

- Streptococcal toxic shock is the isolation of a group A streptococcus (*Streptococcus pyogenes*), hypotension and 2 of the following: renal impairment, coagulopathy, liver involvement, adult respiratory distress syndrome, generalised rash or soft tissue necrosis.
Use:
- benzylpenicillin 1.8 g (child: 45 mg/kg up to 1.8 g) IV, 4-hourly
PLUS EITHER
clindamycin 600 mg (child: 15 mg/kg up to 600 mg) IV, 8-hourly
OR
lincomycin 600 mg (child: 15 mg/kg up to 600 mg) IV, 8-hourly.
For patients hypersensitive to penicillin (excluding immediate hypersensitivity), substitute for benzylpenicillin:
cephalothin 2 g (child: 50 mg/kg up to 2 g) IV, 6-hourly
OR
cephazolin 2 g (child: 50 mg/kg up to 2 g) IV, 8-hourly.
- In toxic shock syndrome, consider the use of IV immunoglobulin after expert advice: normal immunoglobulin 0.4 to 2 g/kg IV, for 1 or 2 doses during the first 72 hours.

streptococcal
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staphylococcal
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- Staphylococcal toxic shock syndrome is a toxin-mediated disease which may appear from an apparently minor infection. It resembles streptococcal toxic shock syndrome. Aggressive resuscitation and treatment of the source are important aspects of therapy. Use:
di/flucloxacillin 2 g (child: 50 mg/kg up to 2 g) IV, 6-hourly.
- The addition of clindamycin may stop toxin production although there is no clinical evidence to support this
- For patients hypersensitive to penicillin (excluding immediate hypersensitivity), use:
cephalothin 2 g (child: 50 mg/kg up to 2 g) IV, 6-hourly
OR
cephazolin 2 g (child: 50 mg/kg up to 2 g) IV, 8-hourly.