PRIMARY CARE ADULT Empirical Treatment of Infection Guidance

NHS Tayside

When male and female are stated within this policy, it refers to sex assigned at birth

- STOP AND THINK BEFORE YOU PRESCRIBE ANTIBIOTICS DOES YOUR PATIENT ACTUALLY HAVE AN INFECTION AND REQUIRE TREATMENT?
- TO REDUCE EMERGENCE OF RESISTANCE AND *CLOSTRIDIUM DIFFICILE* 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 AND DOSES STATED ASSUME NORMAL RENAL AND HEPATIC FUNCTION
- FULL GUIDANCE IS AVAILABLE ON NHS TAYSIDE ANTIMICROBIAL WEBSITE, TAYSIDE AREA FORMULARY OR LINK ON STAFFNET HOME PAGE

CNS

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 transfer time is >1 hour. Benzylpenicillin (IV/IM) 1.2g or if known anaphylaxis Cefotaxime or Ceftriaxone 2g (IV/IM). Health Protection Team will deal with prophylaxis for contacts.

EYE

ORBITAL CELLULITIS Medical emergency – transfer to hospital immediately.

PERI-ORBITAL/PRE-SEPTAL CELLULITIS See guidance for treatment. If any concerns seek specialist opinion.

CONJUNCTIVITIS Treat only if severe, most cases are viral or self limiting. For further advice and treatment see Ophthalmology guidance

OPHTHALMIC SHINGLES Start treatment ideally within 72 hours but up to 7 days after rash onset. Refer to ophthalmology if there are clinical signs or symptoms of eye involvement. Aciclovir 800mg 5 times daily or valaciclovir 1g tds **(7 days)** + lubricating eye drops if lesions near eyelid.

DENTAL

ALL DENTAL — Refer to GDP. Dental abscess 1st LINE Penicillin V 500mg qds or Metronidazole 400mg tds **(5 days)** SDCEP guidance

ENT

TONSILLITIS/ PHARYNGITIS/ SORE THROAT Av. length illness 1 week. Most are viral. If ≥4 on FeverPAIN score, consider immediate antibiotic if severe, or 48hr back up prescription. In most cases antibiotics reduce duration of symptoms by <1 day.
1st LINE Penicillin V 1g bd or 500mg qds **(5 days)** 2nd LINE Clarithromycin 500mg bd (**5 days**, penicillin allergy only)

SINUSITIS Av. length illness 2.5 weeks. If ≤10 days symptoms there is no benefit from antibiotics unless clear evidence of systemic illness. If >10 days multiple or worsening symptoms consider back up antibiotic.
1st LINE Penicillin V 500mg qds or 1g bd **(5 days)** 2nd LINE Doxycycline 200mg day 1 then 100mg daily (**5 days** total)

EPIGLOTTITIS/ SUPRAGLOTTITIS Medical emergency – transfer to hospital immediately

OTITIS MEDIA Most cases will resolve without antibiotics and if used, they generally reduce symptom duration by <1 day. Consider antibiotics if otorrhoea present. 1st LINE Amoxicillin 500mg tds 2nd LINE Clarithromycin 500mg bd (**5 days**)

OTITIS EXTERNA Provide information on aural care. Mild – do not swab. Acetic acid 2% tds (EarCalm®) continuing for 2 days after resolution (max 7 days). Moderate – do not swab. Sofradex® or Otomize® tds. Consult ENT guidance for further options and management of severe cases.

ORAL CANDIDIASIS 1ST LINE Miconazole gel 2.5ml qds or Nystatin 1ml qds 2ND LINE Fluconazole 50mg daily (Immunocompromised 100mg od) **7 days**

RCGP 'leaflets to share with patients' resource:

Treating Your Infection - RTI

For patients with upper respiratory tract infections

LUNG

ACUTE EXACERBATION OF COPD Treat if ↑sputum purulence. If **no** ↑sputum purulence **no** antibiotics unless pneumonia or consolidation on CXR. 1st LINE Amoxicillin 500mg tds 2nd LINE Doxycycline 200mg day 1 then 100mg daily (**5 days**)

ACUTE COUGH/ACUTE BRONCHITIS 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 day 1 then 100mg daily (**5 days**)

ACUTE EXACERBATION OF BRONCHIECTASIS Refer to FULL GUIDANCE

COMMUNITY ACQUIRED PNEUMONIA Start antibiotics immediately. If no improvement or deterioration or bilateral signs discuss admission.

Assess CRB65 score (Confusion new MSQ ≤ 8/10, **R**esp rate ≥30/min, **B**P <90 systolic or ≤60 diastolic, **65** age ≥ 65 years)

0	Usually treat at home	Amoxicillin 1g tds or Doxycycline 200mg day 1 then 100mg daily (**5 days**)
1-2	Usually treat at home	Consider hospital referral (in particular if major co-morbidity)
3-4	Urgent hospital admission	Give Amoxicillin 1g oral or Benzylpenicillin 1.2g IV before transfer (withhold if known anaphylaxis)

HOSPITAL ACQUIRED OR ASPIRATION PNEUMONIA (NON SEVERE) Refer to guidance

RCGP 'leaflets to share with patients' resource:

Treating Your Infection - UTI

For women with un-complicated UTI or recurrent UTIs

GI

C. DIFFICILE INFECTION Refer to CDI guidance to assess severity. Vancomycin 125mg qds **10 days.** Metronidazole may be prescribed initially in community setting if delays in supply of oral vancomycin would result in delayed initiation of treatment.

RECURRENT CDI Refer to recurrent CDI guidance. Seek advice if required from tay.id@nhs.scot

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 **5 days** (or co-amoxiclav 625mg tds monotherapy if unable to take cotrimoxazole)

GU

UNCOMPLICATED FEMALE LOWER UTI Single symptom: self care advice ≥2 symptoms: dipstick for nitrites if feasible and <65 years
+ve & mild symptoms: self care advice or back up prescription
+ve & severe symptoms: 1ST LINE Nitrofurantoin 100mg MR bd 2nd LINE Trimethoprim 200mg bd **(3 days)**

RECURRENT UTI WOMEN (≥2/6month or ≥ 3/year) Consider other options before prophylaxis. See FULL GUIDANCE

PYELONEPHRITIS (MALE OR FEMALE) Send MSSU. Co-trimoxazole 960mg bd or Co-amoxiclav 625mg tds **(7 days)**

LOWER UTI IN CKD See FULL GUIDANCE

UNCATHETERISED MALE UTI Send MSSU. 1st LINE Nitrofurantoin MR 100mg bd 2nd LINE Trimethoprim 200mg bd **(7 days)**
Refer to FULL GUIDANCE for recurrent male UTI

UTI IN OLDER ADULTS **DO NOT USE URINALYSIS. DO NOT TREAT UNLESS CLINICAL SIGNS/SYMPTOMS OF INFECTION.** SEE DECISION AID.

CATHETERISED 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 tds **(7 days).** Change catheter as soon as possible.

Refer to update on quinolone warnings

PROSTATITIS Ofloxacin 200mg bd or Ciprofloxacin 500mg bd. If high risk CDI: Trimethoprim 200mg bd **(28 days)**

Respiratory and renal cautions for nitro-furantoin use

EPIDIDYMO-ORCHITIS See FULL GUIDANCE for essential tests and treatment options

UNCOMPLICATED CHLAMYDIA Doxycycline 100mg bd **(7 days).** If intolerant: Azithromycin 1g od day 1 then 500mg od for 2 days

PELVIC INFLAMMATORY DISEASE See FULL GUIDANCE for essential tests and treatment options

BACTERIAL VAGINOSIS Do not routinely send swabs. Metronidazole 400mg bd (**5 days**) or 2g single dose

VULVOVAGINAL CANDIDIASIS Do not routinely send swabs. Fluconazole 150mg single dose or Clotrimazole 500mg pessary single dose

SKIN

CELLULITIS Flucloxacillin 1g qds or Doxycycline 100mg bd **(5 days)** If systemically unwell or not responding refer to ID: may be suitable for outpatient IV therapy (OHPAT). Consider swabbing for Panton-Valentine Leucocidin if recurrent boils or abscesses. If history or risk of MRSA Doxycycline 100mg bd See FULL GUIDANCE

FACIAL CELLULITIS ***sinus/dental/mandibular source:*** Co-amoxiclav 625mg tds (7 days) SEE FULL GUIDANCE for pen allergy ***cutaneous:*** treat as per cellulitis

FUNGAL SKIN INFECTION See FULL GUIDANCE

FUNGAL NAIL INFECTION **Confirm with nail clippings pre-treatment.** See FULL GUIDANCE

DIABETIC FOOT **Mild:** Flucloxacillin 1g qds or Doxycycline 100mg bd. **Moderate:** Flucloxacillin1g qds + Metronidazole 400mg tds or Doxycycline 100mg bd + Metronidazole 400mg tds. Refer to guidance for definitions, antibiotics for diabetic foot in previous month, or MRSA suspected.

CHRONIC WOUNDS/ULCERS See FULL GUIDANCE for assessment and advice on when appropriate to swab

IMPETIGO Localised lesions: topical hydrogen peroxide 1% cream or fusidic acid 2% cream tds (**5 days**)
If more widespread lesions: 1st LINE Flucloxacillin 500mg qds 2nd LINE Clarithromycin 500mg bd (**5 days**)

CHICKENPOX Consider antiviral if patient presents within 24 hours of onset of rash or immunocompromised: Aciclovir 800mg 5 times daily **(7 days)**

SHINGLES See guidance. Must present within 72 hours of onset of rash: Aciclovir 800mg 5 times daily or Valaciclovir 1g tds **(7 days)**

BITES **DOG/CAT/HUMAN:** See assessment table 1ST LINE Co-amoxiclav 625mg tds 2ND LINE metronidazole 400mg tds + doxycycline 100mg bd
(SEE NOTE IN BOX TO LEFT) **PROPHYLAXIS FOR UNINFECTED BITE: 3 days** **TREATMENT FOR INFECTED BITE: 5 days**
INSECT: Treat as cellulitis if necessary See Lyme Disease guidance for tick bites **OTHER BITES:** Seek ID/Micro advice

FOR ALL DOG/CAT/ HUMAN BITES:

REASSESS PATIENTS IF DEVELOPS INFECTION OR DOES NOT IMPROVE WITHIN 24-48 HOURS