**SUMMARY**

Flow chart for the Management of patients with possible, probable or proven IFI

1. **Fever >38°C after 72-96 hours of broad spectrum antibiotics as per ‘neutropenic sepsis’ Trust guideline.**

2. **Clinical assessment and Investigations:** Review Host factors, and clinical factors. See appendix 2: HRCT, BC, BAL

3. **Consider empirical treatment with caspofungin during investigation according to clinical suspicion and risk. Discuss with haematology and microbiology consultants**

4. **IFI unlikely**
   - Monitor clinical status daily. Reassess at 48-72 hours*. Consider stopping antifungals

5. **Possible IFI**
   - Start Caspofungin with loading dose
   - Reassess at 48 hours*

6. **Probable IFI**
   - **Patient responding to therapy**
     - Continue Caspofungin for 10-14 days. If IFI is later proven please discuss again with Microbiology.
     - No
     - Re-investigate - HRCT chest
     - BAL Discuss with microbiologist
     - Consider second line antifungal therapy. Consider possibility of Zygomycte (Absidia, Mucor, Rhizopus)/Fusarium infection.

7. **Proven IFI**
   - Discuss with microbiologist. For candidaemias, please see section 2.47
   - *If fungi have been isolated, susceptibilities should be obtained where possible in order to guide antifungal therapy.*
1. Aim/Purpose of this Guideline

1.1. This guideline applies to all clinical staff involved in the care of adult patients at the Royal Cornwall Hospital Trust.

1.2. The purpose of this guidance is;

   1.2.1. To ensure early consideration and appropriate management of fungal infection in refractory febrile neutropenia.

   1.2.2. To guide empirical antifungal treatment in ICU and HIV patients admitted to hospital.

   1.2.3. To promote avoidance of empirical treatment of low risk patients.

2. The Guidance

2.1. Invasive fungal infection (IFI) has been redefined as invasive fungal disease (IFD) by the EORTC/MSG Consensus Group (2008). For the purpose of this guidance the two terms are synonymous for the same disease and will be referred to as IFI to avoid confusion with the current guidance from the British Committee for Standards in Haematology (2008). IFI is defined into three different categories; possible, probable and proven based on a combination of host factors, clinical criteria and mycological criteria (see Appendix 2). Sub paragraph.

2.2. A neutrophil count below 0.5 x10^9 /L for more than ten days is considered to confer significant risk of fungal infection. Milder neutropenia however, in combination with other immunosuppressant factors, particularly the prolonged use of steroids, may also represent significant risk. It is also worthy of note that some patients with myelodysplasia may have normal neutrophil numbers but functional deficiency (“functional neutropenia”).

2.3. There must be a high level of clinical suspicion to allow early consideration of IFI in high risk patients. In those neutropenic patients with fever refractory to second line antibacterial agents IFI should always be considered. Risk factors for invasive fungal infection (IFI):

   - Neutropenia (Neutrophil <0.5x10^9/L; risk increases with duration)
   - Steroids
   - GVHD: (Graft Versus Host Disease)
   - Bacterial infection
   - Mucosal colonisation
   - Indwelling central IV line (increased risk of Candida infection)
   - Antibacterials (increased risk of Candida infection)
   - CMV infection (increased risk of Aspergillus infection)
   - Building works (increased risk of Aspergillus infection)

2.4. Neither clinical examination nor any single available test for IFI (radiological or microbiological) is sufficiently sensitive and specific. A positive culture from a non-sterile site does not necessarily imply infection; this may be due to
colonisation or environmental contamination. It is therefore important that these results are interpreted in the context of the patient’s individual risk factors and clinical features by an appropriately experienced clinician.

2.5. The treatments for IFI are both toxic and prolonged and therefore accurate risk assessment is necessary. The diagnosis may also affect other management decisions such as the decision to transplant and long term prophylaxis. It is therefore important to pursue tissue culture and histology when possible to guide management.

2.6. CT findings such as halo sign and cavitation are extremely useful in diagnosing IFI. Pulmonary nodules are less specific. In the event of a normal CT scan, the table below shows how this does not exclude IFI, particularly in the 7-15 days after onset of illness/fever; it is therefore imperative to consider repeating the scan within 7 days.

<table>
<thead>
<tr>
<th>Appearance of radiological signs in IFI</th>
<th>Early (&lt;10 days)</th>
<th>Intermediate (7-15 days)</th>
<th>Late (&gt;10 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halo sign</td>
<td>73-100%</td>
<td>0%</td>
<td>23%</td>
</tr>
<tr>
<td>Cavitation</td>
<td>0</td>
<td>25%</td>
<td>23-100%</td>
</tr>
</tbody>
</table>

2.7. Prophylaxis

2.8. The choice of antifungal used in prophylaxis varies depending on the chemotherapy regimen used (azoles interact with vinca alkaloids) or individual patient factors e.g, previous drug reactions or previous colonisation/infection. Prophylaxis is commenced and discontinued according to the period of risk. In Acute Leukaemia this is from initiation of intensive chemotherapy until resolution of the ensuing neutropenia. In cases of prior proven fungal infection a decision may be made to continue secondary prophylaxis between cycles. The following haematology patients should be routinely taking anti-fungal prophylaxis unless specified.

2.9. Acute Myeloid Leukaemia undergoing intensive chemotherapy:

2.10. First line: Itraconazole oral liquid 200mg bd throughout the duration of neutropenia. If not tolerated posaconazole tablets 300mg bd on day 1 then 300mg once daily. NB dose of posaconazole liquid 200mg tds.

2.11. Second line: Liposomal amphotericin (Ambisome®) intravenous 3mg/kg three days per week (rounded to the nearest 50mg vial).

2.12. Acute Lymphoblastic Leukaemia undergoing UKALL trial chemotherapy:

2.13. If the patient is on vincristine, liposomal amphotericin (Ambisome®)
intravenous 3mg/kg given three times a week on Mondays, Wednesdays and Fridays. Azole may be used safely after phase 1 of induction and this can be itraconazole suspension 200mg bd.

2.14. Lymphoma:

2.15. Patients undergoing outpatient and non-intensive chemotherapy regimens do not require fungal prophylaxis as these involve only a short period of neutropenia and therefore low risk for fungal infection. Refer to specific chemotherapy protocol for inpatient regimens e.g. CODOXM/IVAC as these have a much higher risk of IFI.

2.16. Bone Marrow Transplant patients:

2.17. Autologous transplant: do not require fungal prophylaxis unless previous history of fungal infection.

2.18. Allogeneic transplant: refer to patient specific advice from transplant centre

2.19. Investigation of suspected invasive fungal infection

- Clinical assessment. See appendix 1.
- FBC, U&E, LFT, Calcium, C-reactive protein, Group and Save
- Blood cultures - peripheral and central (each lumen)
- CXR
- Urgent HRCT Thorax
- Sputum should be sent if possible, nasopharyngeal aspirate (NPA) is better, but BAL (+ transbronchial biopsy) is best for culture of microorganisms including Legionella spp. and fungi, and PCR for viruses and P. jirovecci.
- The following tests should be considered where appropriate;
  - CT sinuses
  - Biopsy of skin or mucosa
- Galactomannan, β-D-glucan and panfungal PCR tests are not routinely recommended but may be made available following discussion with microbiology
- Consider other tests not included in the diagnostic work up for IFI;
- Serology for atypical respiratory organisms
  - Urine for culture and legionella antigen
  - Other investigations as part of a septic screen
- DISCUSS WITH MICROBIOLOGIST.
- NB: If the initial HRCT is inconclusive, consider repeat scan within 7 days (for explanation see ‘Timing of CT changes’ on page 2)

2.20. Treatment of invasive fungal infection in HIV patients see BHIVA guidelines.

2.21. Treatment of invasive fungal infection in Critical Care patients

2.22. For possible/probable IFI

2.23. First line fluconazole IV 800 mg loading dose followed by 400mg daily. Administer with caution to patients with liver dysfunction
2.24. **If unresponsive/ second line/ or probable or proven aspergillus** use voriconazole or caspofungin or anidulafungin guided by the microbiologists for 10 to 14 days.

2.25. If specific fungal organisms identified other than candida and aspergillus then follow guidance below.

2.26. **Treatment of invasive fungal infection refractory febrile neutropenia**

2.27. In most cases this refers to suspected invasive aspergillosis but there is an increasing incidence of other species including zygomycoses and invasive candidiasis. The diagnosis of IFI relies on data from CT and culture. The decision to start empirical treatment pending investigation should be made in conjunction with the consultant haematologist and microbiologist based on level of risk and clinical suspicion. This is generally discouraged in national guidance but depends on timing of investigations and the potential risk to the patient of delayed therapy.

2.28. See Appendix 2 for definitions of the following terms of IFI.

2.29. **Possible/ Probable IFI**

2.30. **First line**: Caspofungin for 10 to 14 days.

2.31. If unresponsive, other antifungals may be considered with advice from microbiology. Second line antifungals such as voriconazole and Ambisome® may be considered.

2.32. **Proven IFI**

2.33. This requires discussion with microbiology in conjunction with the regional reference mycology centre regarding likely species and sensitivities.

2.34. See appendix 3 regarding likely organism sensitivities.

2.35. **Proven or probable aspergillosis**

2.36. Commence intravenous voriconazole.

2.37. Continue intravenous voriconazole for 7 days after which switch to oral voriconazole if the oral route of administration is suitable. Patients may be switched to oral earlier than 7 days if a prompt and satisfactory response is observed with initial intravenous therapy.

2.38. If aspergillosis is unresponsive or progressing, please discuss with microbiology and the regional reference mycology centre. Consider therapeutic drug level monitoring 7 days after initiation of therapy for those on long-term therapy. Discuss with microbiology and the reference laboratory.
2.39. Suspected mucormycosis (zygomycosis) or Fusarium infection

2.40. The term mucormycosis (zygomycosis) is used to refer to infections caused by moulds belonging to the Order Mucorales of the Class Zygomycetes. These include the genera of Absidia, Mucor, Rhizomucor, and Rhizopus. Mucormycosis is an uncommon, but often lethal infection in immunocompromised patients. Those at greatest risk include persons with acute leukaemia in relapse, and allogeneic transplant with severe GVHD. There are five major clinical forms of mucormycosis; rhinocerebral, pulmonary, gastrointestinal, cutaneous, and disseminated. The clinical manifestations of pulmonary mucormycosis cannot be distinguished from Gram-negative bacterial pneumonia, or aspergillosis.

2.41. Fusarium can cause a broad spectrum of human diseases. In the neutropenic patient it can present as a persistent fever (greater than 38°C) that is unresponsive to antibacterial and antifungal treatment. Pleurisy, non-productive cough and haemoptysis are other presenting signs. Radiological findings range from non-specific infiltrates to nodular or cavitating lesions.

2.42. Please discuss with microbiology in conjunction with the regional reference mycology centre if treatment for these conditions is being contemplated.
2.43. Flow chart for the Management of patients with possible, probable or proven IFI

Fever >38°C after 72-96 hours of broad spectrum antibiotics as per ‘neutropenic sepsis’ Trust guideline.

Clinical assessment and Investigations: Review Host factors, and clinical factors. See appendix 2: HRCT, BC, BAL

Consider empirical treatment with caspofungin during investigation according to clinical suspicion and risk. Discuss with haematology and microbiology consultants

IFI unlikely

- Monitor clinical status daily. Reassess at 48-72 hours*. Consider stopping antifungals

Possible IFI

- Start Caspofungin with loading dose
- Reassess at 48 hours*

Probable IFI

- Discuss with microbiologist. For candidaemias, please see section 2.47

Proven IFI

- Patient responding to therapy
  - Yes: Continue Caspofungin for 10-14 days. If IFI is later proven please discuss again with Microbiology.
  - No: Re-investigate - HRCT chest BAL Discuss with microbiologist Consider second line antifungal therapy. Consider possibility of Zygomycete (Absidia, Mucor, Rhizopus)/Fusarium infection.

*If fungi have been isolated, susceptibilities should be obtained where possible in order to guide antifungal therapy.
2.44. Special Cases

2.45. All special cases require discussion with microbiology in conjunction with the regional mycology centre.

2.46. Suspected hepatosplenic candidiasis

- Unless aspergillus is excluded use Ambisome® as first line, and consider early switch to caspofungin if poor response
- If hepatosplenic candidiasis is proven, discuss with microbiologist for sensitivities.

2.47. Proven systemic candidiasis

- Blood cultures are usually positive in these cases and treatment should be guided by sensitivities:

2.48. **First line if azole naive**: Fluconazole IV 800 mg loading dose followed by 400mg daily

2.49. **If previous azole prophylaxis, known azole resistance or suspected non-albicans candidiasis**: Caspofungin or liposomal amphotericin (Ambisome®) intravenous 3 – 5mg/kg once daily - discuss with microbiologist.

- Blood cultures should be repeated 48 to 72 hours after commencement of antifungal treatment
- The recommended duration of therapy for candidaemia without persistent fungaemia or metastatic complications is for 2 weeks after documented clearance of Candida from the bloodstream, resolution of symptoms attributable to candidaemia, and resolution of neutropenia.
- All patients should have an ophthalmological review
- Intravascular catheter removal is recommended for catheter related bloodstream infections due to Candida spp., instead of treatment with antifungal lock and catheter retention, unless there are unusual extenuating circumstances (e.g., no alternative catheter insertion site)

2.50. Aspergilloma/fungal ball

2.51. Consider surgical referral as some patients may benefit from resection

2.52. Sinus involvement

2.53. ENT referral is essential for endoscopy and possible biopsy or Debridement

2.54. CNS involvement

2.55. Joint management with neurosurgery +/- implanted reservoir

2.56. **First line**: Voriconazole IV

2.57. **Second line**: Ambisome®
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Appropriate use of antifungal agents in accordance with these guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Haematology Lead Clinician</td>
</tr>
<tr>
<td>Tool</td>
<td>None developed at the time of writing.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Yearly and reported through departmental governance meeting</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Report sent to the Haematology Governance Committee and Antimicrobial stewardship management committee</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Haematology lead clinical to act on any recommendations from the report</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within one month. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 6.
Appendix 1: Clinical signs suggestive of Invasive fungal infection- BCSH guideline 2008:

- Any new fever during prolonged, severe neutropenia or immunosuppression
- Fever resistant to broad spectrum antibacterials while neutropenic
- Symptoms and signs of new, resistant or progressive lower respiratory tract infection; e.g. pleuritic pain, pleural rub
- Prolonged, severe lymphocytopenia in chronic GVHD and immunosuppression
- Symptoms and signs of progressive upper respiratory tract infection
- Periorbital swelling
- Maxillary swelling and tenderness
- Palatal necrosis or perforation
- Focal neurological or meningeal irritation symptoms and signs with fever
- Unexplained mental changes with fever
- Papular or nodular skin lesions
- Intra-ocular signs of SFI (systemic fungal infection)
Appendix 2: Revised EORTC/MSG Definitions of Invasive Fungal Infection/disease except for endemic mycoses (CID 2008: 46; 1813-21)

Possible: 1 host factor + clinical criterion

Probable: 1 host factor + clinical criterion + mycological criterion

Proven: Positive microscopic analysis (by histopathologic, cytopathogenic or direct microscopic examination) of a specimen from a sterile site or positive culture from a sterile specimen/blood or positive cryptococcal antigen in the CSF.

**Host factors**

- Recent history of neutropenia (<0.5 x 109 neutrophils/L [<500 neutrophils/mm3] for >10 days) temporally related to the onset of fungal disease
- Receipt of an allogeneic stem cell transplant
- Prolonged use of corticosteroids (excluding among patients with allergic bronchopulmonary aspergillosis) at a mean minimum dose of 0.3 mg/kg/day of prednisone equivalent for 13 weeks
- Treatment with other recognized T cell immunosuppressants, such as cyclosporine, TNF-a blockers, specific monoclonal antibodies (such as alemtuzumab), or nucleoside analogues during the past 90 days
- Inherited severe immunodeficiency (such as chronic granulomatous disease or severe combined immunodeficiency).

**Clinical criteria**

**Lower respiratory tract fungal disease.**

The presence of 1 of the following 3 signs on CT:

- Dense, well-circumscribed lesions(s) with or without a halo sign
- Air-crescent sign
- Cavity

**Tracheobronchitis**

Tracheobronchial ulceration, nodule, pseudomembrane, plaque, or eschar seen on bronchoscopic analysis

**Sinonasal infection**

Imaging showing sinusitis plus at least 1 of the following 3 signs:

- Acute localized pain (including pain radiating to the eye)
- Nasal ulcer with black eschar
- Extension from the paranasal sinus across bony barriers, including into the
orbit

#### CNS infection

1 of the following 2 signs:
- Focal lesions on imaging
- Meningeal enhancement on MRI or CT

#### Disseminated candidiasis

At least 1 of the following 2 entities after an episode of candidaemia within the previous 2 weeks:
- Small, target-like abscesses (bull's-eye lesions) in liver or spleen
- Progressive retinal exudates on ophthalmologic examination

#### Mycological criteria

**Direct test (cytology, direct microscopy, or culture).**

Mould in sputum, bronchoalveolar lavage fluid, bronchial brush, or sinus aspirate samples, indicated by 1 of the following:
- Presence of fungal elements indicating a mould
- Recovery by culture of a mold (e.g., Aspergillus, Fusarium, Zygomyces, or Scedosporium spp.)

**Indirect tests (detection of antigen or cell-wall constituents)**

Aspergillosis
- Galactomannan antigen detected in plasma, serum, bronchoalveolar lavage fluid, or CSF

Invasive fungal disease other than cryptococcosis and zygomycoses
- \( \beta \)-D-glucan detected in serum
Appendix 3: Organism sensitivities: Spectrum of activity of selected antifungal agents (Sanford Guide to Antimicrobial Therapy 2011)

<table>
<thead>
<tr>
<th>Organism</th>
<th>Fluconazole</th>
<th>Itraconazole</th>
<th>Voriconazole</th>
<th>Posaconazole</th>
<th>Ambisome</th>
<th>Caspofungin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candida albicans</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Non albicans Candida</td>
<td>Variable</td>
<td>Variable</td>
<td>Yes</td>
<td>Yes</td>
<td>Variable</td>
<td>Yes</td>
</tr>
<tr>
<td>Aspergillus Spp.</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Zygomycete (Absidia, Mucor, Rhizopus)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fusarium</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cryptococcus</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>No</td>
</tr>
</tbody>
</table>
APPENDIX 4.

There is a checklist for all patients commenced on voriconazole at [www.mhra.go.uk](http://www.mhra.go.uk).

Summary of that checklist below

**VFEND® (voriconazole) Healthcare Professional Checklist**

Please complete this Checklist at each visit with your patient being treated with VFEND® (voriconazole). Each of the three sections includes important risk information followed by a series of check boxes to help in the management of your patient for whom you prescribed VFEND.

- **A) Minimizing the Risk of Phototoxicity and Skin Squamous Cell Carcinoma**
  - VFEND has been associated with phototoxicity and pseudoporphyria. It is recommended that all patients, including children, avoid exposure to direct sunlight during VFEND treatment and use measures such as protective clothing and sufficient sunscreen with high sun protection factor (SPF).
  - The frequency of phototoxicity reactions is higher in the paediatric population. As an evolution towards SCC has been reported, stringent measures for the photoprotection are warranted in this population of patients. In children experiencing photoaging injuries such as lentigines or ephelides, sun avoidance and dermatologic follow-up are recommended even after treatment discontinuation.
  - Squamous cell carcinoma (SCC) of the skin has been reported in patients taking VFEND, some of whom have reported prior phototoxic reactions.
  - If phototoxic reactions occur, multidisciplinary advice (e.g., a consultation with a dermatologist) should be sought for the patient. VFEND discontinuation and use of alternative antifungal agents should be considered.
  - Dermatologic evaluation should be performed on a regular basis whenever VFEND is continued, despite occurrence of phototoxicity-related lesions, to allow early detection and management of premalignant lesions.
  - VFEND should be discontinued if premalignant skin lesions or skin SCC are identified.
  - SCC has been reported in relation with long-term VFEND treatment. Treatment duration should be as short as possible. Long-term exposure (treatment or prophylaxis) greater than 180 days (6 months) requires careful assessment of the benefit risk balance and physicians should therefore consider the need to limit the exposure to VFEND.
  - For prophylaxis use, dose adjustments are not recommended in the case of lack of efficacy or treatment-related adverse events. In the case of treatment-related adverse events, discontinuation of voriconazole and use of alternative antifungal agents must be considered. Refer to the Summary of Product Characteristics for full prescribing information.


## Appendix 5. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Clinical Guideline for the Management of Invasive Fungal Infection in Adult Haematology and Oncology Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>June 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>June 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>June 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Neil Powell, Antibiotic Pharmacist</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252590</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Clinical guideline for the treatment of invasive fungal infections.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Antifungal, invasive, fungal infection</td>
</tr>
<tr>
<td>Target Audience</td>
<td><strong>RCHT</strong></td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>New document</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New Document</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Medications Practice Committee (20.05.16) CSSC Governance DMB</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Karen Jarvill, Associate Director CSSC</td>
</tr>
</tbody>
</table>
| Name and Post Title of additional signatories | Bryson Pottinger, Haematology lead clinician  
Richard Bendall, Medical Microbiologist  
Emma Nicholls, Haematology/oncology pharmacist  
Maggie Fitzgerald, Intensive care pharmacist |
| Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings | {Original Copy Signed}  
Name: Janet Gardner, Governance Lead CSSC |
| Signature of Executive Director giving approval | {Original Copy Signed} |
Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet | ✓ Intranet Only
---|---|---
Document Library Folder/Sub Folder: | Clinical / Haematology
Links to key external standards
Related Documents: | RCHT Management of Neutropenic Sepsis in Cancer patients - Clinical Guideline
Training Need Identified? | No

**Version Control Table**

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<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>Mar 16</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Neil Powell, Antibiotic Pharmacist</td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

**Controlled Document**

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### Appendix 6. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)</th>
<th>Provide brief description: Clinical Guideline for the Management of Invasive Fungal Infection in Adult Haematology and Oncology Patients</th>
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</thead>
<tbody>
<tr>
<td>Directorate and service area: Haematology</td>
<td>Is this a new or existing Policy? New</td>
</tr>
<tr>
<td>Name of individual completing assessment: Neil Powell, Antibiotic Pharmacist</td>
<td>Telephone: 01872 252590</td>
</tr>
<tr>
<td><strong>1. Policy Aim</strong>&lt;br&gt;Who is the strategy / policy / proposal / service function aimed at?</td>
<td>Provide guidance on the effective treatment of invasive fungal infections.</td>
</tr>
<tr>
<td><strong>2. Policy Objectives</strong></td>
<td>Effective treatment of invasive fungal infections</td>
</tr>
<tr>
<td>*<em>4. <em>How will you measure the outcome?</em></em></td>
<td>Audit appropriate use of antifungal agents in accordance with these guidelines</td>
</tr>
<tr>
<td><strong>5. Who is intended to benefit from the policy?</strong></td>
<td>Haematology patients</td>
</tr>
<tr>
<td><strong>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</strong>&lt;br&gt;<strong>b) If yes, have these *groups been consulted?</strong>&lt;br&gt;<strong>C). Please list any groups who have been consulted about this procedure.</strong></td>
<td>No</td>
</tr>
</tbody>
</table>
7. The Impact

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
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<td></td>
</tr>
<tr>
<td>Race / Ethnic communities / groups</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
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<td>Religion / other beliefs</td>
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<tr>
<td>Marriage and civil partnership</td>
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<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No |
9. If you are not recommending a Full Impact assessment please explain why.

No potential for differential impact identified

Signature of policy developer / lead manager / director | Date of completion and submission

Names and signatures of members carrying out the Screening Assessment

1. Neil Powell
2. 

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.
Signed ________________

Date ________________