. Based on the toxicity of amphotericin B products and the availability of safer and equally effective alternative agents, amphotericin B products were considered a category 2B recommendation for prophylaxis. If an amphotericin B product is used, a lipid formulation is generally preferred because of less infusional and renal toxicity compared to conventional amphotericin B. This recommendation is made more strongly for patients at high risk for renal failure, such as those with pre-existing renal disease, HSCT recipients and co-administration of other nephrotoxic agents.[172, 173]

Aerosolized delivery of amphotericin products has been considered for several years, and has the advantage of local delivery to lungs while avoiding systemic toxicity. A recent randomized, placebo-controlled trial found that aerosolized liposomal amphotericin B was useful for preventing invasive pulmonary aspergillosis in patients with prolonged neutropenia.[382] Limitations to aerosolized amphotericin B as prophylaxis include different nebulizers and amphotericin B formulations, lack of optimization of dosing, and lack of direct

comparative data with systemically administered mold-active azoles or echinocandins.[383]

The echinocandin micafungin is approved[384] for prophylaxis against *Candida* infections in patients undergoing HSCT (category 1). In a randomized, double-blind trial in autologous and allogeneic HSCT recipients, the success rate with micafungin was superior to fluconazole (80% vs 73.5%; absolute difference +6.5%; 95% CI, 0.9-12%; *P*=0.03) based on pre-specified criteria for treatment success (absence of suspected, proven or probable invasive fungal infections during treatment period and absence of proven or probable infection during the 4-week period after treatment).[385] The duration of study drug encompassed the neutropenic period, but not the period after neutrophil recovery where GVHD would be expected to occur. The frequency of breakthrough candidemia was similar in both arms, but there was a trend to fewer episodes of invasive aspergillosis in allogeneic HSCT recipients receiving micafungin. Survival and drug-related toxicity were similar between treatment arms.[385]

Prophylaxis with voriconazole was compared with fluconazole in a large randomized double-blind study that included serum galactomannan surveillance in allogeneic HSCT recipients (N=600).[386] No difference was noted in the primary endpoint (invasive fungal infection-free survival rate at 180 days) between the fluconazole and voriconazole prophylaxis arms (75% vs 78%, respectively), but a trend for reduced incidence of *Aspergillus* infections (17% vs 9%), reduced incidence of invasive fungal infections (11% vs 7%), and less frequent use of empiric antifungal treatment (30% vs 24%) was noted in the voriconazole arm, although the differences were not statistically significant. No differences were noted between treatment arms with regards to relapse free- and overall survival rates, as well as incidence of severe adverse events.[386] There are emerging data to suggest that long-term use of voriconazole may be associated with severe photosensitivity and other adverse events. [387-389] Although these reports are anecdotal cases, further evaluation is warranted to determine the long term side effects associated with voriconazole use.

Posaconazole is currently only available in an oral formulation and should be taken with a full meal or with liquid nutritional supplements to ensure adequate absorption. Pharmacokinetic studies with posaconazole in healthy individuals showed that giving this drug with or after a high-fat meal, or with any meal or nutritional supplement greatly enhanced its absorption.[390] Posaconazole is as effective as fluconazole as primary therapy for oropharyngeal candidiasis,[391] but has not been evaluated as primary therapy for invasive fungal infections. In a multicenter randomized trial that evaluated prophylaxis with posaconazole compared with fluconazole or itraconazole in neutropenic patients with acute myelogenous leukemia (AML) or MDS receiving induction or re-induction chemotherapy, posaconazole was associated with significantly reduced invasive fungal infections during the treatment period (primary end point: 2% vs 8%; *P*<0.001) and during the 100 days following randomization (5% vs 11%; *P*=0.003).[392] In addition, posaconazole prophylaxis reduced the incidence of invasive aspergillosis (1% vs 7%; *P*<0.001) and was associated with a significant survival benefit at 100 days following randomization (*P*=0.04) compared with the fluconazole/itraconazole arm.[392] The NCCN Guidelines panel recommends posaconazole (category 1) for antifungal prophylaxis in neutropenic patients with AML and MDS receiving induction or re-induction chemotherapy (see Guidelines section on Overall Infection Risk in Cancer Patients: Intermediate to High >> Antifungal Prophylaxis). The role of antifungal prophylaxis in patients with acute leukemia receiving consolidation chemotherapy has not been adequately evaluated. Posaconazole as prophylaxis has not been

evaluated during the neutropenic period following conditioning in allogeneic HSCT recipients, and thus the safety of this approach is unknown. As indicated earlier, ingestion of a meal (ideally high-fat) or liquid nutritional supplement with each posaconazole dose is essential for achieving adequate posaconazole serum levels[342]; patients who are unable to tolerate such oral intake should not receive this drug for prophylaxis.

The panel advises that prophylaxis with posaconazole, itraconazole, and voriconazole be avoided in patients receiving vinca alkaloid-based regimens (such as vincristine in acute lymphoblastic leukemia) because of the potential of these azoles to inhibit the cytochrome P450 3A4 isoenzyme, reducing clearance of vinca alkaloids. Severe vinca alkaloid-induced neurotoxicity has occurred when co-administered with itraconazole[393]; data on pairing vinca alkaloids with posaconazole and voriconazole are lacking. Although the package inserts of voriconazole and posaconazole advise caution if co-administered with vinca alkaloids and consideration of dose-reducing the vinca alkaloid, there are no data provided on the level of dose reduction required.[302, 342] Prophylaxis with fluconazole (which is a less potent inhibitor of cytochrome P450 3A4 than the mold-active azoles), an echinocandin, or an amphotericin B formulation should be considered in these patients as a safer alternative to the mold-active azoles.

Patients with chronic severe neutropenia (ANC less than 500/mcL) due to the underlying disease (such as aplastic anemia) are at substantial risk for invasive aspergillosis.[394] Although this population has not been evaluated in clinical trials of antifungal prophylaxis, some panel members advise the use of a prophylactic mold-active agent (e.g., posaconazole or voriconazole) in such patients.

In patients with acute leukemia or MDS and in autologous HSCT recipients, antifungal prophylaxis is administered until neutrophil recovery. Antifungal prophylaxis should be considered until at least day 75 after allogeneic HSCT (see Guidelines section on Overall Infection Risk in Cancer Patients >> Antifungal Prophylaxis). Although many centers reasonably use antifungal prophylaxis in non-neutropenic allogeneic HSCT recipients with GVHD, this practice was evaluated only recently in a properly designed study that focused specifically on this patient group. Posaconazole was compared with fluconazole as prophylaxis in allogeneic HSCT recipients with severe GVHD requiring intensive immunosuppressive therapy in a prospective, randomized, double-blind study.[395] The inclusion criteria included either grade II to IV GVHD, chronic extensive GVHD, or receiving intensive immunosuppressive therapy consisting of either high-dose corticosteroids, antithymocyte globulin, or a combination of 2 or more immunosuppressive agents or types of treatment. Prophylaxis with posaconazole resulted in reduced incidences of invasive aspergillosis, total invasive fungal infections while on treatment, and deaths attributed to fungal infection.[395] Posaconazole is recommended (category 1) as prophylaxis in patients with GVHD receiving intensive immunosuppressive therapy, as defined by the inclusion criteria in this trial. Prophylactic posaconazole can be considered in all patients with GVHD receiving immunosuppressive therapy, although the benefit/risk ratio of mold-active prophylaxis in patients receiving less intensive immunosuppressive regimens has not been established.

Secondary antifungal prophylaxis is defined as administration of antifungal therapy in a patient with a prior fungal infection to prevent recrudescence. The panel recommends secondary prophylaxis with an appropriate antifungal agent in patients with prior chronic disseminated candidiasis[396] or with invasive filamentous fungal infection[397] during

subsequent cycles of chemotherapy or HSCT. In patients with invasive aspergillosis before HSCT, antifungal therapy for more than a month and resolution of radiologic abnormalities correlate with a lower likelihood of post-transplant recurrence of infection.[398] Secondary prophylaxis with a mold-active agent is advised for the entire period of immunosuppression. Secondary prophylaxis is generally administered for the duration of immunosuppression.

Antiviral Prophylaxis and Preemptive Antiviral Therapy

Herpes Simplex Virus

HSV is an important pathogen in patients who develop neutropenia and mucositis. These HSV infections primarily result from reactivation of latent virus. The presence of latent HSV can be determined by pretreatment HSV serology. Reactivation and infection with HSV occur in 60% to 80% of HSCT recipients and in unprophylaxed patients with acute leukemia undergoing induction or re-induction therapy who are seropositive for HSV.[399, 400] Among allogeneic HSCT recipients, HSV disease is most likely to occur within the first month, but may occur in later stages during intense immunosuppression. Although disseminated HSV infection is uncommon, the reactivation infection is frequently associated with increased mucosal damage, resulting in increased pain, limitation of the patient's ability to maintain oral hydration and nutrition, and an increased risk of bacterial and fungal superinfections.

Antiviral prophylaxis (acyclovir, valacyclovir, or famciclovir) against HSV is advised during the period of neutropenia in HSV-seropositive patients receiving chemotherapy (induction or consolidation) for acute leukemia, and during neutropenia and at least 30 days after HSCT for both allogeneic and autologous transplant recipients (see Guidelines section on Overall Infection Risk in Cancer Patients: Antiviral Prophylaxis). A longer period of prophylaxis should be considered in allogeneic HSCT recipients with GVHD or with frequent HSV reactivations before transplantation.[16]

HSV and herpes zoster infections are common in patients with CLL treated with alemtuzumab. For these patients, antiviral prophylaxis is advised until at least 2 months after completion of alemtuzumab therapy or until CD4+ cell counts are 200/mcL or more, whichever occurs later.[38, 401]

Prophylaxis against HSV should be considered in other patients at intermediate risk for HSV reactivation including those with hematologic malignancies with prolonged neutropenia or those receiving high-dose corticosteroids or T-cell depleting agents (e.g., fludarabine). Once a patient has had an HSV reactivation infection requiring treatment, the panel recommends HSV prophylaxis for that patient during all future episodes of neutropenia induced by cytotoxic therapy.

Varicella Zoster Virus

Impaired cellular immunity is the principal risk factor for VZV disease. In allogeneic HSCT recipients with a history of VZV infection without antiviral prophylaxis, about 30% have VZV disease after reactivation. In patients with a history of chicken pox, oral acyclovir (800 mg twice daily) administered from 1 to 2 months until 1 year after allogeneic HSCT significantly decreased the incidence of VZV disease compared to placebo (5% vs 26%, respectively).[402] The frequency of VZV disease in the post-prophylactic period was similar in the 2 groups and predominantly occurred in patients who required systemic immunosuppression. This prolonged course of acyclovir prophylaxis is likely to also prevent HSV reactivations. Subsequent studies have consistently demonstrated the benefit of long-term antiviral prophylaxis against VZV disease in recipients of allogeneic HSCT. Patients who received anti-VZV prophylaxis with acyclovir or valacyclovir for 1 year

post-HSCT had significantly reduced VZV disease compared with those who did not receive long-term prophylaxis (9% vs 25%; *P*<0.001); no evidence of rebound VZV disease was observed.[403] Long-term (1 year post-allogeneic HSCT) prophylaxis with lower doses of acyclovir or valacyclovir was associated with a 19%-35% cumulative incidence of VZV reactivation, but successfully prevented the occurrence of severe VZV disease comprising visceral involvement or serious complications.[404, 405] The panel recommends acyclovir prophylaxis against VZV during the 12-month period after allogeneic HSCT in patients seropositive for VZV pretransplant and recommends considering extending prophylaxis in patients who continue to receive systemic immunosuppressive therapy. Agents used as HSV prophylaxis are also active against VZV.

Among autologous HSCT recipients, the highest risk period for HSV reactivation is during neutropenia following conditioning, whereas the risk of VZV reactivation encompasses the first year.[406] Prophylaxis against VZV should also be considered in other patients at intermediate risk for viral reactivation, including those with hematologic malignancies with prolonged neutropenia or those receiving T-cell depleting agents (e.g., fludarabine, alemtuzumab). Bortezomib, a proteosome inhibitor, is associated with an increased risk of VZV reactivation.[407-410] Prophylaxis with acyclovir, valacyclovir, or famciclovir should be protective and can be considered in these settings.[411, 412] Among patients with CLL receiving alemtuzumab treatment, antiviral prophylaxis is recommended until 2 months after completion of treatment or until the CD4+ cell counts reach 200/mcL or more, whichever occurs later. [38, 401]

Cytomegalovirus

In allogeneic HSCT recipients at risk for CMV reactivation, the following preventative approaches have been evaluated[413]: 1) prophylaxis: antiviral agents are administered to all allogeneic HSCT recipients if either the donor or recipient is CMV seropositive; and 2) pre-emptive therapy: initiation of antiviral agents after detection of asymptomatic CMV infection by active surveillance. Antiviral agents potently active against CMV have substantial toxicity with long-term use. Ganciclovir is associated with marrow suppression that may increase the risk of common and opportunistic infections. Foscarnet can cause nephrotoxicity but is generally well tolerated. Cidofovir (a second-line anti-CMV agent) can be associated with substantial nephrotoxicity. Acyclovir and valacyclovir have an excellent safety profile but are only weakly active against CMV.

In 2 randomized studies, prophylaxis with acyclovir was associated with increased survival in allogeneic HSCT recipients, but the rates of CMV reactivation and disease were fairly high.[414, 415] Ljungman et al compared oral valacyclovir (a valine esterified analogue of acyclovir with high oral bioavailability) with acyclovir as prophylaxis in allogeneic HSCT recipients in whom either the donor or recipient was CMV seropositive.[416] All patients received initial IV acyclovir until day 28 after transplantation or until discharge, and then either oral valacyclovir or acyclovir until week 18 after transplantation. Valacyclovir was more effective than acyclovir in preventing CMV infection (28% vs 40%; hazard ratio=0.59; 95% CI, 0.46-0.76; *P*<0.0001); no difference was observed in CMV disease, adverse events, or overall survival.[416] Thus, acyclovir and valacyclovir are acceptable agents for CMV prophylaxis, but surveillance and pre-emptive therapy with ganciclovir or foscarnet are still necessary.

Highly sensitive methods for early diagnosis of CMV reactivation include detection of the CMV pp65 antigen from peripheral blood leukocytes and of CMV DNA by PCR.[417-419] Triggers for pre-emptive antiviral therapy are either a single positive CMV antigenemia or 2 consecutive positive PCR results. Foscarnet and ganciclovir had similar

efficacy as pre-emptive CMV therapies in allogeneic HSCT recipients, but ganciclovir was associated with significantly higher rates of early discontinuation because of either neutropenia or thrombocytopenia.[420] Pharmacokinetic studies have demonstrated the feasibility and safety of using oral valganciclovir, a pro-drug of ganciclovir, in place of ganciclovir in patients who underwent allogeneic HSCT.[421, 422] Oral valganciclovir used as pre-emptive anti-CMV therapy was shown to have acceptable oral bioavailability and was safe and effective in controlling CMV infection in allogeneic HSCT recipients, including in patients with grades I and II GI GVHD.[421, 423-425] Thus, valganciclovir is a highly acceptable oral option for pre-emptive therapy for CMV in the absence of substantial GI GVHD. Maribavir is another oral anti-CMV agent under investigation in the setting of allogeneic HSCT. An earlier phase II randomized study showed that maribavir was effective as prophylaxis against CMV infection and CMV disease compared with placebo in allogeneic HSCT recipients; moreover, in contrast to agents such as ganciclovir, maribavir was not associated with significant neutropenia or thrombocytopenia.[426] However, a recent phase III double-blind, randomized controlled trial evaluating maribavir versus placebo in allogeneic HSCT recipients failed to demonstrate an advantage with maribavir in reducing the incidence of CMV disease.[427]

Late CMV disease, defined as occurring after day 100 of HSCT, remains a persistent problem in the era of CMV prophylaxis and pre-emptive therapy. In one series, 92% of patients with late CMV pneumonia had chronic GVHD or had received T cell–depleted transplants.[428] Results of T-cell reconstitution at 3 months after allogeneic HSCT appear to be useful in risk stratification for late CMV disease. At 3 months after HSCT, CD4 T-cell counts less than 50/mcL, total lymphocyte counts less than 100/mcL, undetectable CMV-specific T-cell responses, and GVHD were associated with late CMV disease or death in CMV-seropositive allogeneic HSCT recipients.[429] In addition, a CD4+ cell count less than 100/mcL, CD8+ count less than 50/mcL, and use of high-dose steroids (2 mg/kg/day or greater) were significantly predictive of delayed recovery of CMV-specific immunity at 3 months after allogeneic HSCT; use of steroids impaired both CD4+ and CD8+ T-cell function in a dose-dependent manner.[430] Interestingly, in patients who did not receive high-dose steroids and received CMV prophylaxis with ganciclovir, subclinical CMV antigenemia appeared to stimulate functional recovery of both CD4+ and CD8+ cells. This finding may have implications for investigating potential CMV vaccine strategies in this clinical setting. Tetramer technology allows quantification of CMV antigen-specific CD4+ and CD8+ cells as a marker for reconstitution of CMV-specific cellular immunity; it may more precisely stratify the risk for CMV disease and need for CMV surveillance.[431] Although tetramer staining allows for monitoring of quantitative recovery of T cells, it should be noted that it does not assess the functional activity of T cells, which may be impaired; thus, the presence of a large proportion of CMV-specific T cells with impaired function may hinder recovery of CMV immunity.[430, 432]

Based on the available data that predict risk of CMV disease, the NCCN Guidelines panel recommends routine CMV surveillance for at least 6 months after allogeneic HSCT, together with pre-emptive anti-CMV therapy with IV ganciclovir, IV foscarnet or oral valganciclovir. Additional surveillance should be strongly considered during chronic GVHD requiring immunosuppressive therapy and until the CD4+ count is 100/mcL or more. Note that the CD4+ count will be reduced by systemic corticosteroids and by other lymphocyte-depleting agents. The majority of cases of late CMV disease occur within the first year of transplant and less than 5% occur after the second year.[428] Therefore,

the value of CMV surveillance beyond 2 years after HSCT is unknown but can be considered in patients with significant chronic GVHD.

CMV reactivation is common among patients with lymphoproliferative malignancies (most commonly, CLL) receiving alemtuzumab therapy, and occurs most frequently between 3 to 6 weeks after initiation of therapy when T-cell counts reach a nadir.[40, 44-46] Several studies of alemtuzumab in patients with CLL have demonstrated the effectiveness of using routine CMV monitoring coupled with pre-emptive anti-CMV therapy with ganciclovir in preventing overt CMV disease.[40, 44, 45, 433] More recently, a small randomized study in patients with lymphoproliferative disease treated with alemtuzumab-containing regimens (N=40) showed that upfront CMV prophylaxis with oral valganciclovir significantly reduced the incidence of CMV reactivation compared with oral valacyclovir (0% vs 35%; *P*=0.004).[46] The NCCN Guidelines panel recommends routine surveillance for CMV reactivation using PCR or antigen-based methods and monitoring weekly during alemtuzumab therapy and at least 2 months after completion of treatment.[38, 434] Upon confirmation of CMV antigenemia (defined as PCR-positivity for CMV in ≥ 2 consecutive samples obtained 1 week apart[38]), the panel recommends pre-emptive therapy with IV ganciclovir, IV foscarnet, or oral valganciclovir for at least 2 weeks and until CMV is no longer detectable (see Guidelines section on Infection Risk in Cancer Patients: High Risk for Cytomegalovirus Disease >> Alemtuzumab).

Hepatitis B Virus

Reactivation of latent HBV may occur in the setting of significant immunosuppression (e.g., HSCT). HBV carriers with lymphoid malignancies, especially those treated with anthracycline-based regimens, have a high risk of HBV reactivation.[435] Moreover, as previously discussed, patients with B-cell lymphoid malignancies treated with anti-CD20 monoclonal antibodies (e.g., rituximab, ofatumumab) may have increased risks for HBV reactivation and HBV disease, including rare instances of fulminant hepatitis or death.[38, 48] Rare cases of liver failure and death associated with HBV reactivation have occurred in patients receiving rituximab-containing regimens.[48, 49, 436-438]

Fulminant hepatitis and mortality may occur following HBV reactivation in immunocompromised patients. Thus, it is prudent in these settings to assess for prior HBV infection, especially in individuals who have spent significant time in HBV endemic areas or have risk factors for blood-borne exposure.

A positive hepatitis B surface antigen (HBsAg) is associated with active infection (or a window period before the development of protective immunity). False-negative HBsAg results may occur in chronic liver disease.[439] A positive hepatitis B surface antibody (HBsAb) is generally equated with protective immunity, although reactivated HBV disease may occur in the setting of significant immunosuppression in hepatitis B core antibody(HBcAb)-positive individuals.[440] In patients with B-cell lymphoid malignancies treated with rituximab-containing regimens, HBV reactivation was observed in patients with HBcAb positivity (with or without HBsAb positivity), even among those who were HBsAg negative prior to initiation of treatment.[52, 53] In a recent meta-analysis and evaluation of FDA safety reports concerning HBV reactivation in patients with lymphoproliferative disorders, it was reported that HBcAb positivity was correlated with increased incidence of rituximab-associated HBV reactivation.[441] After allogenic HSCT, loss of HBV-specific immunity may occur (i.e., loss of HBsAb and development of HBsAg and HBV PCR positivity); this has been observed in up to 40% of susceptible individuals in one report,[442] and may be confused with hepatic GVHD.

In patients undergoing intensive immunosuppressive therapy, evaluation of HBV surface antigen, core antibody, and surface antibody should be considered at baseline.[443] Evaluation of HBV and hepatitis C virus infection should be routine in HSCT recipients and donors.[443, 444] In HBsAg-positive individuals, baseline quantitative PCR for HBV DNA should be obtained. Based on limited data, antiviral therapy should be strongly considered in patients with active HBV infection undergoing HSCT or other intensive immunosuppression.[435, 445, 446] The optimal antiviral strategy in this setting remains unclear. Tenofovir is the preferred agent for chronic HBV infection, but limited data are available regarding use in patient populations with cancer.[447] Lemivudine, adefovir and entecavir also have activity against hepatitis B.[448] Donors who have not been exposed to HBV should be considered for HBV vaccination before stem cell collection when the recipient is HBsAg-positive.

Vaccination

Both the CDC and the European Bone Marrow Transplant group have published guidelines on vaccination of HSCT recipients.[16, 449] The ACIP has published general recommendations on immunization that include immunocompromised patients.[450] We discuss general principles regarding vaccination in patients with cancer, with a focus on influenza.

Live attenuated viral vaccines have the potential to cause disease in immunocompromised patients. Vaccines that are not live attenuated organisms can be safely administered to the immunocompromised. However, the immunogenicity of the vaccines may be reduced in immunocompromised patients. The potential for protection conferred by antigen-derived vaccines, even if incomplete, is better than no protection if the vaccine is withheld. Persons receiving chemotherapy or radiation therapy for malignancies should not receive live attenuated vaccines for at least 3 months after therapy has been stopped and until the patient is presumed to be immunocompetent.[450] Certain live viral vaccines can be safely administered to household members of severely immunocompromised patients (e.g., measles, mumps, and rubella [MMR]), whereas others cannot (e.g., small pox vaccine) because of the potential risk of transmission. The package insert for the vaccine should be reviewed before administration.

Ideally, patients should be vaccinated at least 2 weeks before receiving cytotoxic or immunosuppressive therapy; however, this timing is often not feasible in patients with cancer. Administering vaccines on the same day as cytotoxic therapy is not advised, because proliferative lymphocytic responses are required for protective immunity. Immunization between cytotoxic chemotherapy courses is likely to be associated with higher response rates than during chemotherapy administration.[451, 452] Patients should be considered unprotected if they were vaccinated less than 2 weeks before starting cytotoxic or immunosuppressive therapy or while receiving these agents. These patients should be revaccinated at least 3 months after therapy is discontinued if immune competence has been restored.[450] Pneumococcal, meningococcal, and Hib vaccines should be administered at least 2 weeks before elective splenectomy.[450]

Influenza infections cause significant morbidity and mortality in cancer patients. Among bone marrow transplant recipients, influenza accounts for 11% to 42% of all community-acquired viral respiratory infections.[453-455] An increased incidence and duration of influenza infections have also been observed in immunosuppressed cancer patients when compared to healthy controls.[456, 457] During community outbreaks, influenza infections may represent a significant proportion of episodes of febrile neutropenia.[458] Influenza infections in severely immunocompromised cancer patients are often associated with hospitalizations, delays in potentially life-saving chemotherapy, and

occasionally, death.[456-458] As a result, annual vaccination against influenza with the inactivated influenza virus is currently recommended for all individuals at increased risk due to immunosuppression.[459] The guidelines also include health care professionals and household members or caregivers in their target group for annual immunization because they can transmit influenza to high-risk patients.[459]

The intranasal vaccine (FluMist) should be avoided in patients with immunosuppression, because FluMist contains live attenuated influenza viruses still capable of replication, which could theoretically lead to infection in immunocompromised individuals.[459, 460] The CDC recommends that persons with known or suspected immunodeficiency diseases or those who are receiving immunosuppressive therapies should not be immunized with the live influenza vaccine.[459, 460] In addition, because no data are available assessing the risk for person-to-person transmission of FluMist from vaccine recipients to immunosuppressed contacts, the CDC also recommends that inactivated influenza vaccine should be used in household contacts, health-care workers, and others who have close contact with immunocompromised patients.[459, 460]

HIV Screening in Hospital Settings

In 2006, the CDC published recommendations for routine HIV testing in all patients (13 to 64 years of age) in the healthcare setting.[461] The testing is intended to be voluntary, and conducted only with consent from patients. Under these guidelines, patients are informed either verbally or in written format that HIV testing would be conducted unless the patient declines testing (opt-out screening). The CDC recommends that patients at high risk for HIV infection be screened at least annually.[461] The implementation of these guidelines would largely dependent upon institutional practices and the prevalence of undiagnosed HIV infections in specific institutions.

Prophylaxis for *Pneumocystis jirovecii* (formerly *Pneumocystis carinii*)

Trimethoprim/sulfamethoxazole (TMP-SMX) prophylaxis for *P.jirovecii* is highly effective in preventing *Pneumocystis* pneumonia[462, 463] Studies have documented the efficacy of this prophylactic therapy in patients with ALL, and similar results have been found in bone marrow transplant recipients. TMP/SMX also has the potential advantage of protecting against other infectious complications (such as common bacterial infections, listeriosis, nocardiosis, and toxoplasmosis) that afflict patients with severe T-cell depletion or impairment. TMP/SMX desensitization can be considered in patients who are intolerant to TMP/SMX. Daily dapsone and aerosolized pentamidine are thought to be effective alternatives to TMP/SMX, although data suggest aerosolized pentamidine may be inferior when used prophylactically in allogeneic transplant recipients.[464] Atovaquone appears to be equivalent to dapsone in HIV patients who cannot tolerate TMP/SMX.[465] Thus, atovaquone is another alternative for patients with cancer who require prophylaxis.

Prophylaxis against PCP should be used in allogeneic HSCT recipients, patients receiving treatment with alemtuzumab [38], and patients with ALL (category 1). Prophylaxis against PCP is also advised in patients receiving concomitant temozolomide and radiotherapy and should be continued until recovery from lymphocytopenia .[466] Some panel members advise prophylaxis against PCP (category 2B) for the following patients: 1) patients receiving fludarabine therapy and other T-cell depleting agents (e.g., cladribine [2-CdA]); 2) autologous HSCT recipients; and 3) patients with neoplastic diseases receiving intensive corticosteroid treatment (e.g., the equivalent of 20 mg or more of prednisone daily for 4 weeks or more).[467-470]

Protected Environments

Although well-designed clinical trials have not validated the use of high-efficiency particulate air (HEPA) filtration, the CDC recommends that allogeneic HSCT recipients be placed in rooms with HEPA filters.[16] It is also reasonable to use HEPA filtration in nontransplant patients with prolonged neutropenia. The principal benefit of HEPA filtration is likely to be related to prevention of mold infections. In a retrospective analysis, HEPA filters were protective in highly immunocompromised patients with hematologic malignancies in the setting of an outbreak of aspergillosis.[471] The value of laminar air flow in preventing infections is unclear and is not generally recommended.

Summary

Substantial progress has been made in preventing and treating infectious complications associated with neutropenia and immunosuppressive therapy in patients with cancer. It is essential to understand the individual patient's quantitative and qualitative immune defects and to stratify the risk for specific pathogens in the context of the underlying malignancy and medical history, physical examination, radiologic, and laboratory data. The development of antipseudomonal beta-lactam agents and the routine use of empiric antibacterial therapy at the onset of neutropenic fever have contributed to reductions in mortality from bacterial infections. More patients were treated with potent cytotoxic regimens (e.g., for acute leukemia) and received allogeneic stem cell transplants; opportunistic viral and fungal infections became an important cause of mortality in these patients. In addition, the increasing prevalence of antibiotic-resistant pathogens has challenged the clinician to use antimicrobial therapy wisely. Infection control should not rely exclusively on antimicrobial prophylaxis but, rather, should continue to incorporate standard infection control measures and demand careful hand-washing by all health care professionals who come into contact with immunocompromised patients.

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