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 tonsillotectomy.

Unable to swallow: Benzylpenicillin IV 1.2g qds (penicillin allergy: clarithromycin IV 500mg bd)

Able to swallow: Penicillin V PO 500mg 4 times daily or 1g bd. Duration: 5 days (penicillin allergy: clarithromycin 500mg bd)

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 from drainage for culture. If no improvement seek microbiology advice.

Post Tonsillotectomy 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 concern 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 >48 hours = Fluocinolone PO 1g qds = STOP when packing removed

Otitis Media: Acute (AOM)

Provide patient information in all cases.

Mild: do not swab. Acetic Acid 2% (Earcalsm®) for 7 days, treat as moderate if no improvement after 3 days.

Moderate: do not swab. Otomycin® 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. 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.

For ENT specialist use or recommendation only : consider use of amoxicillin once or twice daily in paediatric cases.

Otitis Externa

Provide patient information in all cases. Mild: do not swab, Acetic Acid 2% (Earcalsm®) for 7 days, treat as moderate if no improvement after 3 days.

Moderate: do not swab, Otomycin® 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. 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

Dental / Mandibular / Sinus source: PO Co-amoxiclav 625mg tds or Clindamycin* (7 days)

Oro-antral / Pre-septal Cellulitis: Co-amoxiclav PO 625mg tds or IV 1.2g tds (pencillin 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 pencillin 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 CHAP team if suitable for outpatient IV antibiotic therapy.

Tracheostomy Halitosis

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.

Developed by: ENT/Microbiology/Pharmacy Approved by: Antimicrobial Management Group June 2018 Review: June 2021