ENT Infection Management Guidance

NHS Tayside

- **STOP and think before you prescribe antibiotics. Does your patient actually have an infection that requires treatment?**
- **Always document the indication and planned duration for antibiotics in the medical notes and on medicine chart.**
- **Recommendations are for non pregnant adults and doses assume normal renal and hepatic function.**
- ***Clindamycin oral dosing:** **<50kg 300mg tds 50-90kg 450mg tds >90kg or very severe illness 600mg tds or 450mg qds**

Tonsillitis In uncomplicated tonsillitis avoid antibiotics where possible - 90% of cases will resolve in 7 days without treatment. If ≥4 on FeverPAIN score consider immediate antibiotic if severe or 48 hr back up prescription. See SIGN 117 for indications for tonsillectomy.
Unable to swallow: Benzylpenicillin IV 1.2g qds (penicillin allergy: clarithromycin IV 500mg bd)
Able to swallow: Penicillin V PO 500mg qds or 1g bd Duration: **5 days** (penicillin allergy: clarithromycin 500mg bd)

Peritonsillar Cellulitis Benzylpenicillin IV 1.2g qds or Penicillin V oral 500mg qds or 1g bd. Total duration IV/PO: 10 days
Penicillin allergy: Clindamycin* oral (10 days) If unable to swallow IV Clindamycin 600mg – 1.2g qds

Peritonsillar Abscess As Peritonsillar Cellulitis. If not resolving at 48 hours consider adding oral metronidazole to penicillin. (clindamycin gives adequate anaerobic cover)

Supraglottitis Ceftriaxone IV 2g od Send blood cultures
Step down to Co-amoxiclav PO 625mg tds (or in penicillin allergy: Doxycycline PO 100mg bd + Metronidazole 400mg tds) Total Duration IV/PO 7-10 days

Deep Space Neck Infection Co-amoxiclav IV 1.2g tds (penicillin allergy: clindamycin* oral or IV 600mg – 1.2g qds)
Send sample of pus from drainage for culture. If no improvement seek microbiology advice. Duration 7-10 days

Lemierre syndrome Ceftriaxone IV 2g bd + Metronidazole 400mg PO TDS *(only use IV if oral route not available)* Seek ID advice re. duration – up to 6 weeks may be required.

Glandular Fever If positive EBV serology and no signs of bacterial infection **STOP** antibiotics

Acute Rhinosinusitis If ≤10 days symptoms – no benefit from antibiotics unless clear evidence of systemic illness. If >10 days symptoms, consider backup antibiotic if multiple/ worsening symptoms. Penicillin V oral 500mg qds or 1g bd (5 days). Penicillin allergy: Doxycycline 200mg on day 1 then 100mg thereafter (5 days)

Chronic Rhinosinusitis *For ENT specialist use or recommendation only*. Measure serum IgE pre-treatment; high levels of IgE, or smokers, are less likely to respond to antibiotic treatment. Long term treatment should be reserved for patients who have failed to achieve acceptable symptom control with topical corticosteroids and saline irrigation.
Consider trial of doxycycline,co-trimoxazole or macrolide for up to 12 weeks alongside a course of oral steroids.
Note potential QT prolongation and drug interactions with macrolides (including statins) – see Tayside Prescriber).

Epistaxis If packing has been in for >48hours – Flucloxacillin PO 1g qds – STOP when packing removed. Topical antibiotics: Naseptin cream TDS for 14 days OR if peanut/soya allergy mupirocin ointment applied TDS for 7 days

Otitis Media: AOM usually resolves within 3 days without antibiotics. Acute complications including mastoiditis/ and chronic hearing loss are rare with/without antibiotics. Consider no antibiotics with self care/worsening advice or delayed antibiotic prescription. Consider immediate antibiotics if ;<2 years with bilateral AOM, or if otorrhoea or if signs of systemic infection. If myringotomy performed send fluid for culture.
First line: Amoxicillin 500mg tds (**5 days**) Penicillin allergy: Clarithromycin 500mg bd (**5 days**)

Recurrent Considered as ≥3 episodes in 6 months or ≥5 episodes in 12 months
For ENT specialist use or recommendation only : consider use of amoxicillin once daily for 4-6 weeks in paediatric cases.

Mastoiditis Co-amoxiclav IV 1.2g tds/ PO 625mg tds **(14 days)** Penicillin allergy – discuss with ID/Microbiology

Acute Parotitis Consider mumps as differential diagnosis. Ensure strict oral hygiene and appropriate management of dry mouth.
Flucloxacillin 1g qds **plus** Metronidazole 400mg tds (**5 days**)
Penicillin allergy: Doxycycline 100mg od **plus** Metronidazole 400mg tds

Chronic Recurrent Parotitis Antibiotics not usually required. Manage underlying risk factors with good hydration, avoid dry mouth, good oral hygiene and consider use of chewing gum to stimulate saliva flow if appropriate.

Otitis Externa Provide patient information in all cases.
Mild: do not swab, Acetic Acid 2% (Earcalm®) for 7 days, treat as moderate if no improvement after 3 days.
Moderate: do not swab, Otomize® or Sofradex®
If unresolving after one course of treatment for moderate symptoms, then swab ear for culture and sensitivities ensuring sample is labelled as 'otitis externa'. Treat according to sensitivities considering topical gentamicin (as gentamicin HC) or ciprofloxacin (with dexamethasone) which include topical corticosteroid for ear canal oedema. Duration 7-14 days.
For fungal infection use clotrimazole solution 1%, apply 2-3 times daily until 14 days after cure.
Oral or IV antibiotics may be required if there is associated cellulitis or disease extends outside the ear canal - refer to ENT and treat as facial cellulitis + topical therapy as per sensitivities.

Facial Cellulitis
Cutaneous source: Follow cellulitis guideline
Dental / Mandibular / Sinus source: PO Co-amoxiclav 625mg tds or Clindamycin* (5-7 days)

Orbital Cellulitis Medical Emergency: Transfer to hospital immediately and refer to ENT and/or Ophthalmology.
Ceftriaxone IV 2g bd + Flucloxacillin IV 2g qds + Metronidazole 400mg PO TDS *(only use IV if oral route not available)*
(Penicillin allergy: seek advice) Step down to Co-amoxiclav PO 625mg tds (10-14 days total)

Peri-orbital /Pre-septal Cellultiis: Co-amoxiclav PO 625mg tds or IV 1.2g tds (penicillin allergy: Clindamycin*) Duration: 7-10 days

Skull Base Osteomyelitis Associated with pain, cranial nerve palsy, granulation in ear. 12% mortality risk. Seek micro advice.
Piperacillin/tazobactam IV 4.5g QDS (as 30min infusion). May be given as a 3 hour extended infusion in critical illness if feasible. If penicllin allergy or oral route suitable Ciprofloxacin PO 750mg bd. Sensitivities essential. Treat for 6 weeks initially then reassess. If continued inflammation on scan or ↑ CRP continue for a further 6 weeks. May require up to 6-12 months of treatment. Refer to OHPAT team if suitable for outpatient IV antibiotic therapy.

Tracheostomy Where treatment is required in malodorous tumours, apply metronidazole 0.75% gel liberally twice daily.

Halitosis	When secondary to ENT tumours: Metronidazole 400mg tds for 14 days. Re-treat for 14 days if recurrence, and consider indefinite treatment with 200mg bd thereafter. Consider short term use of metronidazole suppositories if oral route not possible.

Developed by: ENT/Microbiology/AMG Updated: Antimicrobial Management Group September 2021 Review: May 2025