UWTASP
tele-antimicrobial stewardship program

IDWEEK Highlights 2026

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11.17.2026

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Sessions I attended

- Infectious risks in leukemia and hematopoietic cell transplant
- Case-based Gu(ID)elines: Aspergillosis, Immunomodulators, and *Staphylococcus aureus* bacteremia
- Expanding our OPAT offerings

Session I will discuss today

- Beyond the 101: Pondering Perplexing Prescribing Issues
- Accelerating the PDSA thru data science
- IS IT TIME TO STOP PRESCRIBING ANTIBIOTICS FOR DIVERTICULITIS AND SBP PROPHYLAXIS; AND WHAT'S UP WITH APPENDICITIS

Should Rifampin always be given with quinolones for deep-seated infections?



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(she/her/hers)

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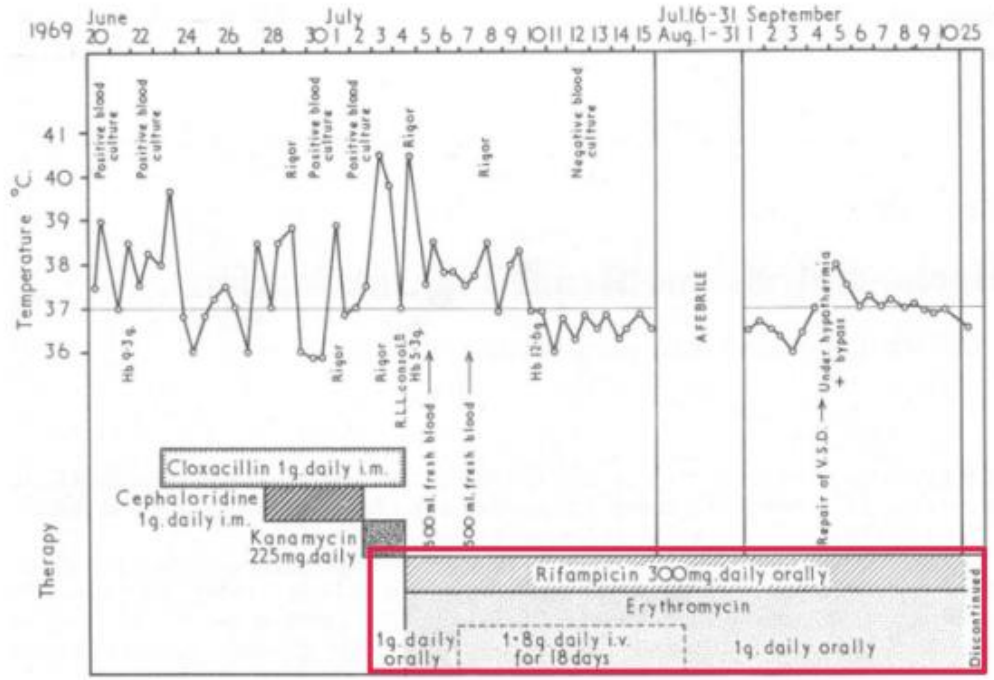
Bottom Line for Deep-Seated Infections

- For Enterobacterales & *Pseudomonas aeruginosa*:
  - Levofloxacin on its own is likely sufficient
- For *Staphylococcus aureus,* especially bone & joint infections:
  - Levo likely benefits from rif…they're peas in a pod 
- For periprosthetic joint infection (PJI) or other hardware-related infection with susceptible organism:
  - Rifampin may be helpful, but other agents might do the trick
  - Further research needed

Slide: Julie Ann Justo, PharmD, MS, FIDP, FIDSA, BCPS

Where Did the FQ + Rifampin Combo Come From?

- 1st clinical case report of rifampin combination in 3 year-old male with native valve methicillin-susceptible *Staphylococcus aureus* (MSSA) infective endocarditis



COMMENT

Conventional sensitivity tests are no guide to the treatment of this disease. The staphylococcus was sensitive to cloxacillin and to cephaloridine, but the condition worsened while these were being given. Only a totally bactericidal combination can eradicate the infection, and tests in vitro are required to identify it. The new combination chosen in this case has two outstanding advantages: both antibiotics can be given by mouth and staphylococci are more sensitive to rifampicin than to any other antibiotic. Nevertheless, rifampicin should not be given for infections other than tuberculosis without very good reasons, and since otherwise bacterial resistance develops rapidly, it should never be used alone.

Peard MC, et al. Br Med J. 1970 Nov 14;4(5732):410-1.

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Randomized Controlled Trial (RCT) Data

Zimmerli et al 1998[1]

N=33 patients with staphylococcal orthopedic implant-related infection (15 PJIs)

2 weeks IV Flucloxacillin or Vancomycin **+ PO Rifampin**	→	**3-6 months** PO Ciprofloxacin + **PO Rifampin**
2 weeks IV Fluc or Vanc + PO Placebo	→	**3-6 months** PO Ciprofloxacin + PO Placebo

Per Protocol Analysis:

Cipro + Rif	vs.	**Cipro + Placebo**
12/12 (100%) cure		**7/12 (58%) cure**

Halted early for safety. **Supported FQ + rif combo**. In 2013 IDSA PJI Guidelines as A-I regimen for staphylococcal PJI with DAIR.

Karlesen et al 2020[2]

N=48 patients with staphylococcal PJI treated with DAIR

Empiric IV Cloxacillin + Vanc + **PO Rifampin**	→	**6 weeks** IV/PO Cloxacilin (or IV Vanc) + **PO Rifampin**
Empiric IV Cloxacillin + Vanc	→	**6 weeks** IV/PO Cloxacilin (or IV Vanc)

Remission Rates (p=0.88):

Clox/Vanc + Rif	vs.	**Clox/Vanc Monotherapy**
17/23 (74%) remission		**18/25 (72%) remission**

No difference with clox/vanc + rif combo, yet cloxacillin and vanc were the partner drugs.

1. Zimmerli W, et al. JAMA. 1998 May 20;279(19):1537-41. 2. Karlesen ØE, et al. J Orthop Surg Res. 2020 Aug 28;15(1):365.

Closing the Loop

Turning data into institutional change: from successful PDSA cycles to durable value, scale and executive sponsorship



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IDSA

The series ends where institutional change begins

A PDSA result is evidence. Institutionalization is an operating model.

1

KNOW THY DATA

- Define the cohort
- Build a valid metric
- Understand data structure

→

2

PLAN → DO

- Test changes rapidly
- Learn from variation
- Adapt with data in hand

→

3

CLOSE THE LOOP

- Translate value
- Secure sponsorship
- Embed, sustain and spread

The endpoint is not “the intervention worked.”

The endpoint is “this is now how the system reliably delivers care.”

What counts as institutional change?

Durability requires more than better outcomes during the pilot

A PROJECT

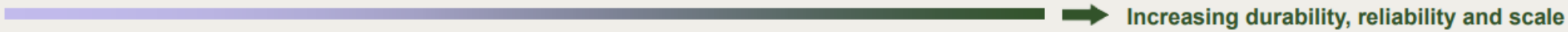
- Depends on a champion
- Uses manual tracking
- Lives outside routine workflow
- Ends when attention or funding ends

A PROGRAM

- Has defined resources and roles
- Uses recurring measurement
- Includes governance and review
- Can survive staff turnover

AN INSTITUTIONAL CAPABILITY

- Embedded in EHR and standard work
- Accountable operational owner
- Leadership-level visibility
- Scalable across sites



Sustainability: improvements persist after implementation and despite workforce turnover (AHRQ, Module 6)

The modern business case: from cost savings to capacity creation

A shorter stay doesn't eliminate fixed cost. It can create reusable capacity.



Key distinction: revenue ≠ margin, and released capacity ≠ realized value

IDSA

CNO, CMO and CMIO: safety, staff and build

The clinical leaders who make it happen and keep it running

CNO · NURSING WORKLOAD

- About 10 days of contact precautions per case
- Gowns, gloves, bleach cleaning, incontinence care
- A blocked private room
- A harm frontline nurses feel directly

"Will this add work for my nurses?"

CMO · HARM AND MEDICAL STAFF

- Mortality, recurrence and readmissions
- Aligning prescribers on fluoroquinolones
- CMS already requires a stewardship program
- The ask is resources, not permission

"Will physicians accept it?"

CMIO · EHR BUILD

- Order-set defaults away from fluoroquinolones
- Indication required at order entry
- Selective susceptibility reporting
- NHSN antimicrobial use data and a dashboard

"What do we build, and who maintains it?"

IS IT TIME TO STOP PRESCRIBING ANTIBIOTICS FOR DIVERTICULITIS AND SBP PROPHYLAXIS; AND WHAT'S UP WITH APPENDICITIS?

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DIVERTICULITIS: BROWN RF ET AL, JAMA 2025

When Should Antibiotics Be Used to Treat Acute Diverticulitis?

For patients with uncomplicated diverticulitis, first-line therapy is observation and pain control. However, antibiotics are recommended for uncomplicated diverticulitis in patients with comorbidities (such as liver cirrhosis, chronic kidney disease, heart failure, or poorly controlled diabetes), those who are pregnant, immunosuppressed, or older than age 80 years. All patients with complicated diverticulitis (eg, abscess, perforation, or fistula) should be treated with intravenous antibiotics.

HINCHEY: ORIGINAL DESCRIPTION 1978



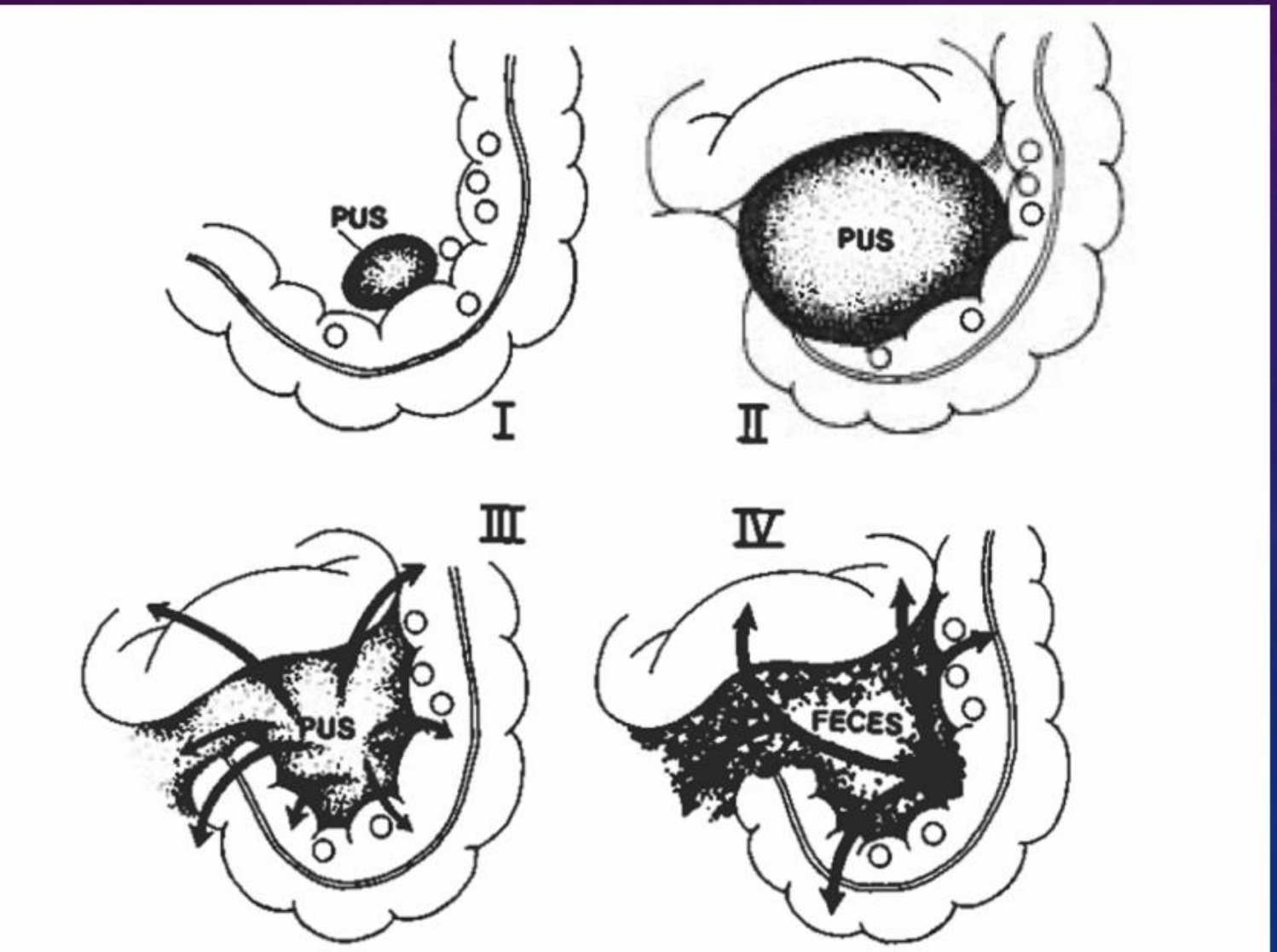
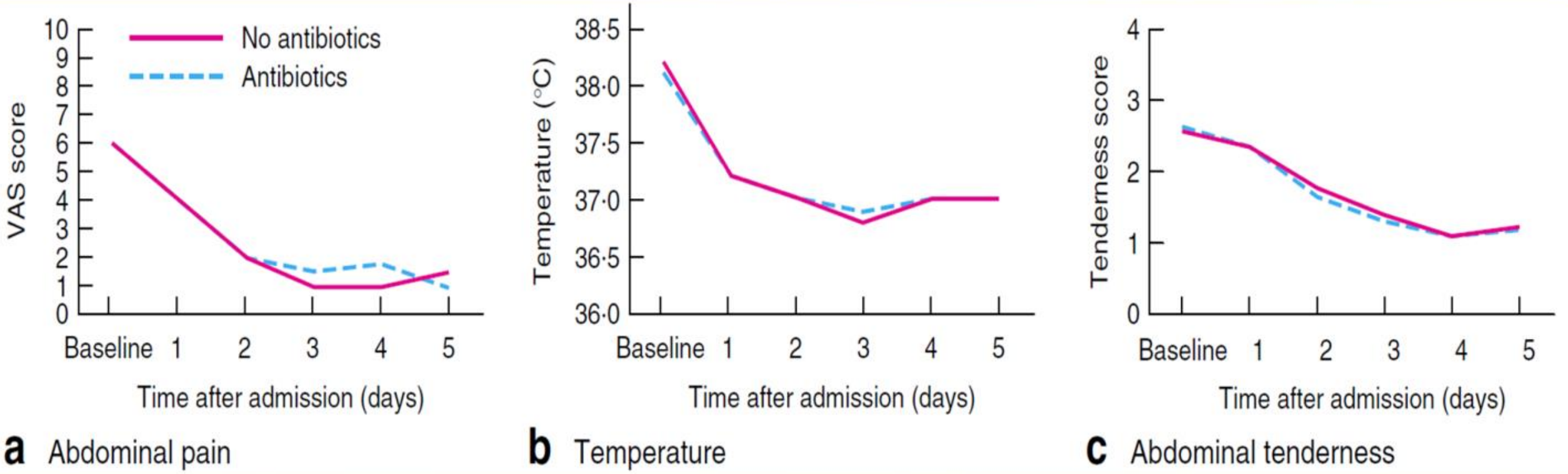


Fig 1. – The four clinical stages of perforated diverticular disease.

Hinchey EJ, et al, Adv Surg 1978

AVOD STUDY: RESULTS



Chabok A, et al, BJS 2012

AVOD STUDY: RESULTS

	No antibiotics ($n = 309$)	Antibiotics ($n = 314$)	P†
Complications	6 (1·9)	3 (1·0)	0·302
Sigmoid perforation	3 (1·0)	3 (1·0)	0·985
Abscess	3 (1·0)	0 (0)	0·080
Sigmoid resections	7 (2·3)	5 (1·6)	0·541
During hospital stay	1 (0·3)	3 (1·0)	0·324
During follow-up	6 (1·9)	2 (0·6)	0·148
Hospital stay (days)*	2·9(1·6)	2·9(1·9)	0·717‡
Recurrent diverticulitis	47 of 290 (16·2)	46 of 292 (15·8)	0·881

Chabok A, et al, BJS 2012

Inclusion criteria	Only left-sided uncomplicated (mild) acute diverticulitis

ER FOR
ARDSHIP
DICINE

AVOD STUDY: 10-YEAR FOLLOW-UP

Table 3 Intention-to-treat analysis of diverticulitis recurrence, surgery and colorectal cancer in patients with acute uncomplicated diverticulitis

	No antibiotics ($n = 275$)	Antibiotics ($n = 281$)	P†
Duration of follow-up (months)*	132 (13–173)	132 (8–165)	0·492‡
Diverticulitis recurrence	86 (31·3)	88 (31·3)	0·986
Diverticulitis complications	12 (4·4)	14 (5·0)	0·737
Acute surgery for diverticulitis	8 (2·9)	6 (2·1)	0·556
Planned surgery for diverticulitis	9 (3·3)	14 (5·0)	0·316
Colorectal cancer	1 (0·4)	6 (2·1)	0·061

Isacson D, et al, BJS 2019

ARE SURGEONS BUYING THIS?

DOUGLAS C ET AL, 2026 ANZ J SURG

Eligible for discharge	Site 1	Site 2	Total
Admitted to ward (all received antibiotics)	91	39	130
SSU	5	0	5
Discharged home	40	54	94
Total	136	93	229
Eligible patients discharged with PO antibiotics	38	48	86
Eligible patients discharged without antibiotics	2	6	8/229 (3.5%)

PRACTICAL APPROACH

- Evaluate in emergency department for risk of failure and underlying illness, then:
  - Admission + antimicrobials
  - Discharge with no antimicrobials

Takeaways

- Nursing:
  - If institutional change is your goal for QI, then learn the language that will make your C-suite want to support you
- Pharmacy:
  - Protect levofloxacin with rifampin when treating *S. aureus*
- Prescribing Clinicians:
  - Plenty of data supporting pain and observation for uncomplicated diverticulitis. Is this feasible in your institution?