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 tonsillotomy.

**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 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)

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

**Post Tonsillectomy Haemorrhage**
If evidence of infection Amoxicillin IV 1g tds or Clarithromycin IV 500mg bd
Switch to oral Amoxicillin 500mg tds or Clarithromycin 500mg bd as soon as possible
Duration: 7 days total IV/PO Consider use of tranexamic acid if no evidence of infection

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

**Rhinosinusitis:**
In uncomplicated rhinosinusitis avoid antibiotics where possible as 80% resolve in 14 days without, and they offer only marginal benefit after 7 days NNT=15

**Acute Rhinosinusitis**
Penicillin V oral 500mg qds or 1g bd (7 days) Penicillin allergy: Doxycycline 200mg on day 1 then 100mg thereafter (7 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 clarithromycin 250mg bd for 12 week trial. Where there is potential concerns about prolonged QT interval or interactions (including statins – see Tayside Prescriber) consider use of co-trimoxazole or doxycycline.

**Epistaxis**
If packing has been in for >48hours – Flucloxacillin PO 1g qds – STOP when packing removed

**Otitis Media:**
AOM resolves in 60% of cases in 24hrs without antibiotics; which only reduce pain at 2 days and do not prevent deafness. Consider antibiotics if ≤2 years and bilateral AOM; or bulging membrane and marked multiple symptoms; or otorrhoea. If myringotomy performed send fluid for culture.

First line: Amoxicillin (5 days). Penicillin allergy: Clarithromycin (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 or twice daily in paediatric cases.

**Acute Parotitis**
Consider mumps as differential diagnosis. Ensure strict oral hygiene and appropriate management of dry mouth.
Flucloxacillin 500mg 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 unresolved 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 (as Cilodex®) which include topical corticosteroid for ear canal oedema.

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

**Orbital Cellulitis**
Medical Emergency: Transfer to hospital immediately and refer to ENT and/or Ophthalmology.
Ceftriaxone IV 2g bd + Flucloxacillin IV 2g qds + Metronidazole IV 500mg tds (Penicillin allergy: seek advice)
Step down to Co-amoxiclav PO 625mg tds (10-14 days total)

**Peri-orbital /Pre-septal Cellulitis:**
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 tds (as 30min infusion). If penicillin 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.
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.

Any other queries should be directed to the ENT/Microbiology/Pharmacy OHPAT team.