Scottish Society of Gastroenterology SSG

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Abstract Submission Form

TITLE	**Audit of secondary prophylaxis in spontaneous bacterial peritonitis**
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ABSTRACT DETAILS:	
Background:	Prophylactic antibiotics against spontaneous bacterial peritonitis (SBP) have a role in the following scenarios outlined by EASL (1): acute gastrointestinal haemorrhage, low total protein in ascitic fluid (primary prophylaxis) and previous history of SBP (secondary prophylaxis). 1-year survival after an SBP is 30-50% and recurrence rate is 70%. One RCT showed that prophylactic antibiotic (norfloxacin) reduced recurrence from 68% to 20%. (1)
Method:	Patients with SBP between 2014 and 2017 in GRI and QEUH who survived to discharge were identified. Patients with a short prognosis were excluded. Notes and discharge letters were reviewed for a prescription of prophylaxis (including rifaximin).
Results:	48 episodes were identified. 32 patients (67%) were discharged with secondary prophylaxis. In one case pre-admission prophylaxis was stopped on discharge. The most commonly prescribed agents were co-trimoxazole (n=21), rifaximin (n=12) and ciprofloxacin (n=6). 7 patients were discharged with 2 antibiotics; in all rifaximin was the second agent. 14 had not been taking prophylaxis before admission (45%) and 17 had been. Changes to regimes were made in 4 instances. Although not statistically significant (p=0.066), there was a trend towards survival benefit in those discharged on prophylaxis. When data were analysed without rifaximin, 27 (56%) patients were discharged on prophylaxis. 9 had already been taking prophylaxis and no changes were made to the regimes. 18 had not been taking prophylaxis when they presented (18/39, 46%).
Conclusions:	In this selected group just under half were given prophylactic antibiotic on discharge (45% when rifaximin included, 46% when not). Changes to the regimes were rarely made. There was a suggestion of survival benefit just outwith statistical significance. The reasons for low rates might include withholding prophylaxis during an acute episode and failure to recommence it. Another possibility is that the discharge is prepared by junior members of the team who might not have the knowledge or confidence to add this treatment.
References:	1) EASL clinical practice guidelines on the management of ascites, spontaneous bacterial peritonitis, and hepatorenal syndrome in cirrhosis (2010)