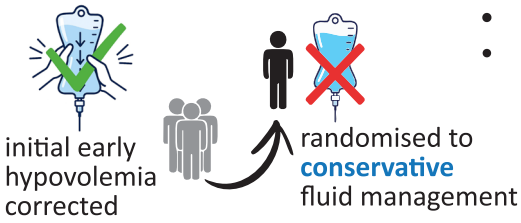
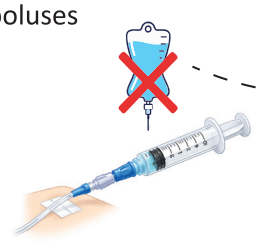
SepTiC
Sepsis Trials in Critical Care

Fluid intervention strategy

As soon as possible after randomisation:

- No routine maintenance IV
  (normal feeding should continue)
- IV drugs in smallest acceptable volumes
- Avoid IV boluses

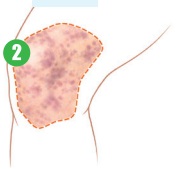




unless

Overt signs of hypovolemia:

Skin mottling
(beyond kneecap, score 2)



- BP target not maintained
  (despite up-titration vasoactive drugs)
- Serum lactate ≥ 3 mmol/L
- Urine output < 0.25 ml/kg/h
  (on Day 1 only)

Day 1 fluid management

Replace blood or other measured fluid/drain losses

then consider 250ml **bolus** and reassess

After 1 litre (maximum) **reassess**

if no improvement
STOP and continue to Day 2 - 5 assessment
(low likelihood of benefit from further fluid boluses)

if improvement
STOP and continue to Day 2- 5 assessment

assess daily

- Noradrenaline < 0.2 mcg/kg/min
  (and not increasing)
- No signs of hypovolemia
  (as described in Day 1)

i Cardiovascular stability yes/no?

- Cumulative fluid balance >3000ml
- Pulmonary oedema
- Peripheral oedema ≥ 2 sites

ii Fluid overload yes/no?

if either i or ii are **'no'** → **Continue day 1** strategy

if both i and ii are **'yes'** → **continue to** de-resuscitation

aim for **≥ 1000**ml/day negative fluid balance

Day 2 - 5 fluid management

- **Indapamide** 5 mg daily (enteral)
  or equivalent thiazide diuretic
- **Furosemide** 0.25 mg/kg IV bolus
  (10 - 40mg)
- **Furosemide infusion**
  starting at 5 mg/hr, titrated up or down between 2-20 mg/hr

all 3 required
or furosemide infusion paused if a large diuresis occurs

reassess (daily) **until day 5**

end of protocol
day 5 / ICU discharge