# Memorandum

**To:** Perinatal and Newborn Care Providers in Nova Scotia

**From:** Reproductive Care Program of Nova Scotia

**Subject:** Impending shortage of erythromycin ophthalmic ointment

**Date:** 07 November 2019

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There is an impending shortage of all types of erythromycin ophthalmic ointment for newborn ocular prophylaxis until January 2020 (anticipated date for return of product). Erythromycin is the only product licensed for this purpose in Canada. Alternative available ophthalmic antibiotics have not been tested for safety nor efficacy for prophylaxis in newborns.

The available supply will not be sufficient to maintain universal newborn ocular prophylaxis, and so RCP recommends the following approach, which is based on the Canadian Paediatric Society's Position Statement *Preventing Ophthalmia Neonatorum* (2015, reaffirmed 2018) and 2019 media release *Neonatal ocular prophylaxis: Shortage of erythromycin ophthalmic ointment for use in newborns*:

- Health professionals should offer universal antenatal screening for *Neisseriae gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT).

- If the newborn's mother has been tested for GC in pregnancy and found to be negative, **no ocular prophylaxis is necessary** unless the mother is considered to be at high risk of acquiring GC after the test was done.
  ***Due to the extreme shortage of erythromycin please make every effort to review the mother's STI screening results.***

- **If the mother is at high risk** for exposure to GC after last testing,
  **OR** tested positive for GC in pregnancy and was treated but **not followed up**,
  **OR** was **not tested** in pregnancy: **Test the mother at delivery**.
  ***Due to the extreme shortage of erythromycin please make every effort to review the mother's STI screening results.***
  - If close follow-up of the newborn can be assured, the infant may be discharged while awaiting results. The health care professional who will follow the infant should be informed of the situation, and the parents should be informed of who to contact immediately if the infant develops extensive eye irritation or acute significant

mucopurulent discharge. This requires coordination and communication between the health care professionals present at delivery and those who will follow the baby (e.g., paediatrician, family physician, midwife, nurse practitioner or other).
    - If close follow-up of the newborn by a health care provider **cannot** be assured while test results are pending, and there is concern about the parent(s) accessing care for the baby in the community, consider keeping the infant and mother in hospital while awaiting results.
    - If a longer length of stay is not possible and there is concern about community follow-up for the baby, consider giving the baby a dose of intramuscular ceftriaxone (50 mg/kg to a maximum of 125 mg) before discharge.

- **If the mother tested positive for GC in pregnancy but was not treated, and the baby is asymptomatic**: Assume the infant is infected. Test a conjunctival specimen for gonococcus, and treat the infant with a single dose of ceftriaxone, pending test results.

***Note:*** *Ocular prophylaxis with erythromycin has limited or no effect in prevention of chlamydia conjunctivitis. Treatment of exposed asymptomatic infants with a systematic macrolide is not indicated.*

For further details about managing an infected or symptomatic infant, maternal screening, identifying high-risk mothers, and managing infants exposed to chlamydia at birth, refer to:

- *Preventing Ophthalmia Neonatorum* (https://www.cps.ca/en/documents/position/ophthalmia-neonatorum)
- *Canadian Guidelines on Sexually Transmitted Infections* (https://www.canada.ca/en/services/health/publications/diseases-conditions/guidelines-sti-recommendations-chlamydia-trachomatis-neisseria-gonorrhoeae-syphilis-2019.html)