

- **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**
- **LIMIT PRESCRIBING OVER THE TELEPHONE TO EXCEPTIONAL CIRCUMSTANCES**
- CONSIDER A 'NO PRESCRIBING' OR 'DELAYED PRESCRIBING' STRATEGY FOR UPPER RESPIRATORY TRACT INFECTIONS
- NORMAL RENAL AND HEPATIC FUNCTION IS ASSUMED UNLESS OTHERWISE STATED
- FULL GUIDANCE IS AVAILABLE IN TAYSIDE AREA FORMULARY SECTION 5 (www.nhstaysideadtc.scot.nhs.uk or [LINK ON STAFFNET HOME PAGE](#))

CNS

MENINGITIS Transfer all patients to hospital immediately and **only if time permits** give dose of benzylpenicillin (IV/IM) 1.2g or chloramphenicol (IV) 1g. Health Protection Team will deal with prophylaxis for family and contacts.

EYE

ORBITAL CELLULITIS Medical emergency – transfer to hospital immediately.
CONJUNCTIVITIS Usually self-limiting. If necessary use chloramphenicol eye drops 2 hourly for 2 days reducing to 4 times daily plus ointment at night or ointment alone 3-4 times daily. Continue for 48 hours after resolution.
OPHTHALMIC SHINGLES Refer to Ophthalmology- aciclovir 800mg 5 times daily or valaciclovir 1g tds (7 days) +aciclovir eye ointment

DENTAL Refer to GDP

DENTAL ABSCESS amoxicillin 500mg tds (5 days). Add metronidazole 200mg tds (5 days) if spreading infection or pyrexia
PERICORONITIS 1st LINE metronidazole 200mg tds (3 days) 2nd LINE amoxicillin 500mg tds (3 days)
ULCERATIVE GINGIVITIS metronidazole 200mg tds (3 days)

ENT

TONSILLITIS/ PHARYNGITIS/ SORE THROAT Av. length illness 1 week. Most are viral. If 3 or 4 Centor criteria present (fever, purulent tonsils, cervical lymphadenopathy, **no** cough) or history of otitis media then antibiotics may be of more benefit. In most cases antibiotics reduce duration of symptoms by <1 day. 1st LINE penicillin V 1g bd or 500mg qds (10 days) 2nd LINE clarithromycin 500mg bd (5 days, for true penicillin allergy only)
SINUSITIS Av. length illness 2.5 weeks. Reserve antibiotics for severe/deteriorating cases of >7-10 days duration. 1st LINE penicillin V 500mg qds or 1g bd (7 days) 2nd LINE doxycycline 200mg day 1 then 100mg daily (7 days)
EPIGLOTTITIS Medical emergency – transfer to hospital immediately
OTITIS MEDIA 80% resolve in 4 days without antibiotics. 1st LINE amoxicillin 500mg tds 2nd LINE clarithromycin 500mg bd (5 days)
OTITIS EXTERNA Topical aural toilet. Swab reserved for unresponsive cases then treat depending on culture results.
ORAL THRUSH 1st LINE nystatin liquid 1ml qds (7 days or 48h after resolution) 2nd LINE fluconazole 50mg daily (7 days)

LUNG

COMMUNITY ACQUIRED PNEUMONIA Start antibiotics immediately. If no improvement or deterioration consider admission.
Assess CRB65 score (Confusion new MSQ ≤ 8/10, Resp rate ≥30/min, BP <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 (7 days)
1 Usually treat at home Consider hospital referral if major co morbidity
2 Consider hospital referral
3-4 Urgent hospital admission Give amoxicillin 1g oral or benzylpenicillin 1.2g IV before transfer (IV chloramphenicol 1g if allergy)
Bilateral signs of pneumonia Refer to hospital regardless of CRB65 score
ACUTE EXACERBATION OF COPD Treat if ↑sputum purulence. If **no** ↑sputum purulence then **no** antibiotics unless consolidation on CXR or signs of pneumonia. 1st LINE amoxicillin 500mg tds 2nd LINE doxycycline 200mg on day 1 then 100mg daily (5 days)
ACUTE COUGH/ACUTE BRONCHITIS Av. length of illness is 3 weeks. Most are viral and antibiotics in healthy adults may reduce symptoms by < 1 day. More benefit if >65 years. 1st LINE amoxicillin 500mg tds 2nd LINE doxycycline 200mg on day 1 then 100mg daily (5 days)

GI

CLOSTRIDIUM DIFFICILE INFECTION (Refer to CD [guidance](#) in TAF section 5) Stop other antibiotics if possible or use lower risk antibiotic, stop PPIs, laxatives, and anti-motility medicines. If CDI proven and can be managed in the community use metronidazole 400mg tds (10-14 days) Otherwise admit to hospital.
RECURRENT CDI Refer to recurrent CDI [guidance](#) in TAF. Seek advice if required from Tay-UHB.id@nhs.net
ACUTE GASTROENTERITIS No antibiotic treatment required unless patient systemically unwell or post antibiotic, suggesting 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

GU

PRIMARY CARE GUIDANCE FOR MANAGING UTI IN RENAL IMPAIRMENT IS AVAILABLE IN [TAF](#).
CATHETERISED PATIENTS **DO NOT TREAT UNLESS CLINICAL SIGNS/SYMPTOMS OF INFECTION.** Antibiotics do not eradicate bacteriuria. Antibiotic prophylaxis for UTI if catheter in situ is **not recommended**. If new costo-vertebral tenderness or rigors or new onset delirium or fever >37.9 twice in 12h then co-amoxiclav 625mg tds or co-trimoxazole 960mg bd (7 days). Change catheter prior to antibiotics if possible.
UNCOMPLICATED FEMALE LOWER UTI Use trimethoprim 200mg bd OR nitrofurantoin 50mg qds or 100mg MR bd (3 days)
PYELONEPHRITIS Send MSSU - co-amoxiclav 625mg tds or co-trimoxazole 960mg bd (14 days)
UNCATHETERISED MALE UTI Send MSSU - trimethoprim 200mg bd or nitrofurantoin MR 100mg bd or 50mg qds for 7 days. Seek advice if recurrence.
UTI IN PREGNANCY 1st or 2nd trimester nitrofurantoin MR 100mg bd or 50mg qds 3rd trimester trimethoprim 200mg bd (off label). 2nd LINE (any trimester) cefalexin 500mg tds. Treat for 7 days and sample for test of cure.
RECURRENT UTI WOMEN (≥2/month or ≥ 3/year) trimethoprim 100mg or nitrofurantoin 50-100mg (post coital or nightly dose review after 6-12 months as long term antibiotics promote resistance). Avoid if long term catheter in situ. For advice on cranberry extract see [TAF](#).
PROSTATITIS ofloxacin 400mg od or ciprofloxacin 500mg bd, if high risk CDI trimethoprim 200mg bd (all 28 days)
EPIDIDYMO-ORCHITIS If low likelihood of STI ofloxacin 200mg bd or ciprofloxacin 500mg bd (14 days).
CHLAMYDIA azithromycin 1g stat or doxycycline 100mg bd (7 days or 10-14 days if epididymo-orchitis symptoms)
PELVIC INFLAMMATORY DISEASE metronidazole 400mg bd + ofloxacin 400mg bd (14 days)
TRICHOMONIASIS/BACTERIAL VAGINOSIS metronidazole 400mg bd (7 days) or 2g stat

SKIN

CELLULITIS flucloxacillin 1g qds or doxycycline 100mg bd (7-14 days) If systemically unwell or not responding refer to Infectious Diseases Unit. May be suitable for outpatient IV therapy (OHPAT). Consider swabbing for Panton-Valentine Leucocidin if recurrent boils or abscesses. If swab taken add 'PVL' on clinical details.
ATHLETES FOOT If history or risk of MRSA 1st LINE doxycycline 100mg bd 2nd LINE trimethoprim 200mg bd + rifampicin 300mg bd (7-14 days)
DERMATOPHYTE NAIL INFECTION Topical 1% terbinafine od-bd for 7 days.
DIABETIC FOOT Confirm with nail clippings pre-treatment terbinafine 250mg od for 6-12weeks (fingers) 3-6 months (toes)
IMPETIGO 1st LINE flucloxacillin 1g qds for mild or moderate disease. 2nd LINE doxycycline 100mg bd (7 days) for mild disease or co-trimoxazole 960mg bd for moderate disease. Consider addition of metronidazole 400mg tds if anaerobes suspected.
CHICKENPOX Localised lesions topical fusidic acid otherwise 1st LINE flucloxacillin 500mg qds 2nd LINE clarithromycin 500mg bd (7 days)
SHINGLES Prescribe antiviral if patient presents <24 hours of onset of rash, aciclovir 800mg 5 times daily (7 days)
BITES See full guidance in TAF. Must present within 72 hours of onset of rash, aciclovir as above or valaciclovir 1g tds
1ST LINE co-amoxiclav 625mg tds 2ND LINE metronidazole 400mg tds + doxycycline 100mg bd (7 days)