## Adult Vancomycin Loading Dose Recommendations

### Why a loading dose?
A single loading dose of 20 – 30mg/kg (based on actual body weight) can be used to facilitate rapid attainment of target trough serum vancomycin concentration.

### Indications
| In seriously ill patients with infections such as: |
| Severe sepsis or septic shock |
| Meningitis |
| Endocarditis |
| MRSA bacteremia |

Please factor in individual characteristics (e.g. age, other comorbid conditions, weight fluctuations due to ascites, third spacing, fluid overload) Such patients may warrant lower dose

### Administration Guidelines:
- Dosing based on actual body weight (including obese)
- Max initial dose = 2,000 mg (2,500 mg if obese)
  - Obese: BMI>30 or TBW > 20% above IBW
- Standard Rate of Administration: 1,000 mg over 60 minutes
- Max PIV concentration: 5 mg/mL

### Weight | Loading Dose† | Infusion Rate
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30 – 39 kg | 750 mg | 60 min
40 – 49 kg | 1,000 mg | 60 min
50 – 59 kg | 1,250 mg | 90 min
60 – 69 kg | 1,500 mg | 90 min
70 – 85 kg | 1,750 mg | 120 min
86-120 kg | 2,000 mg | 120 min
≥ 120 kg | 2,000-2,500 mg: use clinical discretion | 120-150 min

† Consider using a lower loading dose for renal insufficiency (renal replacement therapy/hemodialysis):
15 – 20mg/kg

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• For isolates with a vancomycin minimum inhibitory concentration (MIC) ≤2 μg/mL (eg, susceptible according to Clinical and Laboratory Standards Institute [CLSI] breakpoints), the patient's clinical response should determine the continued use of vancomycin, independent of the MIC (A-III).

• For isolates with a vancomycin MIC >2 μg/mL (eg, vancomycin-intermediate S. aureus [VISA] or vancomycin-resistant S. aureus [VRSA]), an alternative to vancomycin should be used (A-III).