

2026 SSC Adult Guidelines: Brief Update

September 15, 2026



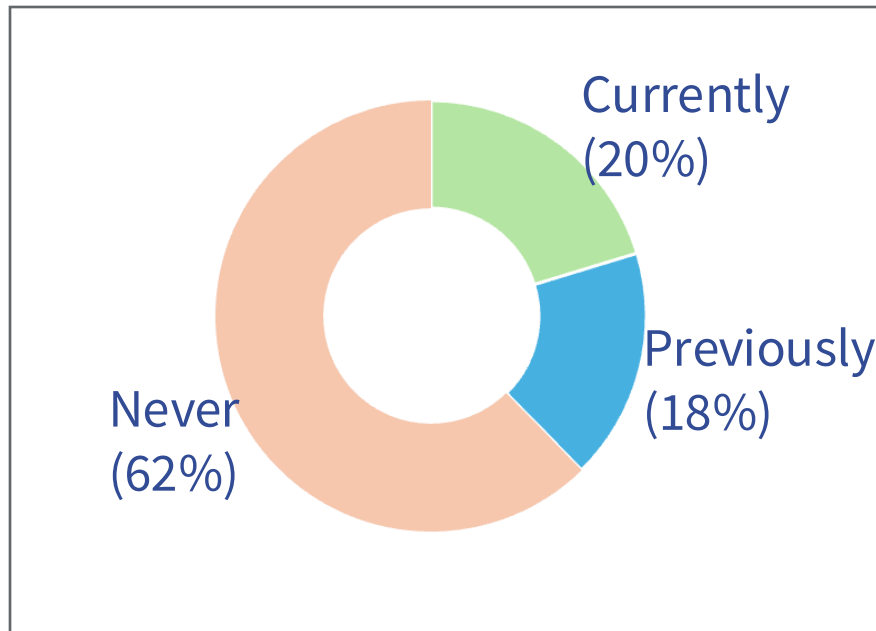
Outline

- Panel
- Methods
- Highlights of 2026 Guidelines
- Q&A

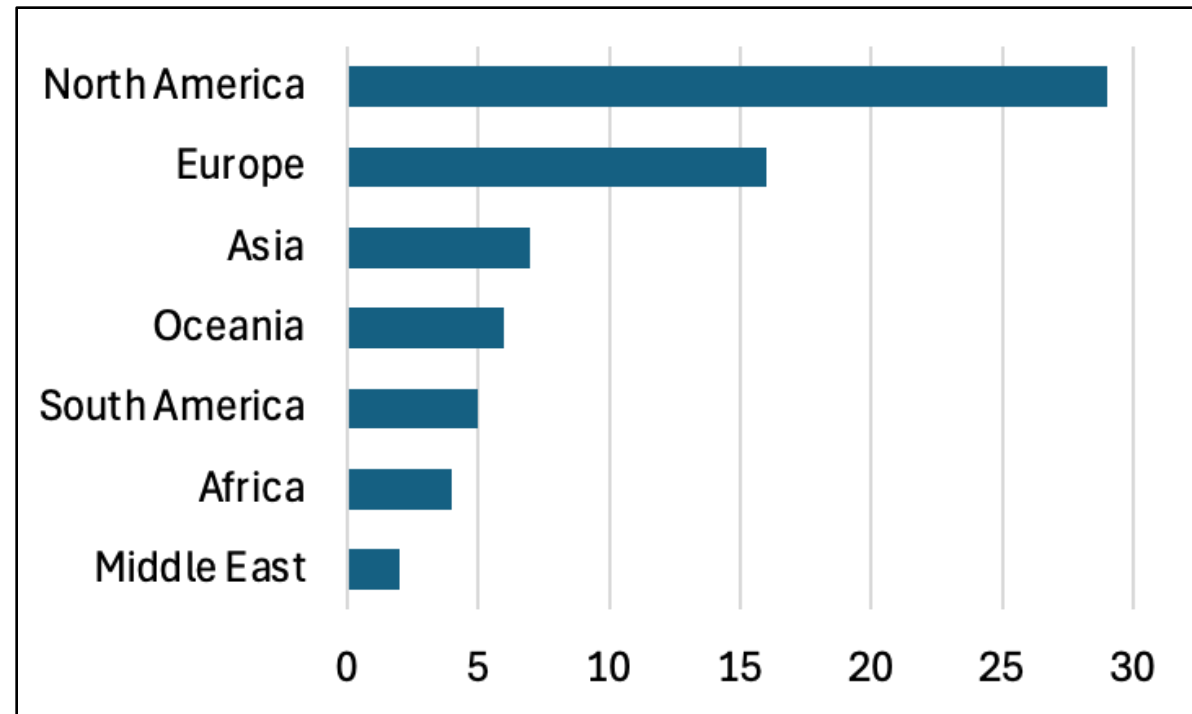


2026 SSC Panel (69 members, 23 countries)

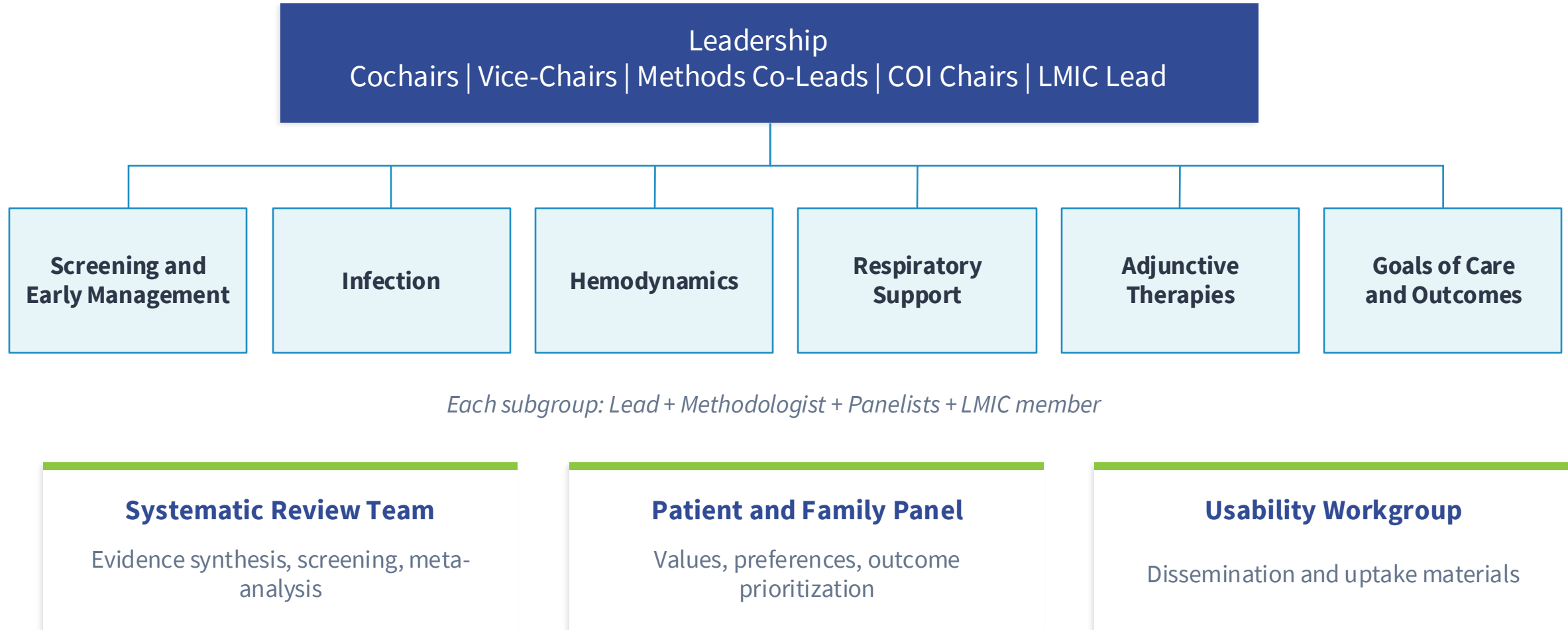
38% have **practiced in a low- or middle-income country (LMIC)** currently or in the past.



35% live outside Europe or North America.



Organizational Structure



Methods Followed Standards for Trustworthy Clinical Practice Guidelines



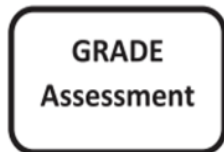
Defined and prioritized questions in PICO format
population (P), intervention (I), comparator (C), outcomes (O)



Systematic review
Research librarian, methodologist, clinical experts.

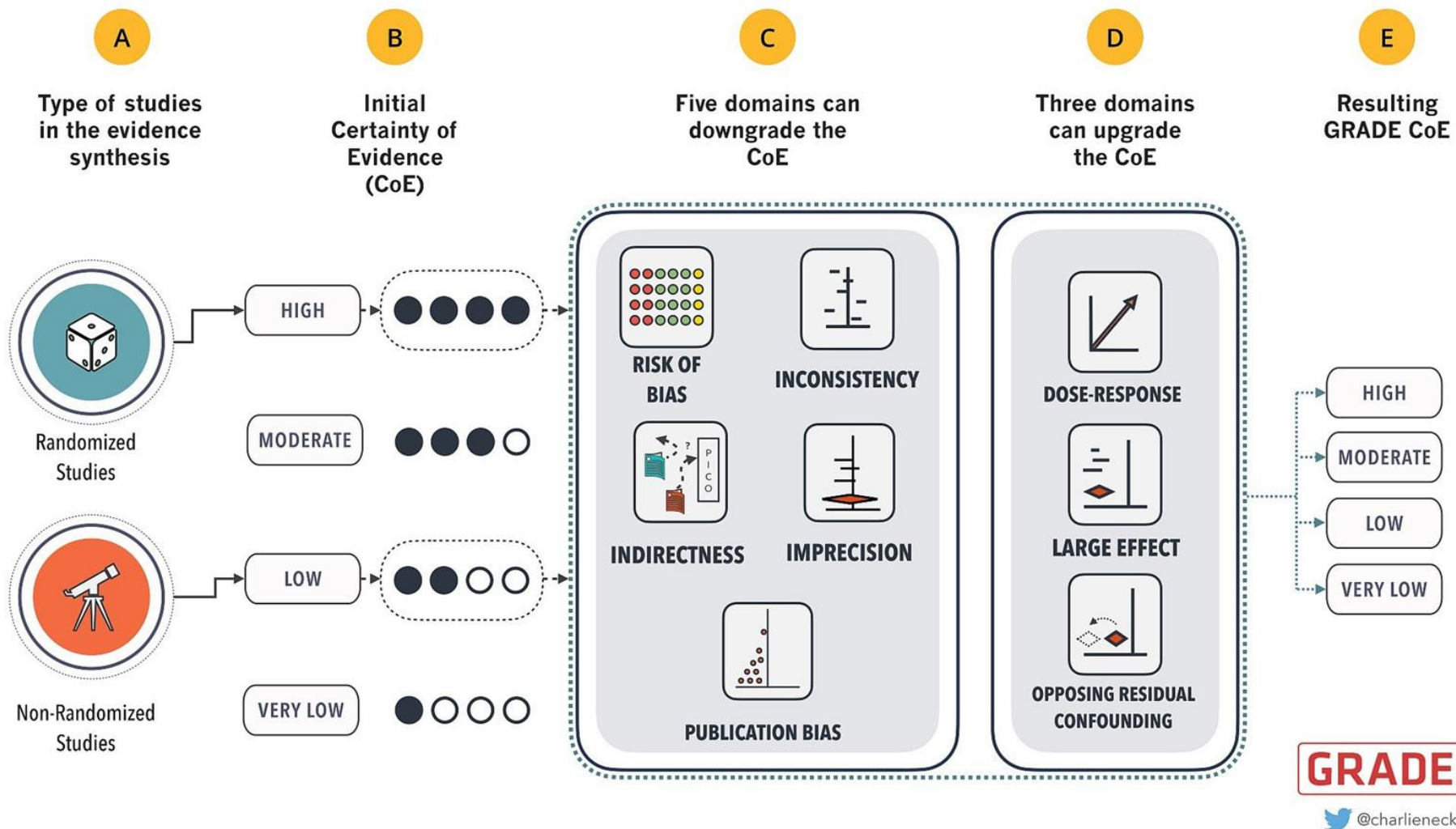


Evidence synthesis Data extraction, meta-analysis, subgroup analyses, risk of bias assessment.

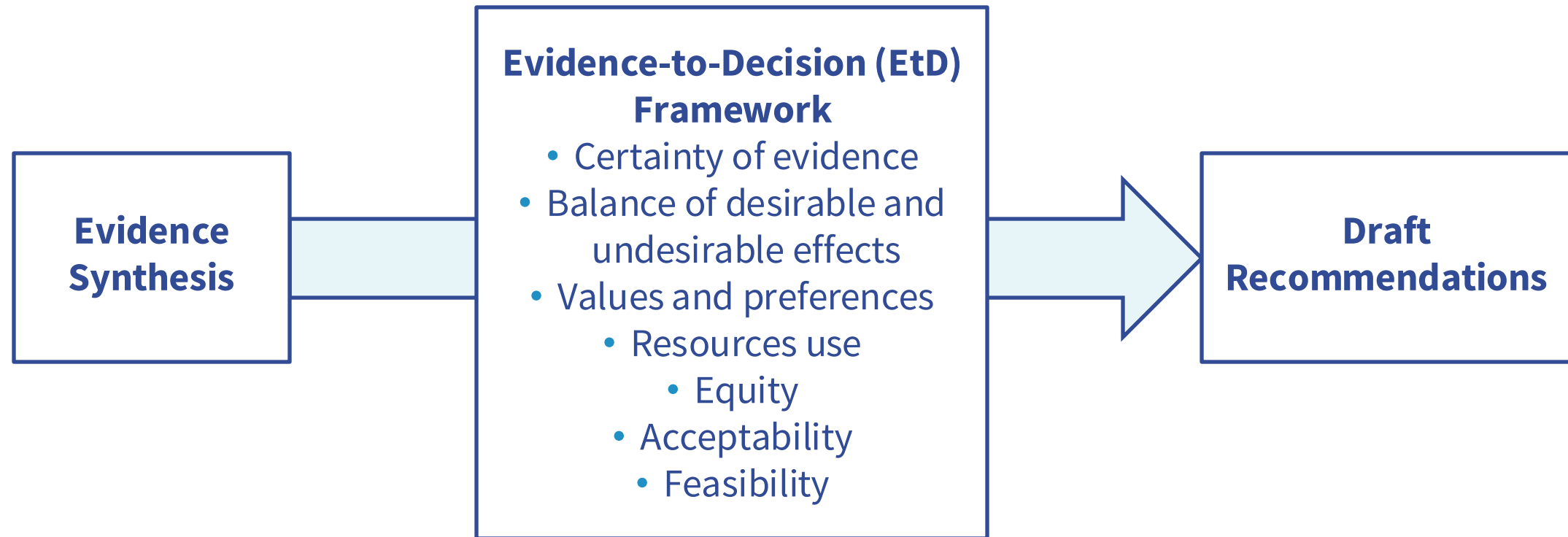


Certainty of evidence assessment and evidence profiles
GRADE methodology

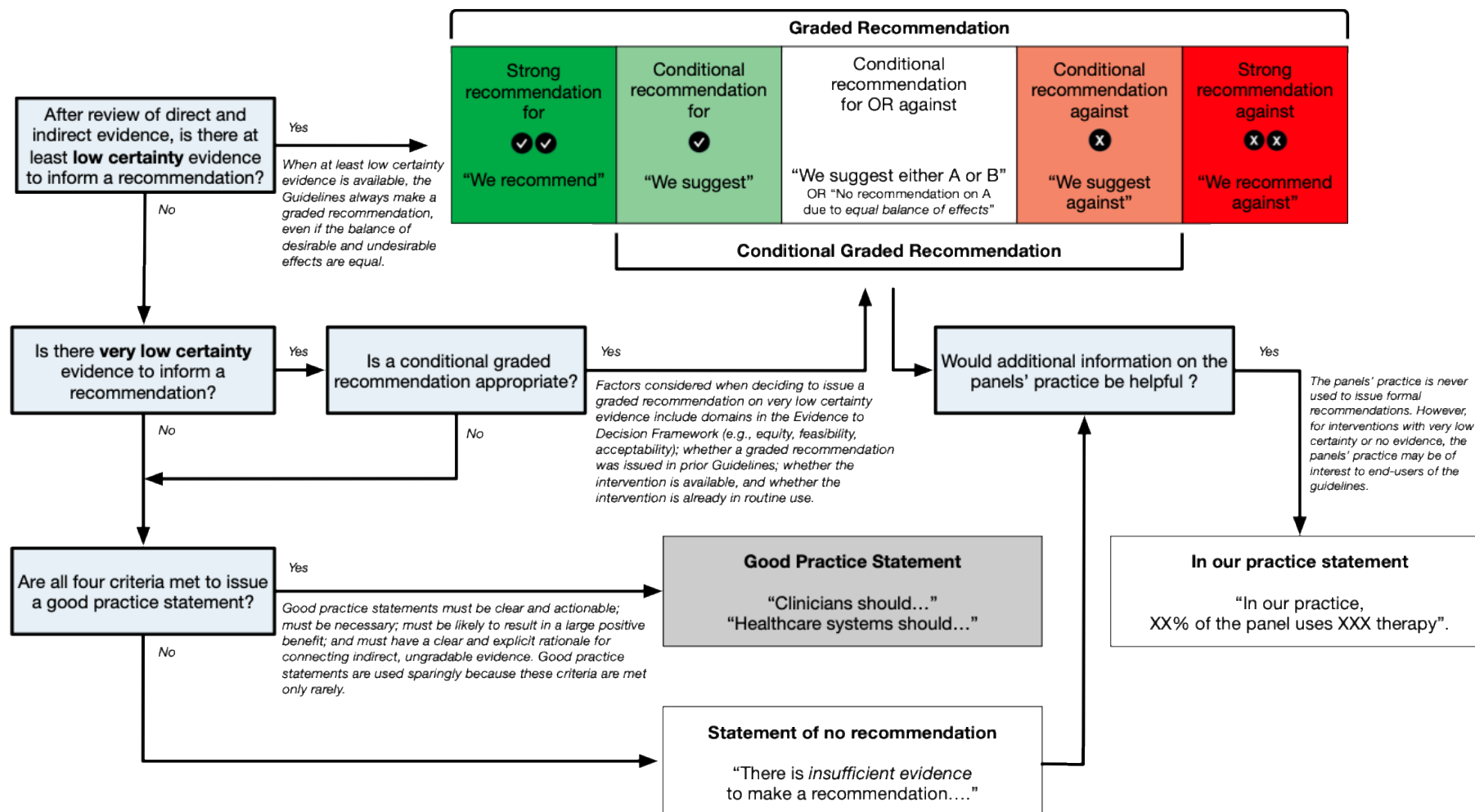
Assessing Certainty of Evidence



Methods: Evidence-to-Decision Framework



Methods: Determining Type of Statement



Methods: Implications of Statements

Implications of Strong Vs. Conditional Recommendations

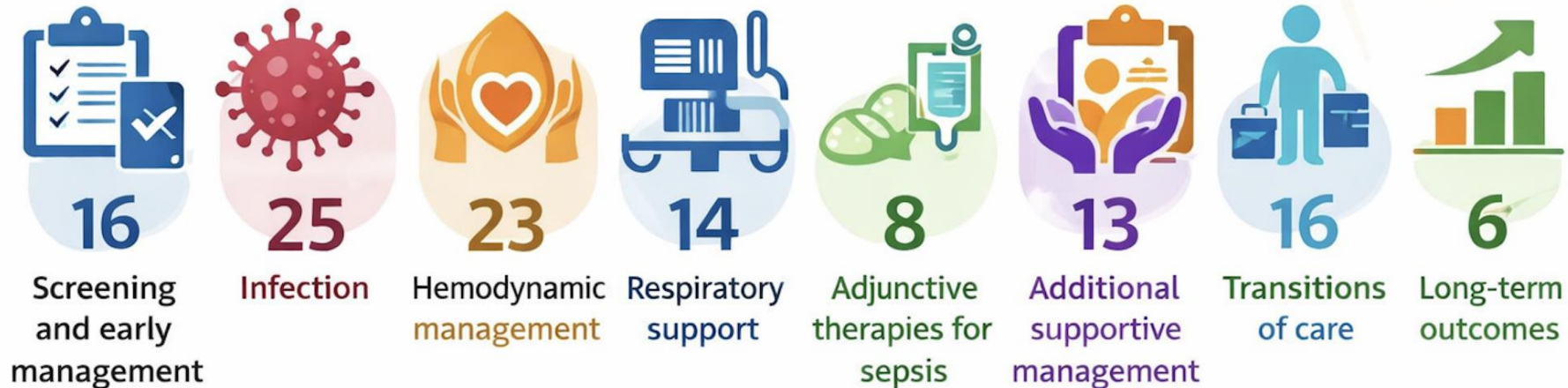
Stakeholder	Strong Recommendation	Conditional Recommendation
Patients and families	All or most would want the intervention.	Most would want the intervention, but a substantial proportion would not.
Clinicians	The intervention should be given to all or most patients. There is little need for shared decision-making for tailoring to context.	The intervention should be done for most patients, but clinicians should consider shared decision-making, clinical context, and resources.
Policy makers	Often more appropriate for policy or performance measure.	May be less appropriate for policy or performance measure.
Researchers	Research resources are better spent on other topics.	Additional research may be warranted and may change future recommendations.

Voting (3 rounds)

	Required	Achieved
Response	$\geq 75\%$	$\geq 98\%$
Agreement	$\geq 80\%$	Nearly all $>90\%$

The 2026 guidelines include 129 statements

covering screening and early management (16 statements) infection (25), hemodynamic management (23), respiratory support (14), adjunctive therapies for sepsis (8), additional supportive management (13), goals of care (16), transitions of care (16), and long-term outcomes (6).



Screening and Early Management



3. In acutely ill adults en route to hospital by ambulance or flight, we suggest using a standard sepsis screening tool over not using a screening tool.



(conditional recommendation, very low certainty evidence)

21.

For adults with definite or probable sepsis and hypotension (i.e., septic shock) and who have an anticipated time to in-hospital medical evaluation of over 60 minutes, we suggest administering antimicrobial therapy in ambulance or flight.

(conditional recommendation, very low certainty evidence)



Remark:



Prehospital antibiotic delivery should be **implemented** only after having a structured process in place to screen for **sepsis in ambulance or flight**, as discussed in recommendation 3.



2. For hospitals and health systems, we suggest using a “code sepsis” or “sepsis huddle” protocol over not using such a protocol.

(Conditional recommendation, low certainty evidence)



Remark: “Code sepsis” or “sepsis huddle” protocols involve a multi-disciplinary team huddle at bedside to discuss and expedite sepsis diagnosis and treatment following a positive sepsis screen.

10. For adults with sepsis-induced hypoperfusion or septic shock, we suggest administering at least 30 ml/kg of intravenous crystalloid in the first 3 hours.

(conditional recommendation, low certainty evidence)

30 ml/kg
of IV Fluids

E.g: 80 kg x 30 ml/kg =
2,400 ml in 3 hours

60 80 100 kg



Remark: Consideration should be given to **individual patient characteristics** and context when selecting initial fluid volume.



Remark: Clinicians prescribing fluids should perform frequent, ongoing reassessment and closely monitor patients to **avoid harms of under- or over-resuscitation**.



Remark: Weight-based fluid volume should be calculated based on **actual body weight**, or **adjusted** or **ideal body weight** in patients with BMI > 30 kg/m².

Thirty Milliliters per kilogram in Liters, by Weight and Height

Weight (kg) (lb.)	Height (m) (feet, inches)		
	1.5 m (4'11 ")	1.7 m (5'7 ")	1.9 m (6'3 ")
50 (110)	1.5	1.5	1.5
60 (132)	1.8	1.8	1.8
70 (154)	2.1	2.1	2.1
80 (176)	1.9	2.4	2.4
90 (200)	2.0	2.4	2.7
100 (220)	2.1	2.5	3.0
110 (242)	2.2	2.6	3.3
120 (264)	2.3	2.7	3.0
130 (287)	2.5	2.8	3.1
140 (309)	2.6	3.0	3.2
150 (331)	2.7	3.1	3.3
160 (353)	2.8	3.2	3.4

White cells, for patients with body mass index (BMI) ≤ 30 kg/m² display 30 mL/kg using actual body weight. Grey cells, for patients with BMI > 30 kg/m² display 30 mL/kg using adjusted body weight. Adjusted Body Weight was calculated as Ideal Body Weight + 0.4*(Actual Body Weight–Adjusted Body Weight), where Ideal Body Weight was calculated using the Devine formula¹²² for males.

Screening and Early Management

Recommendation 6: Insufficient evidence to make a recommendation regarding use of novel rapid host diagnostics.

clinical outcomes of a diagnostic strategy incorporating these tests. Due to the costs of these diagnostic aids, and lack of evidence that they improve patient-centered outcomes or resource utilization, the panel did not recommend the use of any specific sepsis diagnostic aids. Studies evaluating the impact of diagnostic aids on patient outcomes and resource utilization are a research priority. Thus, it is reasonable for health systems and clinicians make use of these novel host response diagnostics when feasible, whereas studying their impact on patient outcomes and resource utilization.

Antibiotic Management

Antibiotic Timing: Consistent with 2021

	Shock is present	Shock is absent
Sepsis is definite or probable	✓✓ Administer antimicrobial therapy immediately, ideally within 1 hour of recognition.	✓✓ Administer antimicrobial therapy immediately, ideally within 1 hour of recognition.
Sepsis is possible		✓ Rapid assessment* of infection vs noninfectious causes of acute illness. Administer antimicrobial therapy within 3 hours if concern for infection persists.

DEFINITE SEPSIS

Sepsis is confirmed based on history, clinical examination, and diagnostic testing. An alternative diagnosis is very unlikely.

PROBABLE SEPSIS

High suspicion for sepsis. Sepsis is the most likely diagnosis based on history, clinical examination, and diagnostic testing. An alternative diagnosis is less likely.

POSSIBLE SEPSIS

Moderate suspicion for sepsis. Sepsis is a possible diagnosis; however, an alternative diagnosis is also likely based on history, clinical examination, and diagnostic testing.

Antibiotic Selection: Greater Focus on Stewardship

28. For adults with sepsis or septic shock without risk factors for anaerobic infection, we suggest using an empiric antibiotic regimen without anaerobic coverage.

(conditional recommendation, very low certainty of evidence)



Remark: Agents with anaerobic activity that are needed to cover possible MDR pathogens (e.g., piperacillin-tazobactam, carbapenems) are reasonable to use to provide adequate MDR coverage if alternative agents without anaerobic coverage are inadequate.



29. For adults with sepsis or septic shock with specific risk factors for anaerobic infection, we suggest using an empiric antibiotic regimen that includes anaerobic coverage.

(conditional recommendation, very low certainty of evidence)



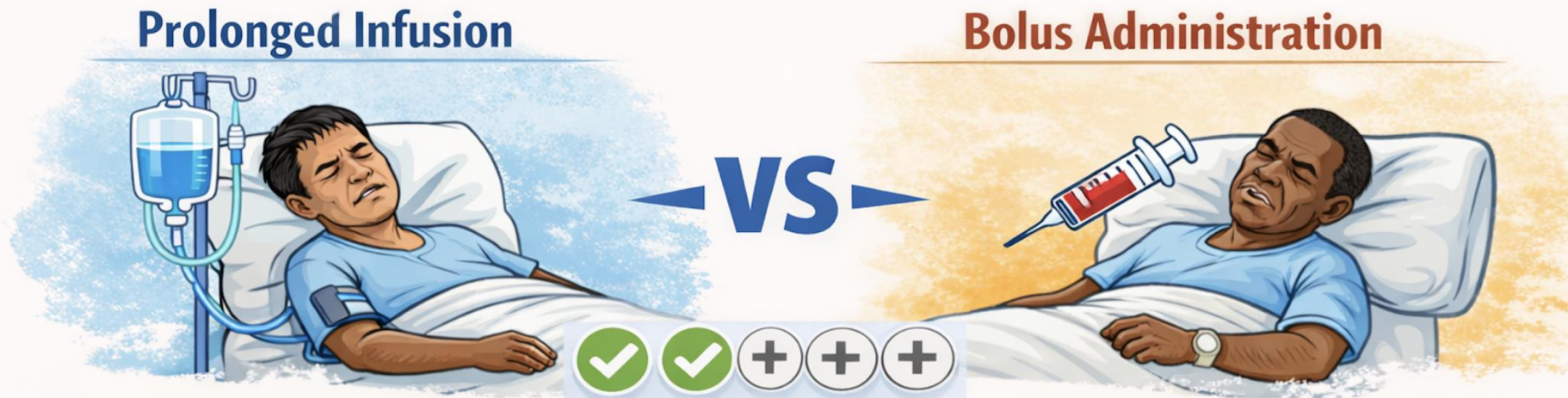
Remark: Risk factors for anaerobic infection include **intra-abdominal** or deep seated gynecological/obstetric source of infection, necrotizing soft tissue infection, head and neck infection, and central nervous system abscesses or empyema.



33. FOR ADULTS WITH SEPSIS OR SEPTIC SHOCK

We recommend using
Prolonged Infusion of Beta-Lactams for
Maintenance (after an initial loading dose) over
Bolus Administration.

Upgraded from a
conditional to
strong
recommendation.



Strong Recommendation, Moderate Certainty Evidence

36. De-escalation of *Antimicrobial Therapy* in Sepsis

For adults with Sepsis or Septic Shock



✓ RECOMMEND

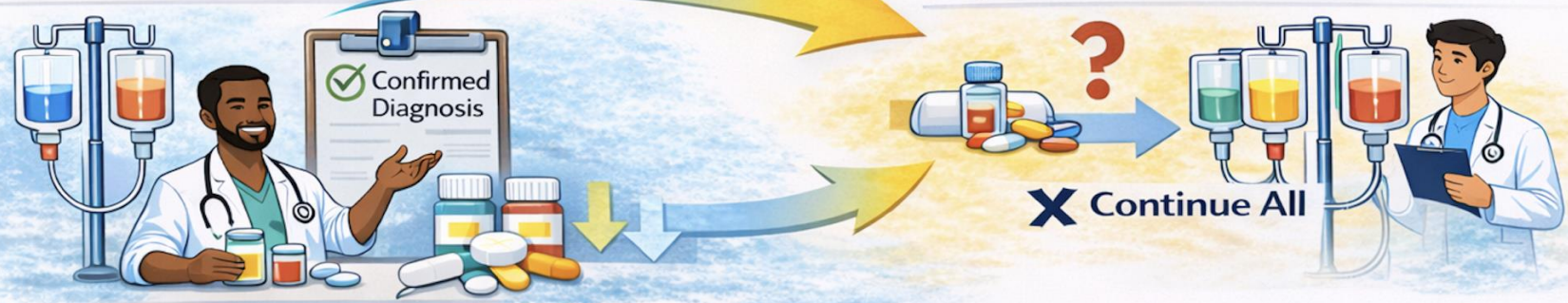


De-escalation of Antimicrobial Therapy over

No De-escalation when a confirmed microbiological diagnosis susceptibility profile is available.

✓ De-escalation:

✗ No De-escalation

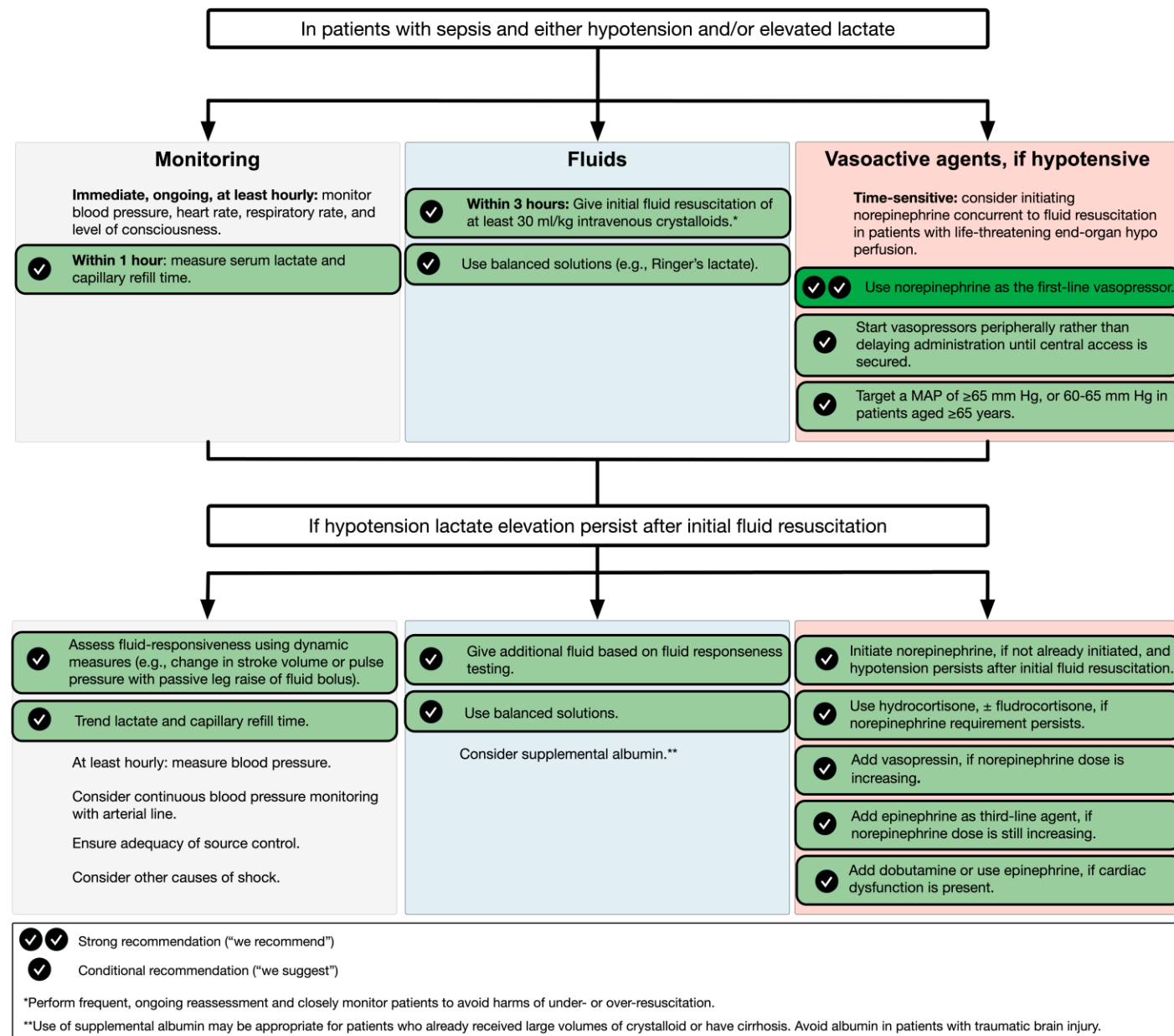


Strong Recommendation, Very Low Certainty Evidence

Remark: De-escalation means discontinuing unnecessary antimicrobial therapy or narrowing spectrum of antimicrobial agents where appropriate.

Upgraded from
conditional to
strong
recommendation.

Hemodynamic Monitoring and Resuscitation



42.

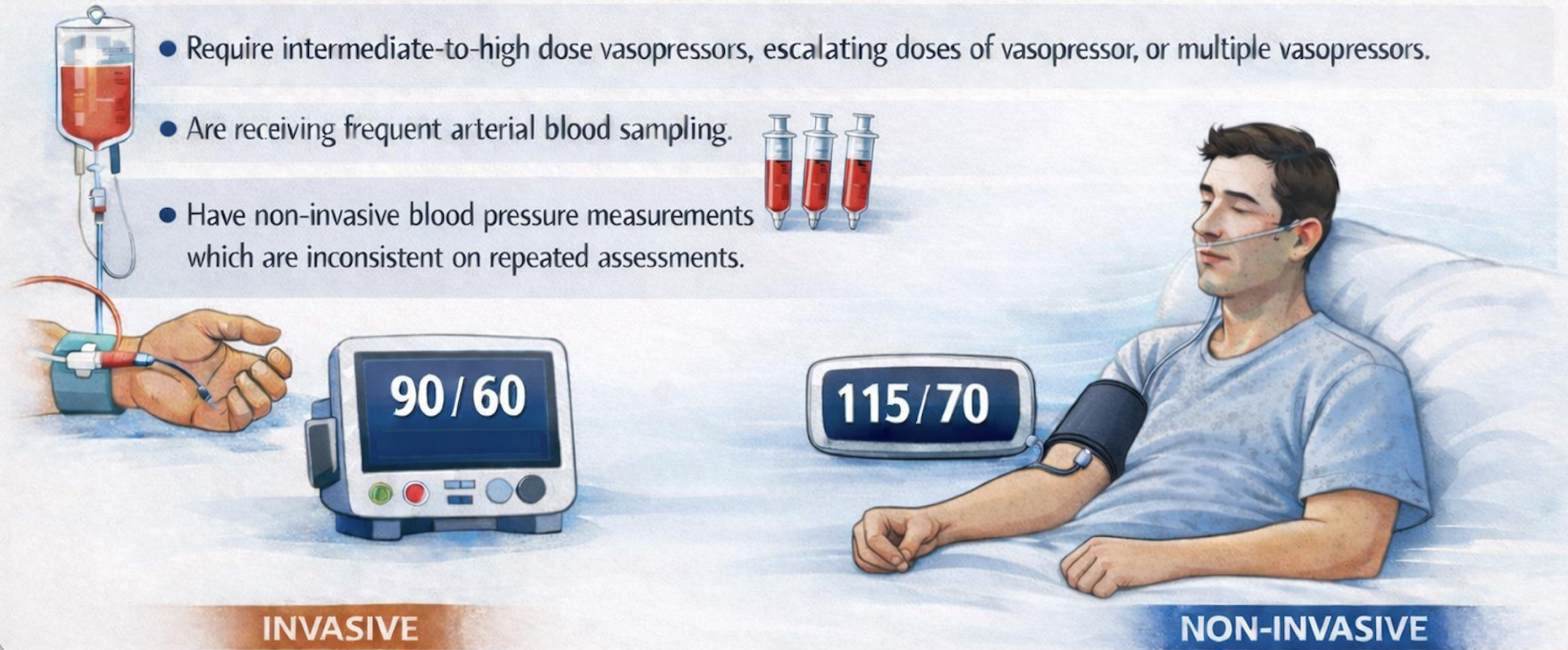
For adults with septic shock, we suggest using either
INVASIVE or **NON-INVASIVE** BLOOD PRESSURE MONITORING.

(conditional recommendation; very low certainty evidence)

REMARK:

Invasive blood pressure monitoring is advised in patients with shock who:

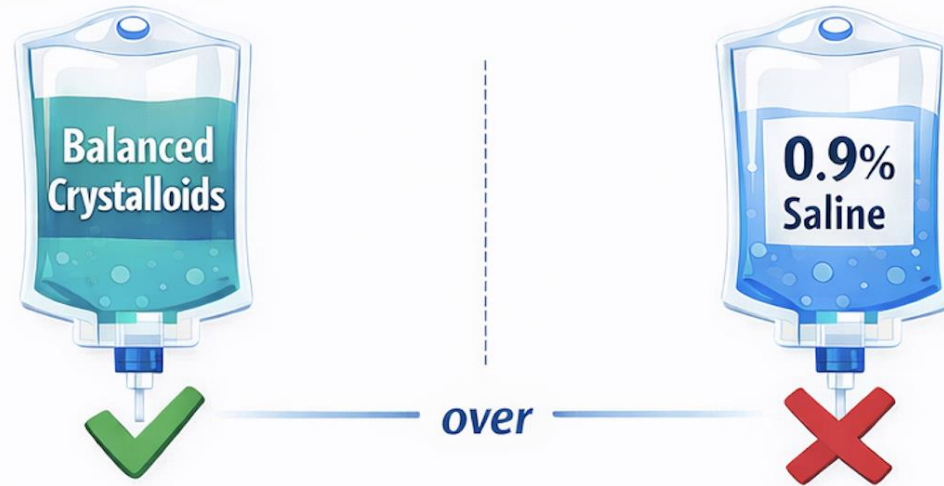
- Require intermediate-to-high dose vasopressors, escalating doses of vasopressor, or multiple vasopressors.
- Are receiving frequent arterial blood sampling.
- Have non-invasive blood pressure measurements which are inconsistent on repeated assessments.



Sepsis Resuscitation

Recommendations

44. For adults with sepsis or septic shock undergoing initial resuscitation, we suggest using:



Upgraded from
low to moderate
certainty evidence.

Balanced Crystalloids over 0.9% Saline

(Conditional recommendation, moderate certainty evidence)

Remark:

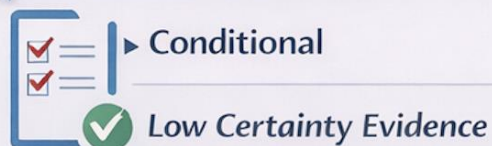


For patients with sepsis and traumatic brain injury, we suggest using 0.9% saline.



49. For adults with sepsis or septic shock, we suggest **using dynamic measures** to guide **initial fluid resuscitation** over physical examination or static measures alone.
(conditional recommendation, low certainty evidence)

Strength of Recommendation



What Are Dynamic Measures?



Passive Leg Raise (PLR)



Stroke Volume (SV)



Stroke Volume Variation (SVV)



Pulse Pressure Variation (PPV)

Why Dynamic Measures?

- ✓ Assess fluid responsiveness
- ✓ Reduce risk of fluid overload
- ✓ More reliable than static measures

Remark: Dynamic measures include response to a passive leg raise or a fluid bolus using stroke volume (SV), stroke volume variation (SVV), pulse pressure (PP), or pulse Pressure Variation (PPV).

Upgraded from
very low to low
certainty evidence.

Long term outcomes

- Comprehensive medication reconciliation
- Discharge instructions and counseling
- Patient and family education on sepsis
- Assessment and follow-up of physical, cognitive, and emotional problems
- Post-critical illness follow-up services

In Our Practice Statements

Peripheral administration of vasopressors
Departmental surveillance cultures to guide empirical antimicrobial therapy
Invasive vs. noninvasive blood pressure monitoring
Minimally invasive and noninvasive cardiac output monitoring in septic shock
Criteria for adding vasopressin to norepinephrine
Criteria for adding epinephrine to norepinephrine ($\pm$ vasopressin)
Methylene blue
Inotropes
Midodrine
SpO₂ target
Use of corticosteroids
Timing of corticosteroids
Type of corticosteroids
Time-limited trials

New Tools on SSC Website

The screenshot shows the homepage of the Surviving Sepsis Campaign website. At the top, there is a navigation bar with the logo on the left and links for 'About', 'Guidelines and Resources', 'News', and 'Join the Community' on the right. Below the navigation bar is a large hero section with a background image of red blood cells. The text 'Surviving Sepsis Campaign' is prominently displayed, followed by the tagline 'COMMITTED TO IMPROVING RECOGNITION AND TREATMENT OF SEPSIS AND SEPTIC SHOCK'. A 'Guidelines and Resources' button is visible. Below the hero section is a search bar and a row of links: 'Guidelines', 'Community', and 'Contact'. The main content area is divided into two columns. The left column contains 'About Surviving Sepsis Campaign', 'SSC Leadership and Committees', and 'History of the SSC'. The right column features the logos of the 'Society of Critical Care Medicine' and 'European Society of Intensive Care Medicine' (ESICM).

About Surviving Sepsis Campaign

The international Surviving Sepsis Campaign (SSC) is a joint initiative of the **Society of Critical Care Medicine** (SCCM) and the **European Society of Intensive Care Medicine** (ESICM), led by multidisciplinary international experts who are committed to reducing mortality and morbidity from sepsis and septic shock, which are leading causes of death worldwide.

SSC Leadership and Committees

Meet the SSC executive, steering, and research committees.
[Learn More >](#)

History of the SSC

Review the phases of the SSC and scroll through a timeline of accomplishments in sepsis.
[Learn More >](#)

Filterable Recommendations

Review the recommendations from the guidelines below. Filter recommendations based on section, strength, or identifier.

Identifier:

- ☐ Active fluid removal
- ☐ Advanced directives
- ☐ Anaerobic coverage
- ☐ Antibiotic initiation
- ☐ Antifungal coverage
- ☐ Antifungal therapy
- ☐ Antimicrobial therapy

For hospitals and health systems, we "recommend" using a performance improvement program for sepsis, including sepsis screening for acutely ill, high-risk patients; standard operating procedures for treatment; and implementation of sepsis quality improvement strategies. Certainty of evidence: moderate for screening and quality improvement strategies, very low for standard operating procedures

Remarks

Performance improvement programs and quality improvement strategies may vary by setting and in accordance with a hospital/healthcare system's ability to implement.

Surviving Sepsis ..
Campaign®

Thank you!

