Vancomycin

<table>
<tr><td colspan="3">Vancomycin dosing is weight based; ensure accuracy of documented weight before administration</td></tr>
<tr><td colspan="3">CAUTION: High Administration Risk Rating</td></tr>
<tr><td colspan="3">CAUTION: Vancomycin is administered as a loading dose followed by a maintenance dose. Double check the correct dose has been prescribed.</td></tr>
<tr><td>Form</td><td>500mg and 1g vials</td><td>Store below 25°C</td></tr>
<tr><td>Reconstitution</td><td colspan="2">Add 10mL WFI to 500mg vial
Add 20mL WFI to 1g vial
Further dilution essential before administration</td></tr>
<tr><td>Compatibility & Stability</td><td colspan="2">Sodium Chloride 0.9%
Glucose 5%</td></tr>
<tr><td>Administration</td><td colspan="2">IV Infusion
After reconstitution as above, dilute each 500mg with at least 100mL compatible infusion fluid, and infuse at a rate not exceeding 10mg/min.

<table>
<tr><th>Dose</th><th>Suggested dilution</th></tr>
<tr><td>500mg</td><td>100mL</td></tr>
<tr><td>750mg-1.25g</td><td>250mL</td></tr>
<tr><td>1.5-2g</td><td>500mL</td></tr>
</table>

Preferably administer via a central venous access device to avoid potential venous irritation. If given peripherally, choose a large vein and monitor the injection site closely.

Fluid restriction: a concentration of up to 10mg per ml may be used- however, this may increase the rate of infusion related reactions.
This concentration (10mg/mL) must be administered via a central line at a rate not exceeding 10mg/min.

<table>
<tr><th>Dose</th><th>Suggested dilution via central line</th></tr>
<tr><td>500mg</td><td>50mL</td></tr>
<tr><td>1g</td><td>100mL</td></tr>
<tr><td>1.25g</td><td>125mL</td></tr>
<tr><td>1.5g</td><td>150mL</td></tr>
<tr><td>2g</td><td>200mL</td></tr>
</table></td></tr>
<tr><td>Monitoring</td><td colspan="2">Vancomycin blood level monitoring is required to ensure efficacy and minimise toxicity.
The first pre-dose (trough) level should be taken on day 3 of treatment.
In renal impairment, the first level should be taken on day 2 of treatment.
Level to be taken within two hours of next due dose (preferably just prior to next dose)
When therapeutic range achieved, levels should be repeated every 3 days (eGRF >50ml/min) or every day in renal impairment.
High or Low levels: Post dose adjustment, levels should be repeated 24 hours later to ensure levels are therapeutic.</td></tr>
</table>

This information has been summarised to act as a guide for those administering IV medication. The monograph should be used in conjunction with the drug data sheet and BNF for information on dose, adverse effects, cautions and contra-indications. Further information is available from Pharmacy on 22146 or 22542

	Refer to CUH Antimicrobial guidelines on Eolas for further guidance. • Monitor renal function before starting and during treatment. • Monitor auditory and vestibular function during treatment.
Extravasation	Vancomycin is very irritant to tissue and may cause necrosis if extravasation occurs.
Additional Information	• To avoid 'red man' syndrome vancomycin should be administered at a maximum rate of 10mg/min. • Other side effects include otoxoticity and nephrotoxicity • The contents of vials for parenteral administration may be used for oral administration in the treatment of C Diff. Refer to CUH Antimicrobial guidelines on Eolas or contact pharmacy for further information. • Use with caution in teicoplanin sensitivity.

Information provided relates to Vancocin® (Flynn Pharma) and Vancomycin (Gerard and Demo)