

Neutropenic sepsis: prevention and management in people with cancer

Clinical guideline

Published: 19 September 2012

www.nice.org.uk/guidance/cg151

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview	4
Who is it for?	4
Introduction	5
Key priorities for implementation	7
Information, support and training	7
Reducing the risk of septic complications of anticancer treatment	7
Managing suspected neutropenic sepsis in secondary and tertiary care.....	7
Managing confirmed neutropenic sepsis.....	8
1 Recommendations	10
1.1 Information, support and training	10
1.2 Reducing the risk of septic complications of anticancer treatment	11
1.3 When to refer patients in the community for suspected neutropenic sepsis	11
1.4 Managing suspected neutropenic sepsis in secondary and tertiary care	11
1.5 Managing confirmed neutropenic sepsis	13
Terms used in this guideline	16
2 Research recommendations	17
2.1 Service provision for neutropenic sepsis in patients with cancer	17
2.2 Patient support and information	17
2.3 Signs and symptoms that predict neutropenic sepsis in the community	17
2.4 Reducing the risk of complications of anticancer treatment in children and young people, and in adults diagnosed with lymphoma	18
2.5 Switching from inpatient intravenous to outpatient oral antibiotic therapy in patients with neutropenic sepsis.....	19
3 Advice from the Health Protection Agency.....	20
Finding more information and resources	21
Update information.....	22

Overview

This guideline covers preventing, identifying and managing neutropenic sepsis in children, young people and adults receiving treatment for cancer in the community and in secondary and tertiary care. It aims to reduce the risk of infection in people with neutropenia (low number of white blood cells) who are receiving anticancer treatment and improve management of neutropenic sepsis.

Who is it for?

- Healthcare professionals
- People receiving treatment for cancer and their families and carers

Introduction

Neutropenic sepsis is a potentially fatal complication of [anticancer treatment](#) (particularly chemotherapy). Mortality rates ranging between 2% and 21% have been reported in adults. Aggressive use of inpatient intravenous antibiotic therapy has reduced morbidity and mortality rates and intensive care management is now needed in fewer than 5% of cases in England.

Systemic therapies to treat cancer can suppress the ability of bone marrow to respond to infection. This is particularly the case with systemic chemotherapy, although radiotherapy can also cause such suppression.

Chemotherapy is most commonly given in a day-case or outpatient setting so most episodes of obvious sepsis, and fever in a person with potential sepsis, present in the community. People receiving chemotherapy and their carers need to be told about the risk of neutropenic sepsis and the warning signs and symptoms. Neutropenic sepsis is a medical emergency that requires immediate hospital investigation and treatment.

A report by the National Confidential Enquiry into Patient Outcome and Death ([Systemic anti-cancer therapy: for better for worse?](#) [2008]) and a follow-up report by the National Chemotherapy Advisory Group ([Chemotherapy services in England: ensuring quality and safety](#) [2010]) highlighted problems in the management of neutropenic sepsis in adults receiving chemotherapy. These problems included inadequate management of neutropenic fever leading to avoidable deaths, and a need for systems for urgent assessment and organisation-level policies for dealing with neutropenic fever. The reports also noted variation in the provision of information on the treatment of side effects and on access to 24-hour telephone advice.

In addition, there is national variation in the use of:

- primary and secondary prophylaxis
- risk stratification in episodes of febrile neutropenia
- oral or intravenous antibiotics
- growth factors
- inpatient or outpatient management policies.

This guideline aims to improve outcomes by providing evidence-based recommendations on the prevention, identification and management of this life-threatening complication of cancer treatment.

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or their parent or carer) should provide informed consent, which should be documented. See the [General Medical Council's Good practice in prescribing medicines – guidance for doctors](#) and the [prescribing advice provided by the Joint Standing Committee on Medicines](#) (a joint committee of the Royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists Group) for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Information, support and training

Information and support for patients and carers

- Provide patients having [anticancer treatment](#) and their carers with written and oral information, both before starting and throughout their anticancer treatment, on:
 - neutropenic sepsis
 - how and when to contact 24-hour specialist oncology advice
 - how and when to seek emergency care.

Reducing the risk of septic complications of anticancer treatment

- For adult patients (aged 18 years and older) with acute leukaemias, stem cell transplants or solid tumours in whom significant neutropenia (neutrophil count 0.5×10^9 per litre or lower) is an anticipated consequence of chemotherapy, offer prophylaxis with a fluoroquinolone^[1] during the expected period of neutropenia only. Follow the [MHRA safety advice on fluoroquinolone antibiotics](#).

Managing suspected neutropenic sepsis in secondary and tertiary care

Emergency treatment and assessment

- Treat suspected neutropenic sepsis as an acute medical emergency and offer [empiric antibiotic therapy](#) immediately.

- Include in the initial clinical assessment of patients with suspected neutropenic sepsis:
 - history and examination
 - full blood count, kidney and liver function tests (including albumin), C-reactive protein, lactate and blood culture.

Starting antibiotic therapy

All patients

- Offer beta lactam monotherapy with piperacillin with tazobactam^[2] as initial empiric antibiotic therapy to patients with suspected neutropenic sepsis who need intravenous treatment unless there are patient-specific or local microbiological contraindications.
- Do not offer an aminoglycoside, either as monotherapy or in dual therapy, for the initial empiric treatment of suspected neutropenic sepsis unless there are patient-specific or local microbiological indications.

Confirming a diagnosis of neutropenic sepsis

- Diagnose neutropenic sepsis in patients having anticancer treatment whose neutrophil count is 0.5×10^9 per litre or lower and who have either:
 - a temperature higher than 38°C or
 - other signs or symptoms consistent with clinically significant sepsis.

Managing confirmed neutropenic sepsis

Assessing the patient's risk of septic complications

- A healthcare professional with competence in managing complications of anticancer treatment should assess the patient's risk of septic complications within 24 hours of presentation to secondary or tertiary care, basing the risk assessment on presentation features and using a validated risk scoring system^[3].

Patients at low risk of septic complications

- Consider outpatient antibiotic therapy for patients with confirmed neutropenic sepsis and a low risk of developing septic complications, taking into account the patient's social and clinical circumstances and discussing with them the need to return to hospital promptly if a problem develops.

Patients at high risk of septic complications

- Offer discharge to patients having empiric antibiotic therapy for neutropenic sepsis only after:
 - the patient's risk of developing septic complications has been reassessed as low by a healthcare professional with competence in managing complications of anticancer treatment using a validated risk scoring system^[3] and
 - taking into account the patient's social and clinical circumstances and discussing with them the need to return to hospital promptly if a problem develops.

^[1] At the time of review (November 2019), fluoroquinolone antibiotics did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the [General Medical Council's Prescribing guidance: prescribing unlicensed medicines](#) for further information.

^[2] At the time of publication (September 2012) piperacillin with tazobactam did not have a UK marketing authorisation for use in children aged under 2 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the General Medical Council's [Good practice in prescribing medicines – guidance for doctors](#) and the [prescribing advice](#) provided by the Joint Standing Committee on Medicines (a joint committee of the Royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists Group) for further information.

^[3] Examples of risk scoring systems include [The Multinational Association for Supportive Care in Cancer risk index: a multinational scoring system for identifying low-risk febrile neutropenic cancer patients](#) (Journal of Clinical Oncology 2000; 18: 3038–51]) and the [modified Alexander rule for children](#) (aged under 18) (European Journal of Cancer 2009; 45: 2843–9).

1 Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

The recommendations in this guideline were developed after discussion of the relevance of the evidence to children, young people and adults with cancer. The recommendations are intended for use in patients of any age. Where age-limited or disease-specific recommendations are made they are clearly indicated as such.

People have the right to be involved in discussions and make informed decisions about their care, as described in [making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Information, support and training

1.1.1 Information and support for patients and carers

1.1.1.1 Provide patients having [anticancer treatment](#) and their carers with written and oral information, both before starting and throughout their anticancer treatment, on:

- neutropenic sepsis
- how and when to contact 24-hour specialist oncology advice
- how and when to seek emergency care.

1.1.2 Training for healthcare professionals

1.1.2.1 Healthcare professionals and staff who come into contact with patients having anticancer treatment should be provided with training on neutropenic sepsis. The training should be tailored according to the type of contact.

1.2 Reducing the risk of septic complications of anticancer treatment

- 1.2.1.1 For adult patients (aged 18 years and older) with acute leukaemias, stem cell transplants or solid tumours in whom significant neutropenia (neutrophil count 0.5×10^9 per litre or lower) is an anticipated consequence of chemotherapy, offer prophylaxis with a fluoroquinolone^[4] during the expected period of neutropenia only. Follow the [MHRA safety advice on fluoroquinolone antibiotics](#).
- 1.2.1.2 Rates of antibiotic resistance and infection patterns should be monitored in treatment facilities where patients are having fluoroquinolones for the prophylaxis of neutropenic sepsis^[5].
- 1.2.1.3 Do not routinely offer [G-CSF](#) for the prevention of neutropenic sepsis in adults receiving chemotherapy unless they are receiving G-CSF as an integral part of the chemotherapy regimen or in order to maintain dose intensity.

1.3 When to refer patients in the community for suspected neutropenic sepsis

- 1.3.1.1 Suspect neutropenic sepsis in patients having [anticancer treatment](#) who become unwell.
- 1.3.1.2 Refer patients with suspected neutropenic sepsis immediately for assessment in secondary or tertiary care.

1.4 Managing suspected neutropenic sepsis in secondary and tertiary care

1.4.1 Emergency treatment and assessment

- 1.4.1.1 Treat suspected neutropenic sepsis as an acute medical emergency and offer [empiric antibiotic](#) therapy immediately.
- 1.4.1.2 Include in the initial clinical assessment of patients with suspected neutropenic sepsis:

- history and examination
- full blood count, kidney and liver function tests (including albumin), C-reactive protein, lactate and blood culture.

1.4.2 Further assessment

1.4.2.1 After completing the initial clinical assessment (see recommendation 1.4.1.2) try to identify the underlying cause of the sepsis by carrying out:

- additional peripheral blood culture in patients with a central venous access device if clinically feasible
- urinalysis in all children aged under 5 years.

1.4.2.2 Do not perform a chest X-ray unless clinically indicated.

1.4.3 Starting antibiotic therapy

All patients

1.4.3.1 Offer beta lactam monotherapy with piperacillin with tazobactam^[6] as initial empiric antibiotic therapy to patients with suspected neutropenic sepsis who need intravenous treatment unless there are patient-specific or local microbiological contraindications.

1.4.3.2 Do not offer an aminoglycoside, either as monotherapy or in dual therapy, for the initial empiric treatment of suspected neutropenic sepsis unless there are patient-specific or local microbiological indications.

Empiric glycopeptide antibiotics in patients with central venous access devices

1.4.3.3 Do not offer empiric glycopeptide antibiotics to patients with suspected neutropenic sepsis who have central venous access devices unless there are patient-specific or local microbiological indications.

1.4.3.4 Do not remove central venous access devices as part of the initial empiric management of suspected neutropenic sepsis.

1.4.4 Confirming a diagnosis of neutropenic sepsis

1.4.4.1 Diagnose neutropenic sepsis in patients having anticancer treatment whose neutrophil count is 0.5×10^9 per litre or lower and who have either:

- a temperature higher than 38°C or
- other signs or symptoms consistent with clinically significant sepsis.

1.5 Managing confirmed neutropenic sepsis

1.5.1 Assessing the patient's risk of septic complications

1.5.1.1 A healthcare professional with competence in managing complications of anticancer treatment should assess the patient's risk of septic complications within 24 hours of presentation to secondary or tertiary care, basing the risk assessment on presentation features and using a validated risk scoring system^[7].

1.5.2 Patients at low risk of septic complications

1.5.2.1 Consider outpatient antibiotic therapy for patients with confirmed neutropenic sepsis and a low risk of developing septic complications, taking into account the patient's social and clinical circumstances and discussing with them the need to return to hospital promptly if a problem develops.

1.5.3 Patients at high risk of septic complications

1.5.3.1 For patients with confirmed neutropenic sepsis and a high risk of developing septic complications, a healthcare professional with competence in managing complications of anticancer treatment should daily:

- review the patient's clinical status
- reassess the patient's risk of septic complications, using a validated risk scoring system^[7].

1.5.3.2 Do not switch initial empiric antibiotics in patients with unresponsive fever unless there is clinical deterioration or a microbiological indication.

1.5.3.3 Switch from intravenous to oral antibiotic therapy after 48 hours of treatment

in patients whose risk of developing septic complications has been reassessed as low by a healthcare professional with competence in managing complications of anticancer treatment using a validated risk scoring system^[7].

1.5.3.4 Offer discharge to patients having empiric antibiotic therapy for neutropenic sepsis only after:

- the patient's risk of developing septic complications has been reassessed as low by a healthcare professional with competence in managing complications of anticancer treatment using a validated risk scoring system^[7] and
- taking into account the patient's social and clinical circumstances and discussing with them the need to return to hospital promptly if a problem develops.

1.5.4 Duration of empiric antibiotic treatment

1.5.4.1 Continue inpatient empiric antibiotic therapy in all patients who have unresponsive fever unless an alternative cause of fever is likely.

1.5.4.2 Discontinue empiric antibiotic therapy in patients whose neutropenic sepsis has responded to treatment, irrespective of neutrophil count.

^[4] At the time of review (November 2019), fluoroquinolone antibiotics did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the [General Medical Council's Prescribing guidance: prescribing unlicensed medicines](#) for further information.

^[5] For more information see the Department of Health's [Updated guidance on the diagnosis and reporting of Clostridium difficile](#) and guidance from the Health Protection Agency and the Department of Health on [Clostridium difficile infection: how to deal with the problem](#).

^[6] At the time of publication (September 2012) piperacillin with tazobactam did not have a UK marketing authorisation for use in children aged under 2 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The child's parent or carer should provide informed consent, which should be documented. See the [General Medical Council's Good practice in prescribing medicines – guidance for doctors](#) and the [prescribing advice](#) provided by the Joint Standing Committee on Medicines (a joint committee of the Royal College of

Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists Group) for further information.

^[7] Examples of risk scoring systems include the [Multinational Association for Supportive Care in Cancer risk index: a multinational scoring system for identifying low-risk febrile neutropenic cancer patients](#) (Journal of Clinical Oncology 2000; 18: 3038–51) and the [modified Alexander rule for children](#) (aged under 18) (European Journal of Cancer 2009; 45: 2843–9).

Terms used in this guideline

Anticancer treatment Treatment that is given with the intent to reduce the level of cancer cells in a patient. It includes, but is not limited to, chemotherapy and radiotherapy.

Empiric An action undertaken prior to determination of the underlying cause of a problem.

Empiric antibiotic An antibiotic given to a person before a specific microorganism or source of the potential infection is known. It is usually a broad-spectrum antibiotic and the treatment may change if the microorganism or source is confirmed.

G-CSF (granulocyte-colony stimulating factor) A type of protein that stimulates the bone marrow to make white blood cells (granulocytes).

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

2.1 Service provision for neutropenic sepsis in patients with cancer

A prospective national cohort study should be carried out to assess the incidence of suspected and proven neutropenic sepsis in patients having [anticancer treatment](#).

Why this is important

The incidence of suspected neutropenic sepsis in England and Wales is difficult to determine. A national cohort study of patients referred for suspected neutropenic sepsis, including diagnoses and clinical outcomes, should be undertaken to improve service planning and delivery. Such a study may also generate hypotheses concerning more and less efficient methods of delivering services for neutropenic sepsis, which could then be formally tested.

2.2 Patient support and information

A descriptive study involving patients who have had neutropenic sepsis and their carers should be undertaken to find out what types of support and information patients and carers were given, which of these they found helpful or unhelpful, and whether they think additional or different types of support or information are needed.

Why this is important

There is a lack of research on the experience of patients who have had neutropenic sepsis and their carers. Better knowledge of the support and information patients and carers are given, how helpful they find it and how they think it could be improved will allow the development of different approaches to providing information and support and test these in practice. This research could improve the experience of patients, and potentially their clinical outcomes. It may also highlight important inequities and suggest ways of addressing them.

2.3 Signs and symptoms that predict neutropenic sepsis

in the community

A prospective study should be carried out to determine which signs and symptoms experienced by patients in the community predict neutropenic sepsis and the outcomes of these episodes.

Why this is important

The initial decision to refer to secondary or tertiary care for investigation for suspected neutropenic sepsis is an important step that has both risks and benefits. An overly inclusive approach will inconvenience many patients and carers, expose patients to unnecessary invasive testing and increase resource use by the health service. Referral criteria that are too narrow will delay the emergency treatment of infection and may lead to death, increased need for intensive or critical care facilities, and reduced overall quality of life for patients with cancer and their carers. The current research base in this area is weak and largely extrapolated from selected populations in hospitals. A clearer, quantitative understanding of how the features of neutropenic sepsis appear in patients may lead to more accurate referral criteria for suspected neutropenic sepsis.

2.4 Reducing the risk of complications of anticancer treatment in children and young people, and in adults diagnosed with lymphoma

Randomised studies should investigate primary prophylaxis of neutropenic sepsis in 2 populations: children and young people (aged under 18) having treatment for solid tumours or haematological malignancies, or stem cell transplantation; and adults (aged 18 and older) diagnosed with lymphoma. The studies should compare the effectiveness of fluoroquinolone antibiotics given alone, fluoroquinolone antibiotics given together with G-CSF preparations, and G-CSF preparations given alone. Outcome measures should include overall mortality, infectious episodes and adverse events. In addition, quality of life should be determined using quantitative and qualitative methods. The resulting data should be used to develop a cost-effectiveness analysis comparing these 3 forms of prophylaxis in children and young people having anticancer treatment, and in adults diagnosed with lymphoma.

Why this is important

Data from studies of adults with leukaemia, stem cell transplantation and many solid tumours suggest that prophylaxis with fluoroquinolone antibiotics reduces the risk of neutropenic sepsis. However, the benefit of fluoroquinolone antibiotics in adults diagnosed with lymphoma is unclear. Children and young people having anticancer treatment are a distinct population and differ from

adults in a number of ways, including the types of cancer they have, the anticancer treatment they are given, their reactions to fluoroquinolones and subcutaneous injections, and the ease with which they can adhere to daily medication. The effects of these differences are not known, but it is known that death rates from neutropenic sepsis are higher in children and young people than in adults. Studies of primary prophylaxis of neutropenic sepsis in children and young adults, and in adults with lymphoma, could be of great value in helping to reduce the risk of neutropenic sepsis in these 2 patient populations.

2.5 Switching from inpatient intravenous to outpatient oral antibiotic therapy in patients with neutropenic sepsis

A randomised controlled trial should be undertaken to evaluate the clinical and cost effectiveness of stopping intravenous antibiotic therapy and switching to oral therapy within the first 24 hours of treatment in patients with neutropenic sepsis who are having treatment with intravenous antibiotics. The outcomes to be measured are overtreatment, death, need for critical care, length of hospital stay, duration of fever and quality of life.

Why this is important

Moderately strong evidence was found to support the use of outpatient therapies for patients with neutropenic sepsis who are at low risk of severe infection. These studies switched from inpatient to outpatient treatment at a variety of time points. A meta-regression undertaken by the Guideline Development Group suggested that very early (before 24 hours) discharge is associated with a greater risk of readmission and need to change treatments, but the evidence was sparse. If a short period of hospital admission was found to be safe and effective for selected patients with neutropenic sepsis, it could provide considerable improvements in their quality of life and reduce the resource burden on hospitals.

3 Advice from the Health Protection Agency

The Health Protection Agency has provided the following advice about NICE's recommendation on reducing the risk of septic complications of anticancer treatment (see [recommendation 1.2.1.1](#)).

Fluoroquinolone prophylaxis is advocated as beneficial for some patients with neutropenia (see [Antibiotic prophylaxis in neutropenic patients: new evidence, practical decisions](#)). However, it raises 2 concerns:

- fluoroquinolone prophylaxis can contribute to selection of resistance, particularly in Enterobacteriaceae
- fluoroquinolones are associated with the selection of *Clostridium difficile*.

Attention should be paid to both risks.

Colonisation with resistant Enterobacteriaceae should be examined at induction of neutropenia and weekly thereafter until prophylaxis is stopped. The easiest method is to plate a rectal swab, or faeces, onto MacConkey agar, and to place a 1 mg (that is, standard) ciprofloxacin disc on the first series of streaks after the inoculum pool. After incubation the plate should be examined for bacterial colonies within the inhibition zone. If growth is found, the bacteria should be identified and their antibiograms determined, since many fluoroquinolone-resistant isolates are resistant to multiple other agents. The results should inform initial empiric therapy if the patient experiences a subsequent febrile episode. Time trends in resistance should be monitored, both in individual patients and within units.

Advice on the diagnosis of *Clostridium difficile*-related disease is provided in [Updated guidance on the diagnosis and reporting of Clostridium difficile](#). This advice should be followed for patients with symptoms of diarrhoea.

Finding more information and resources

You can see everything NICE says on this topic in the NICE Pathways on [neutropenic sepsis and sepsis](#).

To find out what NICE has said on topics related to this guideline, see our web page on [blood conditions](#).

For full details of the evidence and the guideline committee's discussions, see the [full version of the guideline](#). You can also find information about [how the guideline was developed](#), including details of the committee.

NICE has produced [tools and resources](#) to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see [resources to help you put guidance into practice](#).

Update information

Minor changes since publication

January 2020: After a surveillance review, we have updated recommendation 1.2.1.1 with a link to MHRA safety advice on the use of fluoroquinone antibiotics and a footnote on the UK marketing authorisation for their use.

ISBN: 978-1-4731-3669-4

Accreditation

