Primary Care Adult Empirical Treatment of Infection Guidance

- **STOP AND THINK BEFORE YOU PRESCRIBE ANTIBIOTICS**: Does your patient actually have an infection and require treatment?
- **TO REDUCE RESISTANCE TO CLOSTUBRON DIFFICULTY INFECTION USE NARROW SPECTRUM ANTIBIOTICS WHEREVER POSSIBLE AND IN PARTICULAR AVOID CIPROFLOXACIN AND OTHER QUINOLONES, CEPHALOSPORINS, CO-AMOXICLAV AND CLINDAMYCIN**
- **CONSIDER A "NO PRESCRIBING" OR "BACK UP PRESCRIBING" STRATEGY FOR UPPER RESPIRATORY TRACT INFECTIONS OR UNCOMPLICATED LOWER UTI IN FEMALES**
- **RECOMMENDATIONS ARE FOR NON PREGNANT ADULTS**
- **INDICATES STATED ASSUME NORMAL RENAL AND HEPTATIC FUNCTION**
- **FULL GUIDANCE IS AVAILABLE ON NHS TAYSIDE ANTIMICROBIAL WEBSITE, TAYSIDE AREA FORMULARY OR LINK ON STAFFNET HOME PAGE**

**Meningitis**
Urgent hospital transfer. Give antibiotics if non-blanching rash, in combination with signs of meningism or sepsis, and **time permits**. Antibiotics should also be given if fever time is >1 hour. Benzylpenicillin (IVIM) 1.2g or if known ampicillin cefotaxime 2g (IVIM). Health Protection Team will deal with **prophylaxis** for contacts.

**Orbital cellulitis**
Medical emergency – transfer to hospital immediately.

**Peri-orbital/pre-septal cellulitis**
See **ENT guidance** for treatment. If any concerns seek specialist opinion.

**Conjunctivitis**
Usually self-limiting. If necessary use chloramphenicol eye drops 2 hourly for 2 days reducing to 3-4 times daily or just at night if using eye ointment. Continue for 48 hours after resolution.

**Overall Pneumonia**
Queries in **neutrophil count** (6000-10000/mm³) or **fever temperature** >38°C may require chest X-ray. Order chest X-ray if **radiographic signs** of pneumonia are present. Consider sputum microscopy, blood tests, and if necessary swab for pathogenic cause.

**Pneumonia**
Refer to update.

**General Pneumonia**
**CNS**
- **Acute cough/acute bronchitis**
- **Acute exacerbation of COPD**
- **Hospital acquired or aspiration pneumonia (non severe)**
- **Community acquired pneumonia**
  - **Assess CRB65 score** (Confusion, respiratory rate >30min, blood pressure <90 systolic or <60 diastolic, age ≥65 years)

**UTI in Older Adults**
Refer to **CDI guidance**. If CDI proven, and non-severe, metronidazole 400mg (10 days) (2nd LINE)

**Pyelonephritis (male or female)**
Refer to **CDI guidance** in TAF. Seek advice if required from Tay-UHB.tay@nhs.net

**Lower UTI in CKD**
Refer to **CDI guidance**. 1st **LINE** oxacillin 500mg bd + ofloxacin 400mg bd (14 days). Refer to **Full Guidance** for recurrent UTI.

**Uncomplicated Male UTI**
Do not use **urinalysis**. Do not treat unless clinical signs/symptoms of infection. Antibiotic prophylaxis for UTI if catheter in situ is not recommended. Check **decision aid** before prescribing. Co-amoxiclav 500mg bd or co-amoxiclav 625mg (7 days). Urinary catheter as soon as possible.

**Acute Exacerbation of COPD**
Refer to **CDI guidance**. If no sputum purulence no antibiotics unless pneumonia or consolidation on CXR. 1st **LINE** amoxicillin 500mg tds **2nd LINE** doxycycline 200mg daily (10 days). Antibiotics give no significant benefit in clinical improvement but may be considered in the frail elderly. 1st **LINE** amoxicillin 500mg tds 2nd **LINE** doxycycline 200mg daily (7 days).

**CLOSTRIDUM DIFFICILE INFECTION**
Refer to **CDI guidance**. If CDI proven, and non-severe, metronidazole 400mg (10 days) (2nd LINE)

**Acute Gastroenteritis**
No antibiotic required unless systemically unwell or post antibiotic. See **guidance for gastroenteritis or CDI**.

**Diverticulitis**
Uncomplicated acute diverticulitis may respond to analgesia and dietary modification. If antibiotics are indicated use metronidazole 400mg tds plus co-trimoxazole 960mg bd for 5 days.

**Catherised Patients**
Do not use **urinalysis**. Do not treat unless clinical signs/symptoms of infection. Antibiotic prophylaxis for UTI if catheter in situ is not recommended. Check **decision aid** before prescribing. Co-trimoxazole 960mg bd or co-amoxiclav 625mg (7 days). Urinary catheter as soon as possible.

**UTI in Older Adults**
Refer to **CDI guidance**. If no sputum purulence no antibiotics unless pneumonia or consolidation on CXR. 1st **LINE** amoxicillin 500mg tds **2nd LINE** doxycycline 200mg daily (10 days). Antibiotics give no significant benefit in clinical improvement but may be considered in the frail elderly. 1st **LINE** amoxicillin 500mg tds 2nd **LINE** doxycycline 200mg daily (7 days).

**Pelvic Inflammatory Disease**
Doxycycline 100mg bd (7 days). If intolerant to clindamycin 100mg qd (1) then 1000mg qd (2) for 2 days metronidazole 400mg bd + ofloxacin 400mg bd (14 days). See **Full Guidance** for recurrent PID.

**Chlamydia**
doxycycline 100mg (7 days) or azithromycin 1g qd (7 days). If intolerant to doxycycline 100mg qd then 1000mg qd (2) for 2 days metronidazole 400mg bd + ofloxacin 400mg bd (14 days). See **Full Guidance** for recurrent PID.

**Uncomplicated Chlamydia**
doxycycline 100mg (7 days).

**Skin Cellulitis**
fluclaxacin 1g qd or doxycycline 1000mg bd (5-7 days). If systemically unwell or not responding refer to ID. May be suitable for outpatient IV therapy (IVIM). Leucocillin (acetaminophen) + opioids (paracetamol) + anti-inflammatory (NSAID). Swabs taken and **infection assessment**.

**Diabetic foot**
mild: fluclaxacin 1g qd or doxycycline 1000mg bd. Moderate: fluclaxacin 1g qd + metronidazole 4000mg tds or doxycycline 1000mg tds + metronidazole 400mg tds. Refer to **guidance** for definitions, or if antibiotics for diabetic foot in previous month, or MRSA suspected. Localised lesions use topical fusidic acid (5 days) otherwise 1st **LINE** fluclaxacin 500mg qds 2nd **LINE** clarithromycin (500mg bd (7 days)

**Impetigo**
Prevent **antibiotic** if patient presents >3 hours after onset of rash: ofloxacin 500mg bd (5 days) + flucloxacillin 1g qd (7 days)

**Shingles**
See guidance in TAF. Must present within 72h of onset of rash: aciclovir 500mg 5 times daily + valaciclovir 1g tds (7 days)

**Bites**
See decision aid (in box to left).