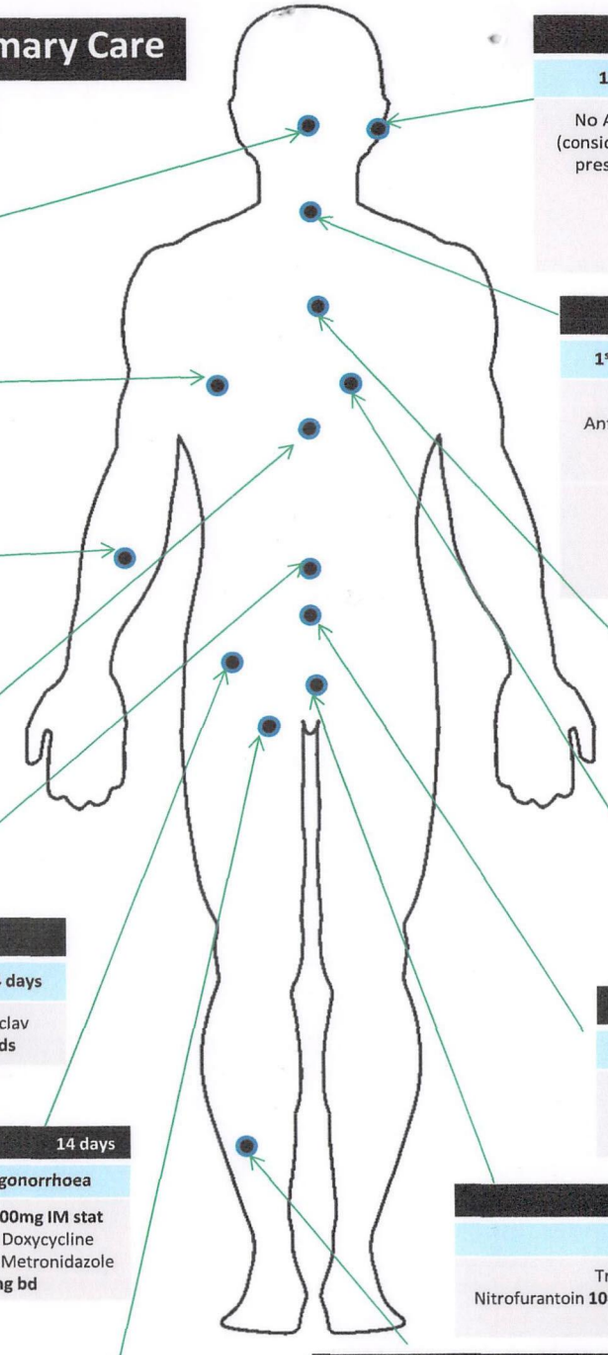
Guidance for Antibiotic Prescribing In Primary Care



Acute Sinusitis: 7 days

1st Line	2nd Line	Penicillin allergy
No Antibiotic (consider delayed prescription)	Amoxicillin **500mg tds** **Or** Doxycycline **200mg od**	Doxycycline **200mg od**

Acute Bronchitis: 5 days

1st Line	2nd Line	Penicillin allergy
No Antibiotic (consider delayed prescription)	Doxycycline **200mg stat** then **100mg od** or Amoxicillin **500mg tds**	Doxycycline **200mg stat** then **100mg od**

Animal / Human bites : 7 days

1st Line	Penicillin allergy
Prophylaxis or treatment: Co-amoxiclav **375-625 mg tds**	Metronidazole **400 mg tds** plus Doxycycline **100mg bd** (cat/dog/man)

Eradication of H.pylori : 7 days

1st Line	Penicillin allergy
PPI **bd** with Amoxicillin **1g bd** plus Metronidazole **400mg bd**	Use PPI bd with Clarithromycin **500mg bd** plus Metronidazole **400mg bd**

Shingles: 7 days

Aciclovir 800mg 5 x a day
Only treat > 50yrs within 72 hrs of rash or active ophthalmic or Ramsey Hunt or Eczema

Acute pyelonephritis: 7-14 days

1st Line -7 days	2nd Line- 14 days
Ciprofloxacin **500mg bd**	Co-amoxiclav **625mgtds**

Pelvic Inflammatory Disease : 14 days

1st Line	High risk of gonorrhoea
Ofloxacin **400mg bd** **PLUS** Metronidazole **400mg bd**	**Ceftriaxone 500mg IM stat** followed by Doxycycline **100mg bd** plus Metronidazole **400mg bd**

C Difficile: 14 days

1st Line	2nd Line
Metronidazole **400mg tds**	Vancomycin **125mg qds**

Acute prostatitis : 28 days

1st Line	2nd Line
Ciprofloxacin **500mg bd**	Trimethoprim **200mg bd**

Acute Otitis Media: 5 days (Child doses only)

1st Line	2nd Line	Penicillin allergy
No Antibiotic (consider delayed prescription)	Amoxicillin **Neonate 7-28 days 30mg/kg TDS** **1 month-1 yr: 125mg TDS** **1-5 years: 250mg TDS** **5-18 years: 500mg TDS**	Clarithromycin **<8kg – 7.5mg/kg bd** **8-11kg – 62.5mg bd** **12-19kg – 125mg bd** **20-29kg – 187.5mg bd** **30-40kg – 250mg bd**

Pharyngitis / sore throat / tonsillitis: 5-10 days

1st Line	2nd Line for 10 days	Penicillin allergy for 5 days
No Antibiotic	Phenoxymethylpenicillin Age 1 month – 1 yr: **62.5mg qds** Age 1-5 yrs: **125mg qds** Age 6-12 yrs: **250mg qds** Adult dose: **2 x250mg qds**	Clarithromycin Adult and child >12 yrs: **250mg bd** up to **500mg bd** if severe. In children, consider Erythromycin syrup 1mth-2yrs: **125mg qds** 2-8yrs: **250mg qds** Adult and child >8 yrs:**250mg - 500mg qds**

Community acquired pneumonia: 7-10 days

If CRB65=0:	If CRB65=1,2 & at home (after hospital assessment)	Penicillin allergy
Amoxicillin **500mg tds**	Amoxicilin **500mg tds** AND *Clarithromycin* ***500mg bd OR*** Doxycycline **200mg stat/100mg od**	Clarithromycin **500mg bd**

Acute Exacerbation of COPD: 5 days

1st Line	2nd Line
Doxycycline **200mg stat** then **100mg od** or Clarithromycin **500mg bd** or Amoxicillin **500mg tds**	Co-Amoxiclav **625mg tds**

UTI in pregnancy: 7 days

1st Line	2nd Line	3rd Line
Amoxicillin 500mg tds (if sensitive) **Nitrofurantoin 100mg m/r bd** (Avoid if greater than 36 weeks)	Trimethoprim **200mg bd (off label)** avoid in first trimester	Cefradine **500mg bd**

UTI in men: 7 days and UTI in women : 3 days

1st Line	2nd Line
Trimethoprim **200mg bd or** Nitrofurantoin **100mg m/r bd** or Pivmecillinam **400mg stat then 200mg tds**	Perform culture in all treatment failures

Cellulitis: 7-14days

1st Line	Penicillin allergy
Flucloxacillin **500mg qds**	Clindamycin **300mg qds** **Stop if diarrhoea occurs**

Impetigo: 7 days

1st Line	Penicillin allergy
Flucloxacillin **500mg qds**	Clarithromycin **500mg bd**

Supporting Evidence

Pharyngitis / Sore Throat / Tonsillitis:

The majority of sore throats are viral; most patients do not benefit form antibiotics.
Patients with more severe symptoms may benefit more from antibiotics but exclude glandular fever.
10 days treatment required to eliminate carriage of Strep pyogenes

Acute otitis Media (AOM):

Antibiotics do not reduce pain in first 24 hours, subsequent attacks or deafness. Optimise analgesia, use ibuprofen or paracetamol. Consider 2-3 days delayed or immediate antibiotics for pain relief if:

- Children < 2 years with bilateral AOM or bulging membranes and > 4 marked symptoms
- Children with otorrhoea

Acute Sinusitis:
AVOID ANTIBIOTICS – 80% resolve in 14 days.
If persistant symptoms use an agent with anti-anaerobic activity e.g. co-amoxiclav

Acute Bronchitis:
Antibiotics offer little benefit if no co-morbidity
Consider a 7 day delayed prescription but symptom resolution can take 3 weeks

Acute Exacerbation of COPD:

Many cases are viral. Treat with antibiotics if :

- Increased sputum purulence
- Increase SOB and/or
- Increased sputum volume

Risk factors for antibiotic resistance include:

- Co-morbid disease
- Severe COPD
- Frequent exacerbations
- Antibiotics in last 3/12

Acute Prostatitis:

4 weeks treatment may prevent chronic infection

Cellulitis:

If MRSA suspected or river or sea water exposure, discuss with microbiologist.
If febrile and ill, or failure of oral treatment refer for IV treatment.

Acute Pyelonephritis:

If referral for admission not needed, send a mid-stream urine for culture & sensitivities and start antibiotics. If no response within 24 hours, refer.

C.Difficle

Do not retest within 28 days, still considered to be same episode. Speak to microbiology for treatment advice, if patient still symptomatic.

UTI in Men & Women

In adult women with uncomplicated UTI (i.e. no fever or loin pain) it is reasonable to start empirical treatment with no culture if dipstick positive for nitrite or leucocyte esterase.
A mid-stream urine culture is always indicated in men, pregnant women, children, those with complicated infection or where empirical treatment has failed.
Patients with urinary catheters will always have an abnormal dipstick and often have bacteriuria and at times pyuria. Urine samples should be sent only if clinically indicated and not routinely, because of the appearance or smell. **Catheter in situ: antibiotics will not eradicate asymptomatic bacteriuria;** only treat if systemically unwell or pyelonephritis likely.Do not use prophylactic antibiotics for catheter changes unless history of catheter-change-associated UTI or trauma.
Only use Nitrofurantoin if GFR over 45ml/min. If GFR 30-45ml/min only use if resistance & no alternative.
Avoid Trimethoprim

UTI in Pregnancy

Send a mid-stream urine for culture & sensitivity before empirical antibiotics.
Short-term use of nitrofurantoin in pregnancy is unlikely to cause problems to the foetus.
Avoid trimethoprim if low folate status, on folate antagonist (eg antiepileptic or proguanil)

Impetigo

Reserve topical antibiotics for very localised lesions to reduce the risk of resistance .
Reserve mupirocin for MRSA.

Oral candidiasis

Miconazole oral gel 2.5ml four times a day is more effective than topical nystatin .

Eradication of H.pylori:

There is normally no need to continue proton pump inhibitors or H2-receptor antagonists unless the ulcer is complicated by haemorrhage or perforation.
Two weeks triple therapy regimes offer higher eradication rates but poor compliance and adverse effects offset this.
Do not use clarithromycin, metronidazole or quinolone if used in past year for any infection.

Pelvic Inflammatory Disease:

Refer woman and contacts to GUM service. Always culture for gonorrhoea and chlamydia. 28% of gonorrhoea isolates now resistant to quinolones. If gonorrhoea likely (partner has it, severe symptoms, sex abroad) use ceftriaxone regimen or refer to GUM.

Community acquired pneumonia:

Use CRB65 score to help guide and review, each scores 1:

- Confusion
- Respiratory rate >30/min
- BP systolic <90 or diastolic ≤60
- Age >65 years

Score 0: suitable for home treatment;
Score 1-2: hospital assessment or admission;
Score 3-4: urgent hospital admission.
Always give safety-net advice and likely duration of symptoms. Mycoplasma infection is rare in over 65years.

If CRB65=1,2 & AT HOME **Clinically assess need for dual therapy for atypicals**

Date produced: September 2015. Review date: September 2017 . BNF issue 68 September 2014
NHS Clinical Knowledge Summaries online guidance – www.cks.nhs.uk
Management of infection guidance for primary care for consultation and local adaption – July 2015
PSS Guidance for Antibiotic Prescribing in Primary Care – November 2014
Produced by Medicine Management Bradford City and Districts CCG in conjunction with BTHFT microbiology department.

NHS
The NHS working together in Bradford