

GENERAL POINTS

- This guidance applies to non pregnant ADULT patients ONLY
- **For pregnant patients refer to [Pregnancy and Postnatal Antibiotic Guidance](#)**
- STOP and think before you prescribe antibiotics. Does your patient actually have an infection that requires treatment?
- Normal renal and hepatic function assumed – adjust doses if necessary
- For all other infections refer to [Hospital Antibiotic Adult](#) or [Primary Care Antibiotic Adult](#) or [Antibiotic Website](#)
- Refer to [MicroGuidance](#) for 'Antibiotic Rules of Thumb' and basic microbiology information on common infections

PELVIC INFLAMMATORY DISEASE

For full guidance, referral criteria, inpatients and pregnant patients refer to separate [guidance](#) document
 Outpatient treatment: ensure appropriate investigations are sent including self or clinician taken vulvovaginal swab for chlamydia and gonorrhoea tests.
High risk of gonorrhoea or <18 years – refer to Sexual Health for IM ceftriaxone 1g IM single dose then doxycycline 100mg bd + metronidazole 400mg bd (14 days)
Low risk of gonorrhoea - ofloxacin 400mg bd + metronidazole 400mg bd (14days)

BARTHOLIN'S CYST

Analgesia + conservative management i.e. hot baths or compresses for 10-20 mins 3 to 4 times daily to encourage abscess to discharge

LABIAL ABSCESS/ BARTHOLIN'S GLAND ABSCESS

Surgical intervention is mainstay of treatment.
 Antibiotic treatment is NOT REQUIRED where there is no surrounding cellulitis.
 In cases with surrounding cellulitis only:
 1st line co-trimoxazole 960mg bd + metronidazole 400mg tds (5 days)
 2nd line co-amoxiclav 625mg tds (5 days)

POST-OP WOUND INFECTION

Postnatal infection – refer to [separate guidance](#)
 Superficial – refer to [cellulitis guidance](#)
 Suspected intra-abdominal source (no peritoneal soiling or with peritoneal soiling i.e. GI perforation)
 1st line co-trimoxazole 960mg bd + metronidazole 400mg tds (5 - 7days then review)
 2nd line co-amoxiclav 625mg tds (5-7 days then review)
 Adjust according to swab results if necessary

PELVIC ABSCESS

Source control with drainage is key to management. Treat as per PID initially and discuss antimicrobial therapy with Microbiology or ID.

ENDOMETRITIS

1st line co-trimoxazole 960mg bd + metronidazole 400mg tds (7 days) 2nd line co-amoxiclav 625mg tds (7 days)
 If uterine tenderness or signs of sepsis refer to hospital urgently for IV therapy (as per IA infection below)

INTRA-ABDOMINAL INFECTION

Refer to [HOSPITAL ANTIBIOTIC ADULT](#)

SEVERE SYSTEMIC INFECTION UNKNOWN SOURCE

Refer to [HOSPITAL ANTIBIOTIC ADULT](#)

URINARY TRACT INFECTIONS

Refer to [FULL GUIDANCE](#)

STIs

CHLAMYDIA/ GONORRHOEA/ TRICHOMONIASIS/ BACTERIAL VAGINOSIS/ SYPHILIS/ GENITAL HERPES/ GENITAL WARTS –
[REFER TO SEXUAL HEALTH GUIDANCE](#)

VULVOVAGINAL CANDIDIASIS

Fluconazole 150mg as a single dose OR Clotrimazole 500mg pessary single dose
 Add clotrimazole 1% cream 2-3 times daily for symptom relief
Severe VVC (extensive erythema/oedema): Fluconazole 150mg on day 1 & day 4 OR Clotrimazole 500mg pessary on day 1 & day 4. Add clotrimazole 1% cream 2-3 times daily for symptom relief
Recurrent: >4 episodes/year with at least 2 confirmed by HVS. Send HVS marked "recurrent thrush" to microbiology. Exclude predisposing factors including HIV test. If confirmed candida: Fluconazole 150mg every 72 hours for 3 doses then weekly for 6 months. Consider referral to Sexual Health if need advice on further management.
Complex VVC Specialist Treatments: guidance under development – seek advice from Sexual Health Team

RETAINED TAMPON

Refer to [FULL GUIDANCE](#)

ADVICE:

Infectious Diseases: tay.id@nhs.scot or bleep 5075

Antimicrobial Pharmacists: tay.antibioticpharm@nhs.scot or bleep 4732

Microbiology: bleep 4039

Sexual Health Team: tay.tsrh@nhs.scot