Southampton, Hampshire, Isle of Wight & Portsmouth along with Surrey Heath & Berkshire East Guidelines for **Antibiotic Prescribing** in the Community **2014**

Adapted from the Public Health England (PHE) and British Infection Association Management of Infection Guidance for Primary Care by the Wessex Pharmacists Antibacterial Group
Foreword

These guidelines are intended to provide advice on the effective and safe treatment of infections commonly presenting in primary care (doses are for adults unless otherwise stated) in mainly Hampshire and the Isle of Wight, but also Surrey Heath and some of Berkshire East. The guidelines also promote the use of narrow-spectrum antibiotics in preference to broad-spectrum antibiotics where safe and appropriate. The audience of users is anticipated to be general practitioners, GP trainees, GP practice nurses, non-medical prescribers, paramedics, hospital emergency department staff and community pharmacists.

The multi-disciplinary guideline development group consisted of general practitioners, hospital consultant medical microbiologists, a consultant in HIV / genito-urinary medicine, podiatry, specialist hospital microbiology / infectious diseases pharmacists, primary care trust, hospital trust, community trust and ambulance trust pharmacists (see below).

The guidelines have been updated from the previous version, published in 2012, taking into consideration feedback from users, emerging evidence and changing epidemiology of antimicrobial resistance. The guidelines are based largely on the Management of Infection Guidance for Primary Care, published jointly by the Health Protection Agency and the British Infection Association, updated in February 2013, and the guideline development group gratefully acknowledges the work of Dr Cliodna McNulty and her colleagues in the PHE and BIA.

Recommendations for when antimicrobial treatment is indicated, based upon cited national or international evidence-based guidelines, have been expanded from the PHE/BIA Guidance, along with recommendations and practical advice for taking specimens for microbiological investigations and interpreting culture and sensitivity laboratory reports. Clinically relevant information on cautions and warnings associated with antimicrobial treatment has also been expanded from the PHE/BIA Guidance including information about risk of Clostridium difficile infection. All statements are fully referenced.

This updated version of the guidelines has been developed in 2014 and the next update will be scheduled for review in November 2016.

Comments and feedback are welcome; please e-mail ruth.ellenby@nhs.net.

Reference
Guideline Development Group

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Aims
- to provide a simple, empirical approach to the treatment of common infections
- to promote the safe, effective and economic use of antibiotics
- to minimise the emergence of bacterial resistance in the community

Principles of Treatment (PHE/BIA)
1. This guidance is based on the best available evidence, as referenced, but professional judgement should be used and patients should be involved in the decision.
2. A dose and duration of treatment for adults is usually suggested, but may need modification for age, weight and renal function. In severe or recurrent cases consider a larger dose or longer course.
3. Lower threshold for antibiotics in immunocompromised or those with multiple morbidities; consider culture and seek advice.
4. Prescribe an antibiotic only when there is likely to be a clear clinical benefit.
5. Consider a no, or delayed, antibiotic strategy for acute self-limiting upper respiratory tract infections.$^A$
6. Limit prescribing over the telephone to exceptional cases.
7. Use simple generic antibiotics if possible. Avoid broad spectrum antibiotics (eg co-amoxiclav, quinolones and cephalosporins) when narrow spectrum antibiotics remain effective, as they increase risk of Clostridium difficile, MRSA and resistant UTIs.
8. Avoid widespread use of topical antibiotics (especially those agents also available as systemic preparations, e.g. fusidic acid).
9. In pregnancy AVOID tetracyclines, aminoglycosides, quinolones, high dose metronidazole (2g). Short-term use of nitrofurantoin (at term, theoretical risk of neonatal haemolysis) is unlikely to cause problems to the foetus. Trimethoprim also unlikely to cause problems unless poor dietary folate intake or taking another folate antagonist such as antiepileptic.
10. We recommend clarithromycin as it has less side-effects than erythromycin, greater compliance as twice rather than four times daily & generic tablets are similar cost. The syrup formulation of clarithromycin is only slightly more expensive than erythromycin and could also be considered for children.
11. Where a ‘best guess’ therapy has failed or special circumstances exist, microbiological advice can be obtained from your local hospital microbiology department.
Risk assessment

<table>
<thead>
<tr>
<th>Risk of <em>Clostridium difficile</em> infection</th>
<th>Risk of antibiotic treatment failure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient</strong></td>
<td>History of infection with resistant microorganism. Recent antibiotic exposure. Immunocompromised.</td>
</tr>
<tr>
<td>Older patients (over 65yr) &amp; antibiotic exposure within previous 2 months</td>
<td></td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td>Infection acquired in healthcare environment</td>
</tr>
<tr>
<td>Contact with patients with <em>Clostridium difficile</em> or recent hospital admission</td>
<td></td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>Consider second-line antibiotics from the following tables</td>
</tr>
<tr>
<td>Withhold antibiotics if safe to do so (watchful waiting). Avoid high risk antibiotics (the 4 Cs):</td>
<td></td>
</tr>
<tr>
<td>• Cephalosporins</td>
<td></td>
</tr>
<tr>
<td>• Ciprofloxacin &amp; quinolones</td>
<td></td>
</tr>
<tr>
<td>• Co-amoxiclav</td>
<td></td>
</tr>
<tr>
<td>• Clindamycin</td>
<td></td>
</tr>
<tr>
<td>(indicated by an asterisk in the following tables)</td>
<td></td>
</tr>
</tbody>
</table>

Evidence Grading

<table>
<thead>
<tr>
<th>Study design</th>
<th>Recommendation grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good recent systematic review of studies</td>
<td>A+</td>
</tr>
<tr>
<td>One or more rigorous studies, not combined</td>
<td>A</td>
</tr>
<tr>
<td>One or more prospective studies</td>
<td>B+</td>
</tr>
<tr>
<td>One or more retrospective studies</td>
<td>B-</td>
</tr>
<tr>
<td>Formal combination of expert opinion</td>
<td>C</td>
</tr>
<tr>
<td>Informal opinion, other information</td>
<td>D</td>
</tr>
</tbody>
</table>
General Practice Sepsis Screening and Action Tool (from THE UK SEPSIS TRUST)

Sepsis is a time critical condition. Screening, early intervention and immediate treatment saves lives. This tool should be applied to all adult patients who are not pregnant who have a suspected infection or their clinical observations are outside of normal limit.

Patient groups to consider screening: those in whom you are considering antibiotic prescription or stewardship discussion, patients with “Flu”, patients with gastroenteritis and the unwell patient without clear cause.

1. Might this be more than a self-limiting infection?
   - Symptoms of infection (e.g. a recent history of fever)
   - Acute deterioration
   - Unexplained illness, especially in immunosuppressed or elderly people

   **Sepsis is unlikely.** Continue usual care.

2. Perform a full set of observations. Are any 2 of the following present?
   - Temperature > 38.3°C or < 36°C
   - Respiratory rate > 20 per minute
   - Heart rate > 90 per minute
   - Acute confusion, disorientation, reduced conscious level
   - Consider blood glucose: > 7.7 relevant in non-diabetics

   **Sepsis may be present**
   Evaluate whether acute referral / admission required, especially if:
   - already on antibiotics
   - partially treated
   - no clear source of infection
   If treating in the community, consider:
   - planned second assessment
   - brief written handover documenting observations
   - specific safety net advice

3. Is any red flag present?
   - Systolic B.P < 90 mmHg
   - Heart rate > 130 per minute
   - Respiratory rate > 25 per minute
   - Oxygen saturations < 91% (may be appropriate to accept SpO2 < 91% in patients with known COPD)
   - Responds only to voice or pain/ unresponsive
   - Purpuric rash

   **Red Flag Sepsis**
   This is a time critical condition, immediate action is required.
   - Dial 999
   - Arrange blue light transfer
   - Write a brief clear handover including observations and antibiotic allergies where present.
   - Administer oxygen and other appropriate immediate care as available
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# Ear Nose and Throat Infections – Acute Sore Throat

## When to treat
Avoid antibiotics as 90% resolve in 7 days without, and pain only reduced by 16 hours.\(^{1A+}\)

See attached sore throat clinical scoring system (FeverPain)

If Fever Score 0 or 1: **do not offer antibiotics**

If Fever score 2 or 3: **consider 2 or 3 day delayed antibiotics.** \(^{1A+}\)

If Fever Score 4 or more: **offer immediate antibiotics**

Average total length of illness is one week.\(^2\) Antibiotics to prevent quinsy NNT >4000.\(^{B-1,2}\) Antibiotics to prevent otitis media NNT 200.\(^{1,2A+}\)

## When to investigate
Throat swabs or rapid antigen tests should not be carried out routinely in the investigation of acute sore throat.\(^2,3\) Suspect glandular fever in a person with a sore throat that fails to improve, or becomes worse, after several days.\(^3\)

## Treatment choices
**First line:**

- Phenoxymethylpenicillin\(^B\) 500mg qds **OR** 1g bd\(^A+\) for 10 days\(^A-\)
  - (1g qds when severe\(^D\))

**If allergic to penicillin:**

- Clarithromycin 250-500mg bd for 5 days\(^A+\)

## Cautions
Prescribing amoxicillin or ampicillin will produce a generalized, itchy maculopapular rash in over 90% of people with glandular fever.\(^3\)

## Evidence
- A recent (2009) meta-analysis shows short-course (including 5 days clarithromycin) broad-spectrum antibiotics are as efficacious as 10-day penicillin for sore throat symptom treatment and GABHS eradication. A 10-day course of phenoxymethylpenicillin remains the treatment of choice. Evidence suggests the use of broader spectrum antibiotics will drive the emergence of bacterial resistance; increases the risk of developing Clostridium difficile associated disease; and is associated with more adverse drug reactions. 5-days clarithromycin should be reserved for those with true penicillin allergy.\(^1\)
- Glomerulonephritis is a rare condition, (2.1 per 100,000 children per year) and treating acute sore throat with antibiotics doesn’t prevent it occurring.\(^1\)
- A retrospective study confirmed the low incidence of Rheumatic Fever in the UK, (0.6 per 100,000 children per year). The risk of developing Rheumatic Fever was not reduced in this study by treating sore throats with antibiotics.\(^1\)

## References
### Sore Throat Clinical Scoring System (FeverPAIN) to predict streptococcal infection

#### Inclusion criteria: patients aged 3 years and over presenting to English primary care clinicians with an acute (<2 weeks) sore throat.

Note: average total length of illness is 1 week.

**FeverPAIN** – one point each for:
- Fever during the last 24 hours
- Pus on tonsils
- Attend rapidly (short prior illness duration of 3 days or less)
- Inflamed (severely) tonsils
- No cough or coryza (‘runny nose’)

**Suggested actions:**
- **Score 0-1:** do not offer antibiotics (<20% streptococci Lancefield Groups A, C, G)
- **Score 2-3:** delayed prescription (39% streptococci)
- **Score 4 or more:** offer immediate antibiotics (63% streptococci)

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a Approximate one third of patients in the original study population had a FeverPAIN score of \( \leq 1 \).

b A prescription was prepared and left in reception, with advice to the patient to collect the prescription after 3-5 days if symptoms were not starting to settle or were getting considerably worse.

This **strategy is expected to reduce antibiotic use in this setting by 29%**.

#### Reference List

### Ear Nose and Throat Infections – Acute Otitis Media (AOM)

#### When to treat

**Optimise analgesia and target antibiotics.**

AOM resolves in 60% within 24h without antibiotics, which only reduce pain at 2 days (NNT15) and do not prevent deafness. Consider 2 or 3-day delayed antibiotic prescription. Consider offering immediate antibiotics for pain relief if:

- **<2 years** AND bilateral AOM (NNT4) or bulging membrane & ≥ 4 marked symptoms
- **All ages** with otorrhoea (discharge in the ear canal) NNT3

Antibiotics to prevent mastoiditis NNT >4000

#### When to investigate

Routine follow up is not required in the absence of persistent symptoms.

#### General advice

Average total length of illness is 4 days.

Use **either** paracetamol or ibuprofen in children with fever who appear distressed. Continue only as long as distress is apparent.

#### Treatment choices (child doses)

<table>
<thead>
<tr>
<th>First-line: <strong>Amoxicillin</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>13.5mg/kg tds (max 500mg tds) for 5 days</td>
</tr>
<tr>
<td>5-10kg: 62.5mg tds</td>
</tr>
<tr>
<td>10-19kg: 125mg tds</td>
</tr>
<tr>
<td>20-39kg: 250mg tds</td>
</tr>
<tr>
<td>≥40 kg: 500mg tds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If allergic to penicillin: <strong>Clarithromycin</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 8kg: 7.5mg/kg bd</td>
</tr>
<tr>
<td>8-11kg: 62.5mg bd</td>
</tr>
<tr>
<td>12-19kg: 125mg bd</td>
</tr>
<tr>
<td>20-29kg: 187.5mg bd</td>
</tr>
<tr>
<td>≥30kg: 250mg bd</td>
</tr>
<tr>
<td>12-18 years: 250mg bd</td>
</tr>
</tbody>
</table>

#### Cautions

**Admission or immediate referral if:** suspected acute complications of (AOM), such as meningitis, mastoiditis, or facial paralysis. Consider admitting children **< 3 months of age with a temperature of 38°C or more, and children 3–6 months of age with a temperature of 39°C or more.**

**Elective referral if:** Persistent effusion or discharge, perforation not healed after 6 weeks, 4 or more episodes in 6 months or impaired hearing after 3 to 6 months. **Note:** children with serious craniofacial abnormalities or immune deficiencies that are not responding to primary care management are at high risk of developing head and neck complications.

#### Evidence

Amoxicillin is as effective as other antibiotics in the treatment of AOM in RCTs. Macrolides concentrate intracellularly and so are less active than penicillin against the extracellular H influenzae. No advantage in using an antibiotic to cover beta-lactamase resistant organisms (e.g. co-amoxiclav) in the initial treatment of AOM. This should be reserved for persistent acute otitis media.

#### References

5. BNF for children, May 2014
# Ear Nose and Throat Infections – Acute Otitis Externa

## When to treat

- Assess whether diffuse inflammation or localized i.e. furuncle or boil.
- Mild diffuse otitis often responds to acetic acid spray, and keeping water out of the ear.
- If more severe or persistent, use a topical antibiotic with or without corticosteroid.
- Aural toilet or a wick may be required for the drops to be effective, which may mean referral.
- Localized otitis externa may respond to analgesia and application of a warm flannel, but consider oral antibiotics where there is reduced immunity eg diabetes, signs of spreading cellulitis, or if the patient is unwell.

## When to investigate

If the treatment strategy fails, consider taking an ear swab for bacterial and fungal microscopy and culture. A swab is best taken from the medial aspect of the ear canal to reduce contamination.

## How to respond to a positive lab report

Reported bacterial susceptibility may not correlate with clinical outcomes because sensitivities are determined for systemic (not topical) administration. Also, higher concentrations of antibiotic can be achieved with topical application. It is not possible to tell from the culture results whether the isolated organisms are causing the disease or are merely contaminants and there is also likely to be a fungal overgrowth after using antibacterial drops.

## Treatment choices

<table>
<thead>
<tr>
<th>First-line: ear drops / spray</th>
<th>Second-line: ear drops / spray</th>
<th>Oral antibiotics are rarely indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetic acid (EarCalm spray®)</td>
<td>Neomycin + steroid</td>
<td>Fluoxacillin 500mg qds for 7 days</td>
</tr>
<tr>
<td>2% one spray tds for 7 days</td>
<td>three drops tds for 7-14 days</td>
<td>If allergic to penicillin: Clarithromycin 500mg bd for 7 days</td>
</tr>
</tbody>
</table>

## Cautions

Adverse effects to consider include aminoglycoside-induced ototoxicity in people with a perforated tympanic membrane, aminoglycoside-induced skin sensitization, and fungal superinfection (particularly with longer treatments).

## Evidence

Acetic acid was as effective and comparable to antibiotic/steroid for the first 7 days, but inferior after this point. It is important to instruct patients to use drops for at least one week, and to continue for up to 14 days if symptoms persist. The oral antibiotics in the trials were often inactive against *P. aeruginosa* (incidence 36%) and *S. aureus* (incidence 21%). Topical antibiotics such as neomycin have a broader spectrum of activity. When using topical antibiotics in the ear bacterial resistance is less of a concern as the high local concentration of the drug will generally eradicate all susceptible organisms, plus those with marginal resistance.

## References

# Ear Nose and Throat Infections – Acute Rhinosinusitis

## When to treat
Avoid antibiotics as 80% resolve in 14 days without, and they only offer marginal benefit after 7 days (NNT15).\(^1\)\(^2\)\(^A\)\(^+\)

NICE estimates that the average duration of acute sinusitis is 2.5 weeks.\(^2\) A systematic review analysed the placebo arms of several randomized controlled trials (RCTs), and found that, after 7–15 days, 73% of people taking placebos experienced some improvement in their symptoms, and 30% had complete recovery.\(^3\)

Use adequate analgesia.\(^1\)\(^2\)\(^B\)\(^+\) Consider 7-day delayed or immediate antibiotic when purulent nasal discharge (NNT8).\(^1\)\(^A\)\(^+\)

Consider an immediate antibiotic prescription\(^3\) only if it is not appropriate to admit the person and they are:
- Systemically unwell, or at high risk of complications because of a pre-existing comorbidity.
- Recommending measures to relieve symptoms, such as analgesia for pain or fever, an intranasal decongestant, irrigation of the nose with normal saline solution, application of warm face packs, drinking adequate fluids, and rest.

## When to investigate
Investigations are not required in primary care because nasal swabs for culture have a poor diagnostic yield and are frequently contaminated (or bacteria found are commensal).\(^3\) Acute sinusitis usually follows a common cold, and is defined as an increase in symptoms after 5 days, or persistence of symptoms beyond 10 days, but less than 12 weeks.

## Treatment choices\(^1\)
### First-line:
- Amoxicillin\(^1\)\(^A\)\(^+\): 500mg (1g if severe\(^1\)\(^D\)) tds for 7 days\(^1\)\(^A\)\(^+\) **OR**
- Doxycycline\(^1\): 200mg stat then 100mg od for 7 days (200mg daily for severe infections\(^3\)).

Some hospital specialists may prescribe high-dose doxycycline 200mg bd for 2 days then 200mg od for 4 days.\(^D\)

### If allergic to penicillin:
- Doxycycline\(^1\): 200mg stat, 100mg od for 7 days\(^1\)\(^A\)\(^+\) (200mg daily for severe infections\(^3\)).

### Second line:
In persistent infection use an agent with anti-anaerobic activity such as Co-amoxiclav\(^1\)* 625mg tds for 7 days\(^1\)\(^A\)\(^+\).

## Cautions\(^3\)
Admit to hospital if there is severe systemic infection, or if a complication of sinusitis is suspected.\(^3\) Suspect intra-orbital involvement if there is periorbital oedema, a displaced globe, double vision, ophthalmoplegia, or reduced visual acuity. Suspect intracranial involvement if there is a severe frontal headache, frontal swelling, symptoms or signs of meningitis, or focal neurological signs.\(^3\)

Consider urgent referral to an Ear, Nose, and Throat (ENT) department if the person is suspected of having a sinonasal tumour (persistent unilateral symptoms, such as bloodstained discharge, crusting, non-tender facial pain, facial swelling, or unilateral nasal polyps).\(^3\) Consider routine referral to ENT if the person has frequent recurrent episodes of sinusitis which are troublesome (such as more than three episodes requiring antibiotics in a year). Seek specialist advice if second-line antibiotics have been ineffective.\(^3\) Doxycycline is contra-indicated in children <12yrs.\(^4\)

* High-risk drug for Clostridium difficile infection and should be avoided in at-risk patients

## Evidence
*S. pneumoniae* susceptibility to tetracycline is falling in the UK (currently 88.1%) but *H. influenzae* susceptibility to tetracycline is 98.7% compared with co-amoxiclav at 93%.\(^5\)

## References
1. Management of Infection Guidance for Primary Care, PHE & BIA, Feb 2013.
3. NICE CKS Sinusitis http://cks.nice.org.uk/sinusitis#a2Tab (Last revised October 2013)
4. BNF 66. March 2014
5. British Society for Antimicrobial Chemotherapy Resistance Surveillance Project
   http://www.bsacsurv.org/reports/respiratory.
Respiratory Tract Infections
Respiratory Tract Infections – Acute Cough, Bronchitis

**When to treat**

Presents as cough with or without sputum, breathlessness, wheeze or general malaise. There are no chest signs other than wheeze and crackles. If crackles are present, they should clear with coughing – if they persist, diagnose pneumonia.  

Antibiotics are not routinely indicated if the patient has no co-morbidities as they offer little benefit and may cause side effects. Viruses are responsible for more than 90% of acute bronchitis infections. Studies show antibiotics reduce symptoms of cough and feeling ill by less than one day in an illness lasting several weeks in total. Consider prescribing an antibiotic if the person has a significantly impaired ability to fight infection (e.g. immunocompromised status, cancer, or those aged >75 with fever) or if acute bronchitis is likely to significantly worsen a pre-existing condition (e.g. heart failure, COPD, angina, or diabetes). A delayed antibiotic prescribing strategy may be considered for people with acute bronchitis where it is felt safe not to prescribe antibiotics immediately. Patients should be advised to use the prescription if symptoms are not starting to settle within 2-3 weeks of their onset or if a significant worsening of symptoms occurs.

**When to investigate**

Routine follow-up is unnecessary. Re-examine people who have deteriorated to exclude pneumonia.

**Treatment choices**

- **First-line:** Amoxicillin 500mg tds for 5 days OR Doxycycline 200mg stat then 100 mg od for 5 days total
- **Second line (if Amoxicillin or Doxycycline unsuitable):** Consider Clarithromycin 500mg bd for 5 days

**General advice**

Patients should be advised to use paracetamol or ibuprofen as required, drink plenty of fluids and to stop smoking. Advise patients that resolution of symptoms can take up to 3 weeks. Acute cough resolves in 90% of children by 25 days.

**Evidence**

A Cochrane Review of antibiotics for acute bronchitis included 17 trials with 3936 participants and reported no difference in participants described as being clinically improved between antibiotic and placebo groups at follow-up. Antibiotics were associated with a half-day shorter mean cough duration. A recent large European multicenter placebo controlled trial of amoxicillin for acute uncomplicated lower RTI, found that antibiotics did not meaningfully alter important outcomes; either symptom severity or duration of more severe symptoms. The development of new or worsening symptoms was, however, significantly different between groups, but the NNT was high (30) and was roughly equivalent to the number needed to harm. Cough medicines are not recommended, although they are unlikely to do harm. Some people may find simple remedies like honey and lemon soothing. Clarithromycin is active against most pathogens involved in acute bronchitis, although resistance is increasing, especially in H. influenzae. Low doses of penicillins are more likely to select out resistance. Do not use quinolones (ciprofloxacin, ofloxacin) first line due to poor pneumococcal activity. Reserve all quinolones (including levofloxacin) for proven resistant organisms.

**References**

1. CKS.NICE.org.uk/ [http://cks.nice.org.uk/cough#azTab](http://cks.nice.org.uk/cough#azTab) (Accessed August 2014, topic last revised September 2010)
# Respiratory Tract Infections – Influenza

## When to treat

Influenza is characterised by the sudden onset of fever, chills, headache, myalgia and extreme fatigue. In healthy individuals, seasonal influenza is an unpleasant but usually self-limiting disease with recovery in 2–7 days.\(^1\)

**Vaccination:** Annual vaccination (ideally between September and early November) is essential for all those at risk of influenza.\(^1,2\)

At-risk groups (not exhaustive – exercise clinical judgement):
- ≥65 years old or child aged 2-4;
- chronic heart disease (not uncomplicated hypertension);
- chronic respiratory, kidney, liver or neurological disease;
- diabetes;
- pregnant women (and up to 2 weeks post-partum);
- immunocompromised individuals\(^1\);
- people living in long-stay residential and nursing homes or other long-stay care facilities;
- all healthcare and social care staff directly involved in patient care (via their occupational health dept.);
- household contacts of immunocompromised individuals and principal carers of dependent individuals.\(^4\)

**Treatment:** For otherwise healthy adults (unless pregnant), antivirals are not recommended unless they are at serious risk of complications.\(^4\)

At risk: Pregnancy (including up to 2 weeks post-partum); chronic respiratory, cardiac, renal, liver or neurological disease; diabetes mellitus; 65 years or older; immunosuppressed; morbid obesity (BMI ≥40).\(^4\)

If flu is circulating in the community and a patient in an at-risk group can start treatment within 48h of onset of flu-like illness (or of close-contact exposure), oseltamivir or zanamivir is recommended.\(^4\) Administration commencing beyond 48 hours is an off-label use.

## When to investigate

Routine follow up in otherwise healthy patients is not necessary, but advise the person they should:
- Return if no improvement after 1 week or they are deteriorating;
- seek urgent medical attention if they develop shortness of breath, pleuritic chest pain or haemoptysis;
- Return if they have a low threshold for seeking help if they are caring for a young child or baby with influenza, as children cannot accurately communicate their symptoms.\(^3\)

In at-risk groups, consider follow up (particularly in frail people) after 1 week to confirm improvement and to exclude complications.\(^3\)

## Treatment choices\(^1\)

<table>
<thead>
<tr>
<th>First line:(^4)</th>
<th>Severe immunocompromised patients ≥ 5yr or where oseltamivir resistance suspected:(^4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oseltamivir 75 mg <em>bd</em> for 5 days.</td>
<td>Zanamivir 10 mg (2 inhalations by diskhaler) <em>bd</em> for 5 days.</td>
</tr>
</tbody>
</table>

(See below for post-exposure prophylactic regimens.)

For detailed advice on paediatric dosing, consult product literature or latest PHE guidance.\(^4\)

## Evidence

After immunisation, antibody levels may take up to 10 to 14 days to reach protective levels.\(^1\)

## References

# Respiratory Tract Infections – COPD Acute Exacerbation

## When to treat
Treat exacerbations promptly with antibiotics if increased purulence of sputum and one or both of increased shortness of breath or increased sputum volume.\(^1,2^\#\)

Patients with exacerbations without more purulent sputum do not need antibiotic therapy unless there is consolidation on a chest radiograph or clinical signs of pneumonia.\(^3\)

## When to investigate
Sending sputum samples for culture in primary care is of very limited value because empirical therapy is effective and should be prescribed promptly if the sputum is purulent. Sending sputum samples in practice is not routinely recommended.\(^3\)

Pulse oximetry is of value if there are clinical features of a severe exacerbation.\(^3\) Consider hospital admission if oxygen saturation <90%.\(^4\)

## Treatment choices\(^1\)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin(^1)</td>
<td>500mg tds for 5 days(^\text{C})</td>
<td></td>
</tr>
<tr>
<td><strong>OR if allergic to penicillin:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline(^1)</td>
<td>200mg stat then 100-200mg od for 5 days(^\text{C-S})</td>
<td></td>
</tr>
<tr>
<td>Some hospital specialists may prescribe high-dose doxycycline 200mg <em>bd</em> for 2 days then 200mg <em>od</em> for 4 days.(^D)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OR if allergic to penicillin &amp; tetracyclines contra-indicated:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarithromycin(^1)</td>
<td>500mg <em>bd</em> for 5 days(^A)</td>
<td></td>
</tr>
</tbody>
</table>

### If resistance risk factors:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-amoxiclav(^1)</td>
<td>625mg tds for 5 days(^A)</td>
<td></td>
</tr>
</tbody>
</table>

Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations, antibiotics in last 3 months.\(^1\)

## Cautions
The following physical signs are features of a severe exacerbation (consider hospitalisation): marked dyspnoea and tachypnoea; pursed-lip breathing; use of accessory muscles at rest; acute confusion; new-onset cyanosis or peripheral oedema; marked reduction in activities of daily living.\(^4\)

## Evidence
A meta-analysis of 21 double-blind RCTs involving 10,698 patients, concluded that a short course (≤5 days) of antibiotic treatment was as effective as the traditional longer treatment in patients with mild to moderate exacerbations of chronic bronchitis and COPD.\(^1\)

Patients who used antibiotics within 30–days of the index hospitalisation date experienced lower odds for all-cause 30-day mortality after hospitalisation than those who did not receive antibiotics (OR 0.83, 95% CI, 0.75 to 0.92). In relation to antibiotic use, macrolides had the lowest relative odds for mortality (OR 0.58, 95% CI 0.47 to 0.73) and fluoroquinolones had the highest relative odds (OR 0.98, 95% CI 0.84 to 1.15).\(^3\)

Although quinolones have performed equally well in clinical trials of lower RTI, no clinical superiority over other antibiotics has yet been shown.\(^3\)

Do not use ciprofloxacin first-line due to poor pneumococcal activity. Reserve all quinolones for proven resistant organisms.\(^1\)

## References
5. BNF 66 March 2014
**Respiratory Tract Infections – Community-Acquired Pneumonia (CAP)**

### When to treat
The presence of either abnormal vital signs (fever >38°C, tachycardia >100/min and tachypnoea >20/min) or an abnormal physical examination of the chest (crackles, decreased breath sounds, dullness to percussion, wheeze) identified patients with radiographically confirmed CAP with a sensitivity of 95%, negative predictive value of 92% and specificity of 56%.¹

Use CRB65 score to help guide and review¹:

<table>
<thead>
<tr>
<th>Each scores 1:</th>
<th>Score 0: suitable for home treatment;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confusion (Abbreviated Mental Test score &lt;8);</td>
<td>Score 1-2: hospital assessment or admission</td>
</tr>
<tr>
<td>• Respiratory rate &gt;30/min;</td>
<td>Score 3-4: urgent hospital admission</td>
</tr>
<tr>
<td>• Age &gt;65;</td>
<td>Give immediate IM Benzylpenicillin or Amoxicillin 1g po (IM Cefotaxime in non-severe penicillin allergy) if delayed admission/life threatening.¹,²</td>
</tr>
<tr>
<td>• BP systolic &lt;90 or diastolic ≤ 60</td>
<td></td>
</tr>
</tbody>
</table>

### When to investigate
For patients managed in the community microbiological investigations are not recommended routinely.¹ Examination of sputum should be considered for patients who do not respond to empirical antibiotic therapy.¹

### Treatment choices²

<table>
<thead>
<tr>
<th>IF CRB65=0:</th>
<th>A+ 500mg tds for 7 days OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin¹⁺ 500mg tds for 7 days</td>
<td>Clarithromycin¹⁻ 500mg bd for 7 days</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>Clarithromycin¹⁻ 500mg bd for 7 days</td>
<td>Doxycycline² 200mg stat/100mg od for 7 days</td>
</tr>
</tbody>
</table>

If CRB65=1 & AT HOME:

| Amoxicillin¹⁺ 500mg – 1g tds AND Clarithromycin¹⁻ 500mg bd both for 7-10 days |
| Doxycycline alone 200mg stat then 100-200mg od for 7-10 days |

Some hospital specialists may prescribe high-dose doxycycline 200mg bd for 2 days then 200mg od for 7-10 days.⁰

### Cautions
In elderly patients, the classic symptoms and signs of pneumonia are less likely, and non-specific features — especially confusion — are more likely.¹ In addition, absence of fever is more common compared to younger patients with CAP.¹  
Aspiration pneumonia is significantly more common in patients who reside in a nursing home or long-term-care facility.⁴  
Do not use ciprofloxacin first line due to poor pneumococcal activity. Reserve all quinolones for proven resistant organisms.²

### Evidence
Consider doxycycline, alone or combined with amoxicillin, if infection with Mycoplasma pneumoniae is suspected (most likely in school age children and young adults with non-severe symptoms if there is a known epidemic).³  
Mycoplasma infection is rare in over 65s.²

### References
Central Nervous System
# Central Nervous System Infections – Meningitis or Suspected Meningococcal Disease

## When to treat

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer all patients to hospital immediately.</td>
<td>1</td>
</tr>
<tr>
<td>If time before admission, and non-blanching rash, give IV benzylpenicillin or cefotaxime 2,3B+, unless hypersensitive</td>
<td></td>
</tr>
<tr>
<td>i.e. history of difficulty breathing, collapse, loss of consciousness, or rash. 1B-</td>
<td></td>
</tr>
<tr>
<td>If a patient with suspected bacterial meningitis without non-blanching rash cannot be transferred to hospital urgently, benzylpenicillin or cefotaxime should be given before the transfer. 1B-</td>
<td></td>
</tr>
</tbody>
</table>

## Treatment choices

<table>
<thead>
<tr>
<th>IV or IM Benzylpenicillin:</th>
<th>OR</th>
<th>IV or IM Cefotaxime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neonate</strong></td>
<td>75mg/kg</td>
<td><strong>Neonate</strong></td>
</tr>
<tr>
<td><strong>Child: 1 month - 1yr</strong></td>
<td>300mg</td>
<td><strong>Child: 1 month - 12yrs</strong>: 50mg/kg (max 1g)</td>
</tr>
<tr>
<td><strong>Child: 1yr - 9yrs</strong></td>
<td>600mg</td>
<td><strong>Child: 12-18yrs</strong>: 1g</td>
</tr>
<tr>
<td><strong>Child: 10-18yrs</strong></td>
<td>1.2g</td>
<td><strong>Adult</strong>: 1g</td>
</tr>
<tr>
<td><strong>Adult</strong></td>
<td>1.2g</td>
<td><strong>Give IM if vein cannot be found.</strong> 1</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>IV or IM Cefotaxime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neonate</strong></td>
</tr>
<tr>
<td><strong>Child: 1 month - 12yrs</strong>: 50mg/kg (max 1g)</td>
</tr>
<tr>
<td><strong>Child: 12-18yrs</strong>: 1g</td>
</tr>
<tr>
<td><strong>Adult</strong>: 1g</td>
</tr>
</tbody>
</table>

If history of immediate hypersensitivity reaction to penicillins or cephalosporins 4

<table>
<thead>
<tr>
<th>IV Chloramphenicol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child: 1 month - 18 yrs</strong>: 25mg/kg IV</td>
</tr>
<tr>
<td><strong>Adult</strong>: 25mg/kg IV</td>
</tr>
</tbody>
</table>

## Prevention of secondary case of meningitis. 5 Only prescribe following advice from Public Health Doctor: 9am - 5pm 0845 055 2022. Out-of-hours contact: 0844 967 0082 (from 1st February 2012).

## Cautions

For suspected meningococcal disease (meningitis with non-blanching rash or meningococcal septicaemia), give parenteral antibiotics (intramuscular or intravenous benzylpenicillin) at the earliest opportunity in primary care, but do not delay urgent transfer to hospital to give the parenteral antibiotics. 2

Only withhold benzylpenicillin in children and young people who have a clear history of anaphylaxis after a previous dose; a history of a rash following penicillin is not a contraindication. 2

## Evidence

The NICE guideline development group recommended benzylpenicillin because it is the most frequently used antibiotic in primary care and they found no evidence to recommend an alternative antibiotic. 1

## References


4. BNF for Children May 2014

Urinary Tract Infections
### Urinary Tract Infections – Uncomplicated UTI in Women

#### When to treat
Women with severe or ≥ 3 symptoms (frequency, urgency, dysuria, polyuria, suprapubic tenderness, haematuria): treat\(^{1B+}\)
- Women with mild or ≤ 2 symptoms: perform dipstick on cloudy urine to guide treatment (morning specimen most reliable).\(^{1,2}\)
  - Positive nitrite indicates probable UTI, if EITHER blood OR leucocytes also positive = 92% positive predictive value\(^{1A-}\)
  - Negative nitrite, leucocytes and blood = 76% negative predictive value\(^{1A-}\)
- Although the probability of UTI is reduced to less than 20% by a negative dipstick test, the evidence suggests that women still derive symptomatic benefit from antibiotics (NNT=4).\(^3\)
- Non-pregnant women with asymptomatic bacteriuria should not receive antibiotic treatment.\(^3\)
- In women with symptoms of vaginal itch or discharge, explore alternative diagnoses and consider pelvic examination.\(^3\)

#### When to investigate
- Do not culture routinely for urinary symptoms in adult women <65 years.\(^2\)
- In sexually active young women, consider Chlamydia trachomatis.\(^2C\)
- Do not send urine for culture in asymptomatic elderly with positive dipsticks; only send urine for culture if two or more signs of infection, especially dysuria, fever > 38°C or new incontinence.\(^2\)
- Perform culture (mid-stream) if failed antibiotic treatment\(^2\), persistent symptoms\(^2\) or patient is immunosuppressed.\(^4\)

#### How to respond to a positive lab report\(^2\)
- Single organism ≥ 10^4 colony forming units (CFU)/mL or ≥ 10^5 mixed growth with one predominant organism or E. coli or Staphylococcus saprophyticus ≥ 10^3 CFU/mL usually indicates UTI in patient with urinary symptoms.
- White cells ≥ 10^4/mL are considered to represent inflammation. In adults ‘no white cells present’ indicates no inflammation & reduces culture significance. Epithelial cells/mixed growth indicates perineal contamination, reducing significance of culture.

#### Treatment choices
- **First line:**\(^1\)
  - Nitrofurantoin\(^{8+}\) 100mg m/r bd for 3 days\(^3,4\)
  - OR Trimethoprim\(^{8+}\) 200mg bd for 3 days\(^{1A+}\)
- **Second line:** Perform culture in all treatment failures\(^{1B}\)
  - Amoxicillin resistance is common; only use if susceptible.\(^{1B+}\)
  - Community multi-resistant Extended-spectrum Beta-lactamase (ESBL) E. coli are increasing: consider nitrofurantoin (or fosfomycin 3g stat on advice of microbiologist).\(^3\)

#### Cautions
- Avoid nitrofurantoin if eGFR<45ml/min, (risk of peripheral neuropathy; ineffective due to inadequate urine concentrations.\(^{3,5}\)), although may be suitable in some patients with a eGFR of between 30 - 44ml/min if a short course (3-7 days) is prescribed. Prescribe for lower UTI where the benefits outweigh the risk of side effects.\(^7\)
- The activity of nitrofurantoin is reduced with increasing pH; avoid alkalinising agents e.g. potassium citrate.\(^1\)
- Trimethoprim resistance has been reported after exposure to Trimethoprim within last 6 months or after multiple courses.\(^4\)

#### Evidence
- Three days of treatment with nitrofurantoin has been shown to be effective in non-pregnant adult women with uncomplicated UTI.\(^3\)
- If dysuria and frequency are present, the probability of UTI is > 90%.\(^3\)

#### References
5. BNF 67, March 2014
## Urinary Tract Infections – Lower UTI in Pregnancy

<table>
<thead>
<tr>
<th>When to treat</th>
<th>Pregnant women with symptomatic UTI should be treated with an antibiotic. Asymptomatic bacteriuria detected during pregnancy should be treated with an antibiotic; asymptomatic bacteriuria is associated with pyelonephritis &amp; premature delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When to investigate</td>
<td>MSU should be performed routinely at the first antenatal visit. If bacteriuria is reported, it should be confirmed with a second MSU. Dipstick testing is not sufficiently sensitive to be used for screening for bacteriuria in pregnant women. Given the risks of asymptomatic bacteriuria in pregnancy, a urine culture should be performed seven days after completion of antibiotic treatment as a test of cure.</td>
</tr>
<tr>
<td>How to respond to a positive lab report</td>
<td>Single organism ≥ 10⁴ colony forming units (CFU)/mL or ≥ 10⁵ mixed growth with one predominant organism or <em>E. coli</em> or <em>Staphylococcus saprophyticus</em> ≥ 10³ CFU/mL usually indicates UTI in patient with urinary symptoms. In adults ‘no white cells present’ indicates no inflammation &amp; reduces culture significance. Epithelial cells/mixed growth indicates perineal contamination, reducing significance of culture. Women with bacteriuria confirmed by a second urine culture should be treated and have repeat urine culture at each antenatal visit until delivery.</td>
</tr>
<tr>
<td>Treatment choices</td>
<td><strong>First line:</strong> Amoxicillin 500mg tds <em>(if known to be susceptible)</em> OR Nitrofurantoin 100mg m/r <em>bd</em> OR Trimethoprim 200mg <em>bd</em> (off-label). Give folic acid (5mg daily) if first trimester. <strong>Second line:</strong> Cefalexin* 500mg <em>bd</em> or 250mg qds for 7 days</td>
</tr>
<tr>
<td>Cautions</td>
<td>The activity of nitrofurantoin is reduced with increasing pH; avoid alkalinising agents e.g. potassium citrate. Trimethoprim is a folate antagonist. Folate supplementation during the first trimester reduces the risk of neural tube defects in offspring of pregnant women treated with trimethoprim. In women with normal folate status, who are well nourished, trimethoprim is unlikely to cause folate deficiency. However, it should not be used by women with established folate deficiency or low dietary folate intake, or by women taking other folate antagonists (e.g. antiepileptic drugs or proguanil). Avoid nitrofurantoin if eGFR&lt;45ml/min, (risk of peripheral neuropathy; ineffective due to inadequate urine concentrations), although may be suitable in some patients with a eGFR of between 30 - 44ml/min if a short course (3-7 days) is prescribed. Prescribe for lower UTI where the benefits outweigh the risk of side effects. *High-risk drug for Clostridium difficile infection and should be avoided in at-risk patients.</td>
</tr>
<tr>
<td>Evidence</td>
<td>Nitrofurantoin has been associated with haemolysis in people with G6PD deficiency. However, the risk seems very small because placental transfer is so low. There is only one reported case of haemolytic anaemia in a newborn whose mother was treated at term with nitrofurantoin. The efficacy and safety profiles of nitrofurantoin are supported in a recent large multicentre study undertaken by the World Health Organization in which 778 pregnant women with asymptomatic bacteriuria were treated with nitrofurantoin [Lumbiganon et al, 2009]. A cure rate of 86% was achieved with a 7-day course.</td>
</tr>
</tbody>
</table>
5. BNF 68 September 2014  

*High-risk drug for Clostridium difficile infection and should be avoided in at-risk patients.
### Urinary Tract Infections – Lower UTI in Men

| When to treat | Conditions like prostatitis, chlamydial infection and epididymitis should be considered in the differential diagnosis of men with acute dysuria or frequency and appropriate diagnostic tests should be considered.\(^1\) In elderly men (over 65 years of age), treatment of asymptomatic bacteriuria does not reduce mortality or significantly reduce symptomatic episodes.\(^1\) Antibiotic treatment significantly increases the risk of adverse events, such as rashes and gastrointestinal symptoms (NNTH 3).\(^1\) |
| When to investigate | A urine sample is recommended because UTI in men is generally regarded as complicated (it results from an anatomic or functional abnormality).\(^1,2\) Send pre-treatment MSU C OR if symptoms mild/non-specific, use negative dipstick (both nitrite & leucocytes) to exclude UTI.\(^3,4\) C |
| How to respond to a positive lab report | Follow up after 48 hours (or according to the clinical situation) to check response to treatment and the urine culture results.\(^4\) Obtaining a clean-catch sample of urine in men is easier than in women and a colony count of \(\geq10^3\) cfu/ml may be sufficient to diagnose UTI in a man with signs and symptoms as long as 80% of the growth is of one organism.\(^1\) |
| Treatment choices | **First line:**\(^3,4\) Treat for 7 days\(^3,4\) C  
Nitrofurantoin\(^{B+}\) 100mg m/r bd OR  
Trimethoprim\(^{B+}\) 200mg bd  

**Second line:**  
Perform culture in all treatment failures\(^3,8\)  
Amoxicillin resistance is common; only use if susceptible.\(^3,9\)  
Community multi-resistant Extended-spectrum Beta-lactamase (ESBL) E. coli are increasing: consider Nitrofurantoin (or Fosfomycin 3g stat plus 2\(^{nd}\) 3g dose 3 days later on advice of microbiologist).\(^3\) |

| Cautions | Trimethoprim resistance has been reported after exposure to Trimethoprim within last 6 months or after multiple courses.\(^4\) Avoid nitrofurantoin if eGFR<45ml/min, (risk of peripheral neuropathy; ineffective due to inadequate urine concentrations.\(^5,6\)) although may be suitable in some patients with a eGFR of between 30 - 44ml/min if a short course (3-7 days) is prescribed. Prescribe for lower UTI where the benefits outweigh the risk of side effects.\(^7\)  
At least 50% of men with recurrent UTI and over 90% of men with febrile UTI have prostate involvement, which may lead to complications such as prostatic abscess or chronic bacterial prostatitis.\(^1\) (Section 5.7 – Acute Prostatitis). |

| Evidence | No high quality evidence for the treatment of bacterial UTI in men was identified.\(^1\) |

5. BNF 67, March 2014  
Urinary Tract Infections – Catheter-associated UTI

When to treat
Between 2% and 7% of patients with indwelling urethral catheters acquire bacteriuria each day, even with the application of best practice for insertion and care of the catheter. All patients with a long-term indwelling catheter are bacteriuric, often with two or more organisms. Treatment of asymptomatic bacteriuria does not reduce mortality or prevent symptomatic episodes and causes harms: increased short-term frequency of symptomatic infection and re-infection with antimicrobial-resistant organisms.

Catheter in situ: antibiotics will not eradicate asymptomatic bacteriuria; only treat if systemically unwell or pyelonephritis likely. Symptoms that may suggest UTI in patients with catheters include fever, flank or suprapubic discomfort, change in voiding patterns, nausea, vomiting, malaise or confusion.

When to investigate
Symptomatic catheter-associated UTI (CA-UTI) cannot be differentiated from asymptomatic bacteriuria on the basis of urine analysis with dipstick tests. Dipstick testing should not be used to diagnose UTI in catheterised patients. Urine samples should only be sent for laboratory culture if the patient has clinical sepsis, not because the appearance or smell of the urine suggests that bacteriuria is present.

A urine specimen for culture should be obtained prior to initiating antimicrobial therapy for presumed CA-UTI because of the wide spectrum of potential infecting organisms and the increased likelihood of antimicrobial resistance.

How to respond to a positive lab report
If urine culture shows that the organism is resistant to the current antibiotic, and:
- If symptoms have not resolved, change to an antibiotic that the organism is sensitive to.
- If symptoms have resolved, consider continuing with the current antibiotic.
- If symptoms recur, start treat with an antibiotic shown in the culture to cover the infecting organism.

Treatment choices

| Lower UTI: | Nitrofurantoin 100mg m/t bd for 7 days OR Trimethoprim 200mg bd for 7 days |
| Upper UTI (fever or loin pain): | See Pyelonephritis |

Cautions
Nitrofurantoin is now contraindicated in patients with an estimated glomerular filtration rate (eGFR) of less than 45 ml/min. However, a short course (3 to 7 days) may be used with caution in certain patients with an eGFR of 30 to 44 ml/min. Treatment may need to be extended to 10-14days in patients with a delayed response. Only prescribe when the benefits of nitrofurantoin are considered to outweigh the risks of side effects.

Evidence
When changing catheters in patients with a long-term indwelling urinary catheter: do not offer antibiotic prophylaxis routinely. Consider antibiotic prophylaxis for patients with a history of symptomatic UTI after catheter change or who experience trauma during catheterisation.

References
4. Management of Infection Guidance for Primary Care, PHE & BIA Feb 2013
7. BNF 67, March 2014
## Urinary Tract Infections – UTI in Children

### When to treat

<table>
<thead>
<tr>
<th>Age</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &lt; 3 months</td>
<td>Refer urgently for assessment</td>
</tr>
<tr>
<td>Child 3 months - 3 years</td>
<td>Send MSU for culture</td>
</tr>
<tr>
<td>Child ≥ 3 years</td>
<td>Use positive dipstick to indicate antibiotics and send MSU for culture</td>
</tr>
</tbody>
</table>

Delay the decision about treating with an antibiotic until the results of urine culture are available for children who have no specific symptoms for UTI, and are at intermediate risk for severe illness (and the urine dipstick tests for nitrite and leukocyte esterase are negative) or low-risk for serious illness. 
Send pre-treatment MSU for all children ≥3 months.
Imaging: only refer if child <6 months, recurrent or atypical UTI.

### When to investigate

Whenever possible a specimen of urine should be collected for culture and sensitivity testing before starting antibacterial therapy – clean catch if possible.

### How to respond to a positive lab report

**Dipstick:**
- Positive nitrite & leucocytes = likely UTI.
- Nitrite positive & leucocytes negative, in sample <4hrs old = likely UTI.

**Single organism ≥ 10⁴ colony forming units (CFU)/mL indicates UTI; in supra-pubic aspirates any growth is significant.**

**White blood cells:** In children pyuria may be absent or, in contrast, present due to fever without UTI.

**Routinely review with the culture result (e.g. at around 48 hours) to ensure that the child is responding to treatment, and to reassess the choice of antibiotic.**

### Treatment choices

**See Children’s BNF for doses**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>First line</th>
<th>Second line</th>
<th>Preventing recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower UTI: Uncomplicated lower UTI in children &gt; 3 months can be treated for 3 days</td>
<td>Nitrofurantoin caps (not m/r unless child &gt;12yrs) or suspension (note: expensive)</td>
<td>In accordance with sensitivity results</td>
<td></td>
</tr>
<tr>
<td>Upper UTI: consider hospital admission</td>
<td>Co-amoxiclav for 7-10 days</td>
<td>If susceptible: Amoxicillin OR Cefalexin</td>
<td></td>
</tr>
</tbody>
</table>

### Evidence

Prophylactic antibiotics for recurrent symptomatic UTI: Although it is effective in reducing the number of positive urine cultures, there is no benefit through a reduction in the number of symptomatic infections or new renal parenchymal defects. It is inconvenient for the patient, compliance is poor, it carries the risks associated with any medication and patients tend to become colonised with resistant organisms. Nitrofurantoin is now contraindicated in patients with an estimated glomerular filtration rate (eGFR) of less than 45 ml/min. However, a short course (3 to 7 days) may be used with caution in certain patients with an eGFR of 30 to 44 ml/min.

### References

# Urinary Tract Infections – Recurrent UTI in Women – Prophylaxis

## When to treat

Recurrent UTI is defined as ≥ 3 UTIs per year. If cystitis is related to sexual intercourse, advise: Using a different contraceptive method if a diaphragm is being used; voiding soon after intercourse; using a lubricant if symptoms could be due to mild trauma rather than infection. Continuous or postcoital antimicrobial prophylaxis should be considered to prevent recurrent uncomplicated cystitis in women in whom non-antimicrobial measures have been unsuccessful. In appropriate women with recurrent uncomplicated cystitis, self-diagnosis and self-treatment with a short course ‘stand-by’ regimen of an antimicrobial agent should be considered.

## When to investigate

Seeking specialist advice before starting continuous antibiotic prophylaxis is recommended pragmatically to decide whether the woman needs investigation to exclude an underlying cause.

## How to respond to a positive lab report

Before any prophylaxis regimen is initiated, eradication of a previous UTI should be confirmed by a negative urine culture 1-2 weeks after treatment. The choice of antibiotics should be based upon the identification and susceptibility pattern of the organism that causes the UTI and the patient’s history of drug allergies.

## Treatment choices

### Non-antibiotic treatment:
- Cranberry products reduce the recurrence rate of cystitis, and are available from shops (not on NHS).
- Cranberry products should not be taken if warfarin is being used.
- High strength capsules (containing at least 200mg of cranberry extract) are recommended because they may be more effective and acceptable than cranberry juice.

### For women in whom episodes of infection are associated with sexual intercourse:
- **Nitrofurantoin** 50mg-100mg caps stat post-coital dose (off-label use)
- **Trimethoprim** 100mg stat post-coital dose (off-label use)

### For women in whom episodes of infection are associated with sexual intercourse:
- **Nitrofurantoin** 50-100mg at night
- **Trimethoprim** 100mg at night

## Cautions

Monitor patients on long term nitrofurantoin for signs of pulmonary fibrosis. Avoid nitrofurantoin if eGFR<45ml/min, (risk of peripheral neuropathy; ineffective due to inadequate urine concentrations.), although may be suitable in some patients with an eGFR of between 30 - 44ml/min if a short course (3-7 days) is prescribed. Prescribe for lower UTI where the benefits outweigh the risk of side effects.

## Evidence

Nightly prophylaxis: pooled data from 10 RCTs of poor methodological quality calculated a Relative Risk of having one microbiological recurrence was 0.21 (95% CI 0.13 to 0.34), favouring antibiotic and the NNT was 1.85 over 6-12 months. But adverse effects do occur and 30% of women did not adhere to treatment.

## References

2. CKS Urinary Tract Infection (lower) – Women – Recurrent cystitis http://cks.nice.org.uk/urinary-tract-infection-lower-women#scenario:
4. BNF 67, March 2014
5. MHRA http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON452539
## Urinary Tract Infections – Acute Pyelonephritis (Upper UTI)

### When to treat
Upper urinary tract infection is defined as: evidence of urinary tract infection with symptoms suggestive of pyelonephritis (loin pain, flank tenderness, fever, rigors or other manifestations of systemic inflammatory response).<sup>1</sup> Upper urinary tract infection can be accompanied by bacteraemia, making it a life threatening infection.<sup>1</sup>

Admit to hospital people who:<sup>2</sup>
- Are significantly dehydrated or who are unable to take oral fluids and medications.
- Have signs of sepsis, including:
  - A temperature greater than 38°C or less than 36°C, and
  - Marked signs of illness (such as impaired level of consciousness, perfuse sweating, rigors, pallor, significantly reduced mobility), or
  - Significant tachycardia, hypotension, or breathlessness.
- Are pregnant and pyrexial.
- Are frail, elderly residents in care homes who have recently been hospitalised or who have had recurrent UTI.
- Fail to improve significantly within 24 hours of starting antibiotics.

### When to investigate<sup>1</sup>
Dipstick test the urine for leucocyte esterase and nitrite for evidence of a UTI.<sup>2</sup>
- If the nitrite test is positive, with or without a positive leucocyte esterase test, a UTI is highly (90%) likely.
- If the leucocyte esterase test alone is positive, a UTI is moderately (50%) likely.
- If both dipstick tests are negative, a UTI is unlikely (5%). Consider and exclude other causes of loin pain and/or fever including: pelvic inflammatory disease; appendicitis; renal calculi.

If hospital admission not needed, send MSU for culture & sensitivities and start antibiotics.<sup>3</sup>

### How to respond to a positive lab report
- **Single organism**
  - ≥ 10⁴ colony forming units (CFU)/mL or ≥ 10⁵ mixed growth with one predominant organism or *E. coli* or *Staphylococcus saprophyticus* ≥ 10³ CFU/mL usually indicates UTI in patient with urinary symptoms.<sup>3</sup> Review culture and sensitivity results when they become available, and change the antibiotic if indicated.<sup>2</sup> Consider IV ertapenem if ESBL risk.<sup>3</sup>
- If no response within 24 hours, admit.

### Treatment choices
- **First line:**<sup>1,3,4</sup>
  - *Ciprofloxacin*<sup>a</sup> 500mg *bd* for 7 days<sup>4</sup> If susceptible: **Trimethoprim** 200mg *bd* for 14 days<sup>1</sup>
- **Second line:**<sup>1,3,4</sup> (if no penicillin allergy)
  - *Co-amoxiclav*<sup>c</sup> 625mg *tds* for 14 days<sup>5</sup>

### Cautions
High-risk drugs for *Clostridium difficile* infection but benefits considered to outweigh risks in acute pyelonephritis.<sup>3</sup> Nitrofurantoin is an ineffective treatment for upper UTI because it does not achieve effective concentrations in the blood.<sup>1</sup>

### Evidence
- **One week of treatment with ciprofloxacin is as effective as two weeks treatment with co-trimoxazole.**<sup>1</sup> Evidence about the effectiveness of less than two weeks treatment with co-amoxiclav is lacking.<sup>1</sup>

### References
# Genital Tract Infections – Criteria for referring patients to specialist care

<table>
<thead>
<tr>
<th>Patient risk factors</th>
<th>Refer patients with the following risk factors for STIs to GUM/Sexual Health Services clinic or general practices with level 2 or 3 expertise in GUM/Sexual Health Services:(^1,^2)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• &lt;25yrs</td>
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<tr>
<td></td>
<td>• no condom use</td>
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<td></td>
<td>• recent (&lt;12mth) or frequent change of sexual partner</td>
</tr>
<tr>
<td></td>
<td>• previous STI</td>
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<td></td>
<td>• symptomatic partner</td>
</tr>
</tbody>
</table>

| Diseases             | • Syphilis – always refer to GUM/Sexual Health Services                                          |
|                      | • Gonorrhoea – always refer to GUM/Sexual Health Services                                       |
|                      | • Genital Herpes – Treat on suspicion and refer to GUM/Sexual Health Services                   |

| Evidence             | See Health Protection Agency and British Infection Association Quick Reference Guide to Management and Laboratory Diagnosis of Abdominal Vaginal Discharge for useful flowchart.\(^3\) |

### Genital Tract Infections – Vulvo Vaginal Candidiasis

#### When to treat
Symptoms suggestive of episodic vulvovaginal candidiasis include external dysuria, vulval pruritus, swelling or redness. Signs include vulval oedema, fissures, excoriation, or thick curdy discharge. The vaginal pH is usually normal (<4.5). Treatment on the basis of symptoms alone is common clinical practice but results in the over-treatment of a large number of women. There is no evidence to support the treatment of asymptomatic male sexual partners in either episodic or recurrent vulvovaginal candidiasis.

#### When to investigate
Microscopy and culture are not routinely done on women with features of typical acute uncomplicated vulvovaginal candidiasis. Microscopy and speciated fungal culture of vaginal secretions to identify yeasts is recommended for: supporting the diagnosis when this is uncertain; severe vulvovaginal candidiasis; treatment failure; recurrent vulvovaginal candidiasis. Request ‘Fungal speciation to non-albicans Candida species’ when treatment fails.

#### How to respond to a positive lab result
Advise the woman to return if symptoms have not resolved within 7–14 days. Refer, or seek specialist advice, if: symptoms are not improving and treatment failure is unexplained; treatment fails again; if diagnosis is unclear.

#### General advice
Routine recommendation of use of vulval moisturisers (such as aqueous cream or Epaderm ointment) as soap substitute and regular skin conditioner (permission may need to be given to the patient that this does not constitute ‘internal use’). Avoid tight fitting synthetic clothing. Avoid local irritants e.g. perfumed products.

#### Treatment choices

| When non-pregnant | Clotrimazole 10% Vaginal Cream (5g) stat | OR Clotrimazole 500mg pessary at night | Flucanazole 150mg orally stat |
| When pregnant | Clotrimazole 100mg pessary at night for 6 nights | Miconazole 2% cream 5g intravaginally bd for 7 days |

#### Cautions
There is evidence from a number of randomized controlled trials that vulval burning and vaginal discharge are more common with intravaginal imidazoles, whilst nausea, headache, and abdominal pain are more common with oral imidazoles. Clotrimazole and Miconazole damage latex condoms and diaphragms.

#### Evidence
No statistically significant differences were observed in clinical cure rates of antifungals administered by the oral or the intravaginal route. At short-term follow-up, 74% cure was achieved with oral treatment and 73% cure with intravaginal treatment (OR 0.94, 95% CI 0.75 to 1.17).

#### References
6. BNF July 14.
<table>
<thead>
<tr>
<th>Genital Tract Infections – Bacterial Vaginosis</th>
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<td><strong>When to treat</strong></td>
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<td><strong>When to investigate</strong></td>
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<tr>
<td><strong>General advice</strong></td>
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<tr>
<td><strong>Treatment choices</strong></td>
</tr>
<tr>
<td><strong>Cautions</strong></td>
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<tr>
<td><strong>Evidence</strong></td>
</tr>
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Genital Tract Infections – Chlamydia Trachomatis

When to treat
In people with signs or symptoms strongly suggestive of Chlamydia, start treatment without waiting for laboratory confirmation (after testing for other sexually transmitted infections as appropriate). In the absence of treatment, 10-40% of infected women will develop pelvic inflammatory disease (PID).

When to investigate
Test for Chlamydia if patients are sexually active with symptoms and signs suggesting Chlamydia. Opportunistically screen all aged 15-25yrs.

How to respond to a positive lab result
Treat partners and refer to GUM service. Positive confirmed reactive nucleic acid amplification technique (NAAT) test. Note: In high-risk populations, tests are not confirmed with culture. Beware of false positive test results in low-risk populations. Patients with reactive unconfirmed NAAT test results should also be offered treatment.

General advice
Patients should be advised to avoid sexual intercourse (including oral sex) until they and their partner(s) have completed treatment (or wait 7 days if treated with azithromycin).

Treatment choices
First line: (non-pregnant) Azithromycin 1g stat OR Doxycycline 100mg bd for 7 days
First line: Pregnant Erythromycin 500mg bd for 14 days OR Amoxicillin 500mg tds for 7 days OR Azithromycin 1g (off-label use) stat (only use if alternatives are inappropriate) or breastfeeding

Cautions
Refer all pregnant patients to GUM/Sexual Health Services. Pregnancy or breastfeeding: azithromycin is the most effective option. Due to lower cure rate in pregnancy, test for cure 6 weeks after treatment.

Evidence
NAATs are more sensitive and specific (90-95%) than enzyme immunoassays (EIAs) (40-70%). Comparative studies of doxycycline and azithromycin have shown similar efficacy at 2-5 week follow-up, with >95% being Chlamydia-negative on retesting. However, there is evidence to suggest that with longer follow-up >10% will be positive on retesting (NAATs may remain positive for up to 5 weeks, even if treatment has been successful). Erythromycin and amoxicillin are less effective than doxycycline or azithromycin.

References
6. BNF 66, March 2014
## Genital Tract Infections – Trichomoniasis

### When to treat
Treat only laboratory confirmed diagnosis.¹ Sexual partner(s) should be treated simultaneously.² Refer to GUM/Sexual Health Services clinic.³

### When to investigate
All symptomatic patients.⁴ Yellow, green frothy discharge. Fishy/offensive odour +/- pruritis, vaginitis, dysuria.⁵ Screening of asymptomatic patients is not recommended.⁴

### How to respond to a positive lab result
Screening for co-existent sexually transmitted infections should be undertaken in both men and women.²

### General advice
Patients should be advised to avoid sexual intercourse (including oral sex) until they and their partner(s) have completed treatment and follow-up.²

### Treatment choices

<table>
<thead>
<tr>
<th>First line:</th>
<th>Symptomatic relief if metronidazole declined (not cure):³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metronidazole</strong>&lt;sup&gt;A+&lt;/sup&gt; 400mg bd for 5-7 days³</td>
<td><strong>Clotrimazole</strong> pessary&lt;sup&gt;B+&lt;/sup&gt; 100mg each night for 6 nights</td>
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<tr>
<td><strong>OR</strong></td>
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<tr>
<td><strong>Metronidazole</strong> 2g stat&lt;sup&gt;3A+&lt;/sup&gt; (consider suspension formulation at night for better tolerability⁶; avoid 2g dose in pregnancy/breastfeeding³)</td>
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</table>

### Cautions
The single dose has the advantage of improved compliance and being cheaper; however there is some evidence to suggest that the failure rate is higher with single dose, especially if partners are not treated concurrently.²

### Evidence
Treating partners does not reduce relapse.⁵⁻⁸ Most strains of T. vaginalis are highly susceptible to metronidazole and related drugs (approx. 95% cure rate). There is a spontaneous cure rate in the order of 20-25%.²

### References
1. CKS Trichomoniasis [http://cks.nice.org.uk/trichomoniasis#azTab](http://cks.nice.org.uk/trichomoniasis#azTab) (accessed May 2014)
[http://www.bashh.org/documents/Sexually%20Transmitted%20Infections%20in%20Primary%20Care%202013.pdf](http://www.bashh.org/documents/Sexually%20Transmitted%20Infections%20in%20Primary%20Care%202013.pdf)
### Genital Tract Infections – Pelvic Inflammatory Disease (PID)

#### When to treat
Signs include: Lower abdominal tenderness which is usually bilateral; adnexal tenderness on bimanual vaginal examination; cervical motion tenderness on bimanual vaginal examination; fever (>38°C).\(^1\) Delaying treatment may increase the risk of long term sequelae such as ectopic pregnancy, infertility and pelvic pain.\(^1\) Because of this, and the lack of definitive diagnostic criteria, a low threshold for empiric treatment of PID is recommended.\(^1\)

Start treatment and refer woman & contacts to GUM service.\(^2\)

#### When to investigate
Always culture for gonorrhoea & Chlamydia as positive result supports PID diagnosis.\(^1\) However, a negative result does not exclude PID.\(^1\)

#### How to respond to a positive lab result
All patients should be offered a pregnancy test when required to exclude pregnancy.\(^1\) Refer woman & contacts to GUM service to screen for sexually transmitted infections.\(^2\)

BASHH Patient information leaflet: [http://www.bashh.org/documents/3633](http://www.bashh.org/documents/3633)

#### General advice
Rest is advised for those with severe disease.\(^1\)^C Appropriate analgesia should be provided.\(^1\)^C Patients should be advised to avoid unprotected intercourse until they, and their partner(s), have completed treatment and follow-up.\(^1\)^C

#### Treatment choices\(^3\)

<table>
<thead>
<tr>
<th>Low risk of Gonococcal infection(^8^+)</th>
<th>High risk of GC(^8^+) (partner has it, severe symptoms, sex abroad)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metronidazole</strong> 400mg <em>bd</em></td>
<td><strong>Ceftriaxone</strong> 500mg IM stat(^c) (seek expert advice if history of severe penicillin allergy)</td>
</tr>
<tr>
<td><strong>PLUS:</strong></td>
<td><strong>PLUS:</strong></td>
</tr>
<tr>
<td>[Doxycycline(^1) 100mg <em>bd OR Ofloxacin</em> 400mg *bd(^8^+)]</td>
<td>Metronidazole 400mg PO <em>bd</em> for 14 days</td>
</tr>
<tr>
<td>All for 14 days</td>
<td><strong>PLUS:</strong></td>
</tr>
<tr>
<td></td>
<td>Doxycycline 100mg <em>bd</em> for 14 days</td>
</tr>
</tbody>
</table>

#### Cautions
PID in pregnancy requires parenteral treatment — refer to specialist.\(^1\)

**Ceftriaxone** is supplied as a powder which needs to be reconstituted with lidocaine solution. To reconstitute, mix the contents of a 1g vial with 3.5mL of 1% lidocaine injection BP: half (2mL) of the resulting solution provides 500mg ceftriaxone. It should be given by deep intramuscular injection.\(^4\)

**Metronidazole** is included in some regimens to improve coverage for anaerobic bacteria.\(^1\) Anaerobes are of relatively greater importance in patients with severe PID and metronidazole may be discontinued in those patients with mild or moderate PID who are unable to tolerate it.\(^1\)

#### Evidence
28% of gonorrhoea isolates resistant to quinolones.\(^3^B^+\)

#### References
2. CKS Pelvic Inflammatory Disease NICE [http://cks.nice.org.uk/pelvic-inflamatory-disease#azTab](http://cks.nice.org.uk/pelvic-inflamatory-disease#azTab)
3. Management of Infection Guidance for Primary Care, PHE & BIA, Feb 2013
## Genital Tract Infections – Acute Prostatitis

### When to treat
Acute prostatitis should be suspected in a man who presents with a feverish illness of sudden onset; irritative urinary voiding symptoms or acute urinary retention; perineal or suprapubic pain; exquisitely tender prostate on rectal examination.\(^1\)
Empirical therapy should be started immediately after urine cultures have been obtained.

### When to investigate
All patients >35 years need mid-stream urine sample for dipstick testing and culture for bacteria and antibiotic sensitivity.\(^1\)
(An STI is much more likely in men <35 years. Send first-catch urine for NAATs).\(^2\)
Admit to hospital if the man is unable to take oral antibiotics, has acute urinary retention or is severely ill.\(^1\)
Refer urgently if the man has a pre-existing urological condition and consider urgent referral if the man has diabetes or is immunocompromised.\(^1\)

### How to respond to a positive lab result
Reassess after 24-48 hours:
Review the culture results and ensure that an appropriate antibiotic is being used.\(^1\)
If there is deterioration or failure to respond to oral therapy, urgent admission and parenteral therapy should be arranged;\(^2\) prostatic abscess may need to be excluded or treated.\(^1\)
Treatment of sexual partners is not required.\(^2\)

### General advice
Adequate hydration should be maintained, rest encouraged and analgesics such as non-steroidal anti-inflammatory drugs if required.\(^3\)
Most men treated appropriately for acute prostatitis will recover completely within 2 weeks (but treatment should be continued for at least a further 2 weeks).\(^1\)
Following recovery, refer for investigation to exclude structural abnormality of the urinary tract.\(^1\)

### Treatment choices
**First line:**\(^3\)
- **Ciprofloxacin** * 500mg *bd for 28 days\(^C\)
- **Ofloxacin** * 200mg *bd for 28 days

**Second line or if allergic to quinolones:**\(^3\)
- **Trimethoprim** 200mg *bd* for 28 days

### Cautions
Avoid quinolones in people with a history of tendon disorders related to quinolones, or a history of seizures or conditions that predispose to seizures. *High-risk drug for Clostridium difficile infection and should be avoided in at-risk patients.

### Evidence
Quinolones achieve higher prostate levels than trimethoprim.\(^3\)
UK guidelines recommend treatment for at least 4 weeks to prevent the development of chronic prostatitis.\(^1\)

### References
# Genital Tract Infections – Balanitis

<table>
<thead>
<tr>
<th>When to treat</th>
<th>When infection is suspected or where symptoms are troublesome or do not resolve with good hygiene.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When to investigate</td>
<td>A sub-preputial swab is not necessary to make a diagnosis, but can be useful for identifying the underlying cause. Take a sub-preputial swab if balanitis is severe, recurrent or persists despite treatment. Check blood glucose levels or urine for glycosuria if balanitis is severe, persistent, or recurrent (especially if Candidal balanitis is present). Only swab for Gardnerella-associated balanitis if this is suspected clinically. If penile cancer is suspected, refer urgently to genitourinary medicine (GUM) or urology. If ulceration, urethritis or inguinal lymphadenopathy is present refer to GUM. If balanitis is recurrent and associated with inability to retract the foreskin refer to urology. If balanitis is recurrent and no underlying cause can be identified, or balanitis persists despite treatment, refer to GUM or urology, depending on the most likely underlying cause.</td>
</tr>
<tr>
<td>How to respond to a positive lab result</td>
<td>If symptoms are worsening or do not start to improve within 7 days, advise patient to stop hydrocortisone, if prescribed, and take a sub-preputial swab (if not already done) to exclude or confirm a fungal or bacterial infection, and adjust treatment (if indicated), or seek specialist advice. Screening should be offered to partners where a sexually transmissible agent is found.</td>
</tr>
<tr>
<td>General advice</td>
<td>Advise daily cleaning under the foreskin with lukewarm water, followed by gentle drying. Soap or other irritants should not be used on the genitalia. Consider prescribing an emollient (such as emulsifying ointment) as a soap substitute.</td>
</tr>
<tr>
<td>Treatment choices</td>
<td><strong>For suspected non-specific dermatitis, with or without candidal colonization:</strong> Prescribe <strong>Clotrimazole</strong> 1% or <strong>Miconazole</strong> 2% cream <em>bd</em> until symptoms settle. <strong>OR</strong> oral <strong>Fluconazole</strong> 150mg stat. If inflammation is causing discomfort consider prescribing <strong>Hydrocortisone</strong> 1% cream or ointment for up to 14 days in addition to treatment. <strong>If suspected / confirmed Gardnerella-associated:</strong> <strong>Metronidazole</strong> 400mg <em>bd</em> for 7 days <strong>If suspected / confirmed Streptococcal balanitis:</strong> <strong>Amoxicillin</strong> 500mg <em>tds</em> for 7 days <strong>OR</strong> if penicillin allergic: <strong>Clarithromycin</strong> 250mg <em>bd</em> for 7 days.</td>
</tr>
<tr>
<td>Cautions</td>
<td>Advise about effect on condoms if creams are being applied.</td>
</tr>
<tr>
<td>Evidence</td>
<td>Oral fluconazole was preferred to topical treatment by approximately 80% of men. Testing and treating partners who have a proven candidal or Gardnerella infection will prevent reinfection and recurrent balanitis.</td>
</tr>
</tbody>
</table>
### Genital Tract Infections – Epididymo-Orchitis

#### When to treat

Have a very low threshold for admitting immediately to exclude testicular torsion.\(^1\) Consider other causes, such as mumps orchitis (may be parotid swelling), Behçet’s syndrome (if recurrent epididymitis), tuberculosis, and amiodarone.\(^1\)

If symptoms are severe or the man or boy is very unwell, consider admitting to hospital, particularly if he has diabetes or is immunocompromised.\(^1\)

Ideally refer for same-day or next-day assessment by a sexual health specialist.\(^1\) If this is not possible: Obtain a mid-steam urine for dipstick, microscopy, and culture and test for sexually transmitted infections.\(^1\) Empirical therapy should be given to all patients with epididymo-orchitis before laboratory results are available.\(^2\)

#### When to investigate

All patients with sexually transmitted epididymo-orchitis should be screened for other sexually transmitted infections.\(^2\)

If a urinary tract infection is confirmed, refer to a urologist to investigate for an underlying structural abnormality or urinary tract obstruction.\(^1\)

#### How to respond to a positive lab result

Tailor treatment according to culture and sensitivity results.

If the patient was gonorrhoea positive, a test of cure should be performed at least 72 hours after completion of antibiotics.\(^2\)

#### General advice

Bed rest, scrotal elevation (such as with supportive underwear), and analgesia.\(^1\)

If symptoms worsen, or do not begin to improve within 3 days, return for reassessment.\(^1\)

#### Treatment choices

- **If sexually transmitted organism related, including gonorrhoea:**\(^3\)
  - Ceftriaxone* 500mg stat IM **PLUS**
  - Doxycycline 100mg bd for 10-14 days
  - No intercourse until review. Notify partner.

- **Most probably due to chlamydia or other non-gonococcal organism (no risk factors for gonorrhoea) consider:**\(^3\)
  - Doxycycline 100mg bd for 10-14 days **OR**
  - Ofloxacin* 200mg bd for 14 days
  - No intercourse until review. Notify partner.

- **All causes, but patient is allergic to tetracyclines and/or cephalosporins:**\(^2\)
  - Ofloxacin* 200mg bd for 14 days

- **If due to an enteric organism (for example, *Escherichia coli)*:**\(^3\)
  - Ofloxacin* 200mg bd for 14 days **OR**
  - Ciprofloxacin* 500mg bd 10 days

#### Cautions

Avoid quinolones in people with a history of tendon disorders related to quinolones, or a history of seizures or conditions that predispose to seizures.\(^1\) *High-risk drug for *Clostridium difficile* infection and should be avoided in at-risk patients.

#### Evidence

Cefixime 400mg oral as a single dose may be an alternative to ceftriaxone where IM route is contraindicated or refused.\(^4\)

Observations in Asia have raised concern over the adequacy of 400mg cefixime for the treatment of genital gonorrhoea.\(^4\)

#### References

1. CKS – Scrotal swellings - management [http://cks.nice.org.uk/scrotal-swellings#azTab](http://cks.nice.org.uk/scrotal-swellings#azTab)
Gastro-intestinal Infections
Gastro-intestinal infections – Eradication of *Helicobacter pylori*

**When to treat: test and treat approach**1,2,6

Patients aged 55 years and older, with new unexplained & persistent (over 4-6 weeks) recent onset dyspepsia, should be referred urgently for endoscopy, to exclude cancer1,3,4,5 otherwise the presence of *H. pylori* (HP) should be confirmed by Stool helicobacter antigen test (SAT) or Urea breath test (UBT) before starting eradication therapy.1,2

Test in the following situations1,2 (see below for type of tests):
- Patients with uncomplicated dyspepsia unresponsive to lifestyle change, antacids single course of PPI for 1 month and without alarm symptoms
- Patients with a past history of gastric ulcer (GU) or duodenal ulcer (DU) who have not previously been tested
- Patients before starting or taking NSAIDs especially if a prior history of gastro-duodenal ulcers
- Patients with unexplained iron-deficiency anaemia, idiopathic thrombocytopenic & vitamin B12 deficiency
- Patients with low grade MALT lymphoma

Do not test or offer eradication for gastro-oesophageal reflux disease (GORD) or to children with functional dyspepsia.

**When to investigate**

- Test eligible patients for HP (see above) using a SAT. A UBT may be available if following endoscopy.
- Do not perform SAT or UBT within at least 2 weeks of PPI or 4 weeks of antibiotics
- Patients testing negative – reassure as NPV is >95%. Treat as functional dyspepsia with low dose PPI or H2A for one month, then as required. Consider re-testing for HP,1,7 preferably by UBT, but SAT is an alternative1,7. Withhold re-testing for at least 2 weeks after PPI or 4 weeks after antibiotic treatment.
- If poor compliance or local high resistance rates
- Patients with complicated peptic ulcer or MALTOMA
- Patients requiring aspirin or NSAID in whom a PPI is not co-prescribed, especially with history of peptic ulcer

**Treatment choices**

**First choice:** Triple-therapy regimen with twice daily dosing for 7 days1,4,6,7 (See ‘Evidence’ below for longer duration)

PPI eg: **Lansoprazole** 30mg or **Omeprazole** 20mg or **Pantoprazole** 40mg *bd*

PLUS 2 antibiotics (not prev used):
- Either **Amoxicillin** 1g and **Clarithromycin** 500mg *bd*
- **OR** Amoxicillin 1g and **Metronidazole** 400mg *bd*
- **OR** Clarithromycin 250mg and **Metronidazole** 400mg *bd*

**Second Line:** Quadruple-therapy for 14 days PPI twice daily

eq: **Lansoprazole** 30mg or **Omeprazole** 20mg or **Pantoprazole** 40mg *bd*

PLUS **Tripotassium dictratobismuthate** 240mg *bd*

PLUS any 2 antibiotics (not prev used) from the following:
- Tetracycline hydrochloride 500mg *qds*
- Metronidazole 400mg *bd*
- Clarithromycin 500mg *bd*
- Amoxicillin 1g *bd*

continued overleaf
Gastro-intestinal infections – Eradication of Helicobacter pylori (continued)

Cautions
If diarrhoea develops, consider Clostridium difficile infection and review need for treatment.1

Evidence
Helicobacter test & treat strategies will benefit patients with ulcer disease
Eradication rate is about 85%1,6. Increasing the duration of PPI-based triple therapy to 7 or 10 days, increases HP eradication rates8. However patients experience a marginal significant increase in adverse events though the rate of discontinuation of treatment showed no significant difference.8

References
1. Test and treat for Helicobacter pylori in dyspepsia – Quick reference guide for primary care. PHE & BIA 2012
   (accessed 15 September 2014)
4. NICE Clinical Guideline no. 184: Dyspepsia and gastro-oesophageal reflux disease: investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease or both. September 2014
5. NICE Clinical guideline no. 141: Acute upper gastrointestinal bleeding: management. June 2012
   http://www.nice.org.uk/Guidance/CG141 (accessed 15 September 2014)
6. BNF September 2014
   http://cks.nice.org.uk/#azTab (accessed 15 September 2014)
8. Uuan Y et al., optimum duration of regimens for Helicobacter pylori eradication (Review) Cochrane Collaboration. The Cochrane Library 2013, Issue 12
Gastro-intestinal infections – Infectious Diarrhoea

When to treat
Definition of acute diarrhoea: 3 or more episodes a day, <14d and sample takes shape of pot.¹
Empirical treatment for patients well enough to be managed in primary care is not usually recommended because the majority of illnesses seen in the community do not have an identifiable bacterial cause.²
If Campylobacter is strongly suspected as the cause of diarrhoea (e.g. undercooked meat and abdominal pain), consider empirical treatment with clarithromycin if treating early.²
Urgently refer all previously healthy children with acute painful, bloody diarrhoea or confirmed E. coli O157.¹

When to investigate
Send a stool specimen for culture and sensitivity if:
• systematically unwell; blood or pus in the stool;
• it is necessary to exclude other pathologies;
• immunocompromised;
• diarrhoea occurs after high risk foreign travel (also request tests for ova, cysts, and parasites);
• recent antibiotics or hospitalisation (also request C. difficile);
• diarrhoea is persistent (e.g. >1week).³
If the diarrhoea has stopped, culture is rarely indicated, as recovery of the pathogen is unlikely.¹
Consider blood tests if infection and other causes of acute diarrhoea excluded and a chronic cause is suspected.³
Consult local HPU if: Suspected public health hazard; outbreaks of diarrhoea in the family or community; infected with certain organisms (e.g. E. coli O157) where there may be serious clinical sequelae to an infection.³

How to respond to a positive lab result¹
Most patients in whom pathogens are detected will NOT require specific treatment unless systemically unwell or treatment is advised by a microbiologist or consultant in communicable disease control.
Campylobacter: Antibiotic therapy has little effect on duration of symptoms unless given very early in illness course.
Giardia lamblia and Entamoeba histolytica should be treated according to sensitivity results.
Unless symptoms persist, Blastocystis and Dientamoeba fragilis do not usually require treatment if otherwise healthy.
C. difficile: See C. difficile recommendations.

Treatment choices
Fluid replacement is essential.
If systemically unwell and campylobacter suspected consider Clarithromycin 250-500mg bd for 5-7days if treated early.²

Evidence
There are no routine methods for detecting enterotoxigenic E. coli, the commonest cause of traveller’s diarrhoea.¹
Quinolones are not recommended because there is increasing resistance in Campylobacter to quinolones.²

References
1. PHE 2010 Infectious diarrhoea Quick reference guide for primary care
2. Management of Infection Guidance for Primary Care, PHE & BIA, Jan 2012.
**Gastro-intestinal infections – Diverticulitis**

### When to treat

Antibiotic treatment is recommended for the routine management of diverticulitis, either at home or as an inpatient. People with mild, uncomplicated diverticulitis can be managed at home with paracetamol, clear fluids, and antibiotics. Arrange admission for people with diverticulitis when:

- pain cannot be managed with paracetamol;
- hydration cannot be easily maintained with oral fluids;
- oral antibiotics cannot be tolerated;
- the person is frail or has a significant comorbidity that is likely to complicate their recovery (particularly if immunocompromised);
- the person has any of the following suspected complications: rectal bleeding that may require transfusion, perforation and peritonitis, intra-abdominal abscess, fistula.

*There is low level evidence that patients suitable for management at home may be managed without the use of antibiotics. In general a course of antibiotics is recommended.*

### When to investigate

If symptoms persist after 48 hours despite conservative management at home admit patient to hospital.

### General advice

Review within 48 hours or sooner if symptoms deteriorate. Arrange admission if symptoms persist or deteriorate. Prescribe paracetamol for pain. Recommend clear liquids only. Gradually reintroduce solid food as symptoms improve over 2-3 days.

### Treatment choices

**First choice:**

- **Co-amoxiclav**
  - 625mg tablets tds for at least 7 days (7-10 days)

**Second choice or if allergic to co-amoxiclav:**

- **Metronidazole**
  - 400mg tds for 7 days

- **Ciprofloxacin**
  - 500mg bd for at least 7 days (7-10 days)

*High-risk for *C. difficile* infection. Alternative option **Co-trimoxazole**

- 960mg bd **PLUS**
  - **Metronidazole** 400mg tds for at least 7 days.

### Evidence

Avoid nonsteroidal anti-inflammatory drugs (NSAIDs) and opioid analgesics such as co-codamol, which have been identified as risk factors for diverticular perforation.

### References

### Gastro-intestinal infections – Clostridium difficile Infection

#### When to treat

*C. difficile* spectrum ranges from asymptomatic carriage to severe life-threatening illness and management is based on clinical presentation and symptoms. Asymptomatic carriage does not require treatment. People with mild disease may not require specific *C. difficile* antibiotic treatment. Treat patients with mild-to-moderate CDI. Patients who are Glutamate Dihydrogenase (GDH) positive will not need treatment if toxin negative. If the patient has features of severe or life-threatening CDI, or their condition is rapidly deteriorating, admit to hospital. If the condition has improved considerably or resolved without treatment, consider possibility of false-positive result. **Mild CDI:** No increased white cell count (WCC) and typically associated with <3 episodes of loose stools/day. **Moderate CDI:** Increased WCC but <15 x 10⁹/L and typically associated with 3–5 loose stools per day. **Severe CDI:** WCC >15 x 10⁹/L, or an acutely rising serum creatinine (>50% above baseline), or a temperature >38.5°C, or evidence of severe colitis. The number of stools may be a less reliable indicator of severity. **Life-threatening CDI:** Signs and symptoms include hypotension, partial or complete ileus, or toxic megacolon.

#### When to investigate

Send stool specimen for *C. difficile* investigation if a clinical diagnosis of CDI is suspected, and the person is symptomatic with liquid/loose stools (consistency that takes the shape of the container). Consider risk factors for CDI, including advanced age, any recent antibiotic treatment (particularly Clindamycin, Cephalosporins, Ciprofloxacin, Co-amoxiclav), underlying morbidity (abdominal surgery, cancer, chronic renal disease, tube feeding), current use of PPI’s or other acid-suppressive drugs, recent hospitalization, exposure to other cases, inflammatory bowel disease, history of CDI. Do not re-test people with a positive CDI if they are still symptomatic within a period of 28 days. Do not repeat tests to confirm clearance in asymptomatic patients. Only re-test to confirm recurrent CDI if the symptoms resolve and then recur.

#### How to respond to a positive lab result

2-stage CDI testing uses a screening test to detect the presence of *C. difficile* bacteria and a Toxin test to detect the excretion of toxin causing disease.

- **Screening test negative** (Negative Predictive Value = 98.9%) CDI very unlikely to be present.
- **Screening test positive BUT Toxin test negative** – potential for carriage or active CDI, manage based on symptoms, consider alternative cause of diarrhea or possibility of false negative Toxin test.
- **Screening test positive AND Toxin test positive** (Positive Predictive Value = 91.4%) – CDI likely to be present and associated with poor outcome.

Start treatment based on results AND clinical assessment. Discontinue precipitating antibiotic(s) wherever possible; agents with less risk of inducing CDI can be substituted if an underlying infection still requires treatment. Discontinue other drugs that might cause diarrhoea. Stop unnecessary PPI’s.

#### Treatment choices

**General advice:**
Review the person daily and monitor for signs of increasing severity of disease as they may deteriorate rapidly.

- **First episode (mild and moderate CDI only):**
  - *Metronidazole* 400-500mg tds for 10-14 days

- **Second episode or severe/ type027:**
  - *Oral Vancomycin* 125mg qds for 10-14 days

- **Recurrence within 30 days AND CDI toxin positive:**
  - *Fidaxomicin* * 200mg bd for 10-14 days

*only on the recommendation of a consultant medical microbiologist following recurrent relapse

#### Cautions

Antimotility agents (such as loperamide) should be avoided in acute infection due to the risk of precipitating toxic megacolon. If possible, avoid other drugs with anti-peristaltic effects (such as opioids). Hand hygiene with soap and water, avoid alcohol hand rubs.

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*continued overleaf*
### Gastro-intestinal infections – *Clostridium difficile* Infection (continued)

| Evidence | 70% of patients respond to Metronidazole in 5 days; 92% in 14 days. Administration of currently available probiotics is not recommended to prevent CDI or antibiotic associated diarrhoea.  
Recurrent disease occurs in about 20% of patients treated initially with either Metronidazole or Vancomycin and in 50-60% patients following a second episode of CDI. A variable proportion of recurrences are reinfections (20-50%) as opposed to relapses due to the same strain. Relapses tend to occur in the first two weeks after treatment cessation. |
| References | 1. PHE Updated guidance on the management and treatment of Clostridium difficile infection. May 2013  
2. DH. Clostridium difficile infection: How to deal with the problem. December 2008.  
4. DH. Updated guidance on the diagnosis and reporting of Clostridium difficile. March 2012.  
### Gastro-intestinal infections – Travellers’ Diarrhoea (Stand-by or Prophylactic Treatment)

#### When to treat
Travellers’ diarrhoea is, for most people, a non-serious, self-limiting illness, lasting 3-4 days which will recover without antibiotic treatment.⁴ Do not routinely offer prophylactic or standby antibiotics for prevention of travellers’ diarrhoea.⁴

**Prophylactic antibiotics:** Consider if the patient is at high risk of diarrhoea and: Is immunocompromised; at high risk of complications (e.g. Crohn’s disease, UC, colostomy, renal disease, congestive heart failure) or if diarrhoea could severely impact the purpose of a critical trip.⁴

**Standby antibiotics:** Only consider for high risk remote areas or for people at high risk of severe illness with travellers’ diarrhoea (unless eligible for prophylaxis).⁴

High-risk countries are defined as most of Asia, the Middle-East, Africa, Mexico, Central and Southern America.²

#### When to investigate
Advise travellers to seek medical care if symptoms do not improve within two days (earlier if elderly) or they have a fever or are passing blood/mucous. Seek immediate attention for children with diarrhoea if dehydration; vomiting; fever or blood.³

#### General advice
Provide advice on food hygiene and safe drinking water if the person is travelling to locations with low standards of hygiene and sanitation.¹

#### Treatment choices

| First line: | Prophylaxis: Ciprofloxacin 500mg od (on private Rx) for up to 3 weeks. If contra-indicated seek specialist advice¹ |
| Start if symptoms moderate/severe: | Standby: (start if symptoms moderate/severe):<br>Ciprofloxacin 500mg bd for 3 days (on private Rx)² OR If ciprofloxacin contra-indicated or travelling to Thailand/Far East: Azithromycin 500mg od for 3 days (on private Rx)¹ |

- **Loperamide** can be considered for travellers in whom frequent diarrhoea is inconvenient.³ Avoid loperamide in children and patients with inflammatory bowel disease, a fever or blood in stool.³

#### Evidence
Azithromycin, bismuth salicylate, loperamide and probiotics are not recommended for prophylaxis.¹ Antibiotic treatment is associated with shorter duration of diarrhoea but higher incidence of side-effects.⁴ The combination of loperamide and an antibiotic in moderate diarrhoea may lead to more rapid improvement compared with either agent alone.³

#### References
<table>
<thead>
<tr>
<th><strong>Genital Tract Infections – Threadworms</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When to treat</strong>¹</td>
</tr>
<tr>
<td><strong>When to investigate</strong>¹</td>
</tr>
<tr>
<td><strong>General advice</strong>²</td>
</tr>
</tbody>
</table>
| **Treatment choices** | **First line for adults and children aged >6 months:**²  
Mebendazole 100mg stat chewable tablet (off label if <2yrs)  
Repeat in 2 weeks if infestation persists¹ |
| | **For children aged <6 months:**¹  
6 weeks strict hygiene to prevent faecal-oral re-infectionC |
| **Cautions**¹ | Treatment with an anthelmintic is contraindicated in children less than 3 months and women in the first trimester of pregnancy. Women in the second or third trimester and women who are breastfeeding may prefer not to take an anthelmintic and use hygiene methods. |
| **Evidence**¹³ | Neither mebendazole nor piperazine kills eggs, therefore adequate personal and environmental hygiene is essential to prevent reinfestation from recently swallowed eggs, or eggs already in the environment.  
It is generally accepted that mebendazole has a 90-100% cure-rate³, however it has few contraindications and post-marketing surveillance has revealed no serious safety concerns.¹  
Hygiene measures, plus physical removal advice is based on expert opinion.¹ |
| **References** | 1. CKS Threadworm (Available at [http://cks.nice.org.uk/threadworm#!/topicsummary](http://cks.nice.org.uk/threadworm#!/topicsummary) Date accessed 24.7.14)  
3. NHS Choices Threadworms (Available at [http://www.nhs.uk/Conditions/Threadworms/Pages/Treatment.aspx](http://www.nhs.uk/Conditions/Threadworms/Pages/Treatment.aspx) Date accessed 24.7.14) |
## Skin & Soft Tissue Infections – Impetigo

### When to treat

Although usually self-limiting, treatment is recommended for all cases, as untreated impetigo is highly contagious and there is a risk it may become generalised. Topical antibiotics should be reserved for very localised lesions and oral antibiotics used for extensive, severe or bullous impetigo.

Non-bullous impetigo (also known as impetigo contagiosa or crusted impetigo) is the most common form. Lesions begin as vesicles or pustules, which rapidly burst and evolve into gold-crusted plaques. The area around the mouth and nose is most commonly affected.

Bullous impetigo, which commonly affects neonates, presents with flaccid, fluid-filled vesicles and blisters. These easily burst leaving raw skin, and eventually form thin, flat, brown-to-golden crusts. Tends to involve the axillae, neck folds, and nappy area. Lesions are usually painful, are often multiple and spread rapidly.

### When to investigate

Skin swabs are not necessary to diagnose impetigo.

Take a swab (for bacterial identification and sensitivity) if the infection is: very extensive or severe; recurrent (consider nasal swab for staphylococcal carriage); suspected as being a community outbreak; suspected as being caused by MRSA.

Advise the person to attend a follow-up appointment if there is no significant improvement after 7 days.

### How to respond to a positive lab result

Review any culture results and ensure that an appropriate antibiotic is being used.

### General advice

Advise that hygiene measures are important to aid healing and stop the infection spreading to other sites on the body and to other people.

### Treatment choices

<table>
<thead>
<tr>
<th>Small localised infections (topical antibiotics):</th>
<th>More generalized/widespread infections (oral antibiotics):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fusidic Acid</strong> 2% topically tds for 5 days</td>
<td><strong>If MRSA isolated:</strong> <strong>Mupirocin</strong> 2% topically tds to affected area(s) for 5 days</td>
</tr>
<tr>
<td><strong>Flucloxacillin</strong> 500mg qds for 7 days</td>
<td><strong>If penicillin allergic:</strong> <strong>Clarithromycin</strong> 250-500mg bd for 7 days</td>
</tr>
</tbody>
</table>

### Evidence

Topical antibiotics are reserved for treatment of very localised lesions because fusidic acid is an antibiotic that is also used systemically and there are concerns that widespread use will lead to increased resistance. If a topical antibiotic is used, a short course (such as 5 days) reduces exposure and the risk of resistance.

### References

3. BNF 66, September 2013-March 2014
### Skin & Soft Tissue Infections – Eczema

| When to treat | If **no visible signs of infection**, use of antibiotics (alone or with steroids) encourages resistance and does not improve healing. In eczema with **visible signs of infection**, use treatment as in impetigo. Admit to hospital urgently if eczema herpeticum (disseminated herpes simplex virus infection) suspected. Signs of eczema herpeticum are: • rapidly worsening, painful eczema; • clustered blisters • punched-out erosions which may coalesce to form larger areas of erosion that can extend over the entire body; • possible fever, lethargy, or distress. Refer urgently (within 2 weeks) to a dermatologist if infected eczema has not responded to treatment Refer to a dermatologist if recurrent secondary bacterial infection. |
|---|
| Evidence¹ | Oral antibiotics were not associated with benefit in small trials of eczema without visible signs of infection. |
## Skin & Soft Tissue Infections – Cellulitis

### When to treat\(^1,2\)
Cellulitis presents with an acute onset of red, painful, hot, swollen, and tender skin, with possible blister or bullae formation. The leg is the most commonly affected site, presentation is usually unilateral. Often (but not always) associated with a break in the skin (portal entry). If patient afebrile and healthy other than cellulitis, can be managed in primary care.\(^2\)

### When to investigate\(^1,2\)
- **If patient febrile and ill, admit for IV treatment**
  Consider admission for patients with severe or rapidly deteriorating cellulitis; an uncertain diagnosis with sinister signs or symptoms (e.g. possible necrotizing fasciitis); severe systemic illness; comorbidities that may complicate or delay healing; facial* or periorbital cellulitis; lymphoedema; or for the very young, elderly or frail people.
  - *Mild facial cellulitis can be managed in primary care (see treatment below)*
  - **If river or sea water exposure, discuss with microbiologist**

  Consider taking a swab for culture and sensitivity testing if there is a visible portal of entry for bacteria (e.g. an open wound); other investigations are not usually necessary.

### How to respond to a positive lab result
Alter treatment in response to culture and sensitivity results of potential pathogens.
Refer people who fail to respond to oral antibiotics or have frequent recurrence of cellulitis, for example more than two episodes at the same site.\(^1\)

### General advice
- Before treatment, draw around the extent of the infection with a permanent marker pen for future comparison.\(^1\)
  - Advise patient to have an adequate fluid intake.\(^1\)
  - Elevation of the affected area speeds improvement by promoting gravity drainage of the oedema/inflammatory substances.\(^3\)
  - In patients with lymphoedema antibiotic prophylaxis should be offered to patients who have two or more attacks of cellulitis per year.\(^4\)

### Treatment choices\(^2\)

<table>
<thead>
<tr>
<th>First Line:</th>
<th>If penicillin allergic:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Flucloxacillin</strong> 500mg qds for 7 days</td>
<td><strong>Clarithromycin</strong> 500mg bd OR <strong>Clindamycin</strong> 300-450mg qds for 7 days</td>
</tr>
<tr>
<td><strong>Mild facial cellulitis:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Co-amoxiclav</strong> 625mg tds for 7 days</td>
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</tr>
</tbody>
</table>

**If slow response continue antibiotics for a further 7 days.**

### Cautions
Stop clindamycin if diarrhoea occurs.

### Evidence\(^2\)
- Expert consensus that people with no signs of systemic toxicity and no uncontrolled co-morbidities can usually be managed with oral antibiotics.

### References
2. Management of Infection Guidance for Primary Care; revised Feb 13.
3. Infectious Diseases Society of America 2005. Practice Guidelines for the Diagnosis and Management of Skin and Soft-Tissue Infections
Skin & Soft Tissue Infections – Leg Ulcers

When to treat
Signs of an infected leg ulcer include enlarging ulcer with abnormal, bleeding or bridging granulation tissue, increased exudate, increased disproportionate pain, pyrexia, systemic inflammatory response syndrome, sepsis, foul odour or cellulitis, lymphangitis and lymphadenopathy.¹,²,³,⁸
See local leg ulcer guidelines for full guidance.² Leg ulcers are always colonised and antibiotics will only promote healing during active infection.⁴
If the patient has an active infection, start empirical antibiotics after taking a wound swab for cultures and sensitivity.

When to investigate
Ulcers should not routinely be swabbed unless there is clinical evidence of infection. Treat the patient, NOT culture results.⁸ Take a swab from all infected leg ulcers before prescribing an antibiotic.¹
Use a swab with transport medium, to aid survival of fastidious organisms. Clean the ulcer with a sterile solution to remove debris, pus or other foreign material first, and gently pass the swab over the area in a zigzag motion ensuring it is turned in a circular motion so that the entire swab is covered. Swab from the centre to the outside of the wound ensuring any exudate is thoroughly absorbed onto the swab. Ensure that a full history is given when sending the swab to the pathology department.¹

How to respond to a positive lab result
Swab results determine organisms present and antimicrobial susceptibilities, they do not determine the presence of infection.⁵ Inclusion of antibiotic susceptibilities in a microbiology report does not necessarily mean an organism is significant or that it requires antibiotic treatment. Group A ß-haemolytic streptococci can be associated with significant infection and delay healing. Significance of other organisms depends on presence of the clinical criteria above. Review antibiotics after culture results.⁴ Seek microbiology advice if colonised with MRSA.⁵
The use of topical antibiotics in the management of infected wounds should generally be avoided to minimise the risk of allergy and the emergence of bacterial resistance.¹,³
The use of a topical antimicrobial should be considered if the wound is thought to be critically colonised and may be of some benefit as an adjunct to systemic treatment in infected wounds.²,⁶

General advice
Advise patients to keep mobile, elevate legs when immobile, avoid trauma and wear appropriate footwear, use an emollient frequently even after the ulcer has healed, examine legs regularly for deterioration and wear compression bandages or stockings as advised.¹

Treatment choices⁴
First line if evidence of active infection: Flucloxacillin 500mg-1g (dependant on BMI)⁷ qds for 7 days. If slow response continue for a further 7 days.⁵
If penicillin allergic: Clarithromycin 500mg bd for 7 days. If slow response continue for a further 7 days.⁵

Evidence
Available evidence suggests that no differences in complete wound healing were detected when silver-impregnated dressings, povidone iodine or honey-based preparations were compared with non-antimicrobial dressings for venous leg ulcers (see advice from tissue viability specialist).⁸
More research study participants were healed when given cadexomer iodine compared with standard care but cadexomer iodine dressings should only be used when there is evidence of heavy bacterial load/local wound infection and these dressings should be stopped once local infection has been controlled and for no longer than 3 months continuously.⁸,⁹

References
7. SIGN Management of Chronic Venous Leg Ulcers a national clinical guideline 120. August 2010 Available from: [http://www.sign.ac.uk/pdf/sign120.pdf](http://www.sign.ac.uk/pdf/sign120.pdf)
### Skin & Soft Tissue Infections – Diabetic Foot Ulcer

#### When to treat
- Antibiotics should not be used for foot ulcers without signs of infection as they do not enhance healing or prevent infection.1,6
- The clinical diagnosis of foot infection is based on ≥ two of the following: purulent discharge from an ulcer or signs of inflammation (i.e. erythema, pain, tenderness, warmth or induration).2 Other signs may include foul odour, nonpurulent secretions, friable or discoloured granulation tissue, undermining of wound edges.3
- Ideally refer anyone with new diabetic foot infection to a multidisciplinary foot-care team within 24 hours.2,3 If this is not possible and the infection is superficial and non-limb-threatening, consider taking swabs then start empirical antibiotic treatment.3
- Mild infections are those where the cellullitis or erythema extends > 0.5cm but ≤ 2cm around the ulcer, and infection is limited to the skin or superficial subcutaneous tissues and there are no other local complications or systemic illness.2
- Moderate infections (erythema > 2cm, or involving structures deeper than skin and subcutaneous tissues eg, abscess, fasciitis; and no systemic inflammatory response signs – SIRS) should be referred for inpatient management in the presence of complications e.g. severe peripheral arterial disease.3
- If the infection is severe (> 2 SIRS criteria), refer for urgent inpatient management.1,3 Patients with any of the following should be referred for urgent inpatient management: pink or pale, painful, pulseless foot (indicating critical ischaemia); spreading cellulitis, lymphangitis; crepitus; lack of response of infection to oral antibiotics; suspicion of bone involvement or deep seated infection; immunocompromised patients or those with poor diabetic control.3,4

#### When to investigate
Swabs should be taken from the deepest part of the cleaned wound after removal of surface contamination and exudate.2,3 Ensure that the person is reviewed within 48 hours.3

#### How to respond to a positive lab result
Patients should be reassessed 24 to 72 hours after initiating empiric antibiotic therapy to evaluate their response and modify the antibiotic regimen, if indicated by early culture results.1 Clinical failure of appropriate antibiotics may be due to patient nonadherence, antibiotic resistance, superinfection, undetected abscess or osteomyelitis or severe tissue ischaemia.1

#### General advice
Care of people with foot ulcers should include re-distribution of foot pressures, investigating vascular insufficiency, optimising glycaemic control and wound management.3 Advise them to seek urgent medical attention if their symptoms or general condition become worse.3 Elevation of the affected area speeds improvement by promoting gravity drainage of the oedema/inflammatory substances.2

#### Treatment choices

<table>
<thead>
<tr>
<th>Mild infection</th>
<th>Moderate infection with complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Line:</strong></td>
<td><strong>If known to be infected/colonised with MRSA within the last year:</strong></td>
</tr>
<tr>
<td><strong>Flucloxacillin</strong></td>
<td><strong>Doxycycline</strong></td>
</tr>
<tr>
<td>500mg qds for 7 days</td>
<td>100mg bd for 7 days</td>
</tr>
<tr>
<td><strong>If penicillin allergic:</strong></td>
<td><strong>PLUS</strong></td>
</tr>
<tr>
<td>Clarithromycin</td>
<td><strong>Moxifloxacin</strong></td>
</tr>
<tr>
<td>500mg bd for 7 days</td>
<td>400mg bd for 7-14 days</td>
</tr>
<tr>
<td>Consider adding</td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td>400mg tds to cover anaerobes (e.g. if foul odour).4</td>
</tr>
</tbody>
</table>

#### Evidence
- Consider continuing antibiotics for a further 7 days depending on severity of infection and speed of response to treatment.2,3
- Continue antibiotic therapy until the infection has resolved but not necessarily until a wound has healed.2 Several antibiotics have been shown to be effective, but no single regimen has shown superiority.1

#### References
Skin & Soft Tissue Infections – MRSA (meticillin-resistant *Staphylococcus aureus*)

**When to treat**

For **MRSA colonisation**, prescribe suppression regimen for all patients with positive cultures awaiting elective procedures.¹

Consider treating patients with **active MRSA infection** that has been confirmed by laboratory tests.² Do not give systemic antibiotics to patients with minor skin and soft tissue infections or small abscesses (<5 cm). Incise and drain small abscesses without cellulitis and do not give antibiotic therapy.³

MRSA infections most commonly affect the skin presenting as boils; abscesses; styes; carbuncles; cellulitis; impetigo; wound infections.⁴ If MRSA enters the bloodstream it can affect almost any part of the body.⁴ Consider admitting people who are MRSA positive if they have worsening signs of infection (e.g. sepsis, worsening cellulitis, fever, or tachycardia), particularly if they are likely to require parenteral antibiotic therapy and/or surgical drainage.⁴

**When to investigate**

**Screening for colonisation:** GPs or pre-admission clinics should screen all patients awaiting elective admissions.¹ Local or national exceptions may apply. Swabs should be taken from the nose and any skin lesions or wounds.¹ The swab should be wiped around the inside of the patient’s nose for 5 seconds.¹

**Diagnosing active infection:** Swab for pathogens including MRSA, or obtain a specimen if appropriate, if the person has an active infection and one or more of the following risk factors: elderly or debilitated people with critical or chronic illness; surgical wounds, open ulcers, intravenous lines, or catheter lines; infected pressure sore; history of MRSA colonisation or infection; recent surgery; recent hospital discharge; regular nursing home contact or a nursing home resident; recent antibiotic use (especially cephalosporins, fluoroquinolones, and macrolides); dialysis; permanent urinary catheter.⁴

**Panton-Valentine Leukocidin (PVL)** is a toxin produced by 2% of *S. aureus*. It can rarely cause severe invasive infections in healthy people. Send swabs if **recurrent boils/abscesses**. At risk: close contact in communities or sport; poor hygiene.²

**How to respond to a positive lab result**

Suppression of colonisation should take place within the 5 days prior to operation as it may not be successful in the long term.¹ For active MRSA infection use antibiotic sensitivities to guide treatment.² If severe infection or no response to monotherapy after 24-48 hours, seek advice from microbiologist on combination therapy and use of Linezolid.²

**Treatment choices**

**SUPPRESSION:**¹ Treat underlying skin conditions (e.g. eczema), remove and/or replace invasive devices and treat skin breaks. Use both nasal and skin regimens:

**Nasal:** *Naseptin* nasal cream qds for 10 days OR (if allergic to peanut, soya or chlorhexidine) 2% *Mupirocin* in paraffin base tds for 5 days⁴

**Skin:** 4% *Chlorhexidine gluconate* body-wash/shampoo daily for 5 days Alternatives: 7.5% *povidone iodine* or 2% *Triclosan* daily for 5 days

**ACTIVE TREATMENT:**² for MRSA confirmed by lab results: *Doxycycline* alone² 100mg bd for 7 days OR *Trimethoprim* 200mg bd for 7 days

**Cautions**

*High-risk drug for *C. difficile* infection and should be avoided in at-risk patients. Stop clindamycin if diarrhoea occurs.²

**References**


### Skin & Soft Tissue Infections – Animal Bite

**When to treat**
Prescribe prophylactic antibiotics if the wound is less than 48 hours old, and there is a high infection risk*. Antibiotics are not usually needed if the wound is more than 48 hours old and there is no sign of local or systemic infection.

*High Infection risk: bite to the hand, foot, and face; puncture wounds; all cat bites; wounds requiring surgical debridement; wounds involving joints, tendons, ligaments, or suspected fractures; wounds that have undergone primary closure; wounds to people who are at risk of serious wound infection (e.g. those who are diabetic, cirrhotic, asplenic, immunosuppressed, people with a prosthetic valve or a prosthetic joint)

Refer to A&E for further assessment and management if wound closure is necessary.

Admit anyone who has severe infection or who is systemically unwell as IV antibiotics may be required.

Assess risk of tetanus and rabies. If any risk of rabies contact the Local Health protection Team (Public Health England):
https://www.gov.uk/contacts-phe-regions-and-local-centres

**When to investigate**
Where infection suspected, send a pus or deep wound swab for culture before cleaning the wound and starting antibiotics (state on form that swab is from an infected animal bite).

Advise all patients to attend urgently for review if the infection worsens or if they feel increasingly unwell. For infected wounds, review at 24 and 48 hours to ensure that infection is responding to treatment (particularly for penicillin allergic regimens – see below).

**How to respond to a positive lab result**
Alter treatment in response to culture and sensitivity results.

For bites from animals not covered in this guidance, seek microbiology advice for the most appropriate treatment.

**General advice**
If the wound has just occurred, remove any foreign bodies from the wound and encourage it to bleed. Clean and irrigate the wound.

**Treatment choices**

<table>
<thead>
<tr>
<th>Cat or Dog bite first line prophylaxis or treatment:</th>
<th>Cat or Dog bite prophylaxis or treatment if penicillin allergic:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-amoxiclav 375-625mg tds for 7 days</td>
<td>Metronidazole 200-400mg tds <strong>PLUS</strong> Doxycycline 100mg bd for 7 days</td>
</tr>
</tbody>
</table>

*Penicillin allergy: reassess at 24 and 48 hours after starting a course of antibiotic treatment because the recommended regimen (above) covers the majority, but not all, of the likely pathogens from an animal bite*

**Cautions**
Antiseptic cleansers are not necessary, and there is some concern that they damage tissue and delay wound healing.

**Evidence**
Co-amoxiclav recommended first line for treatment or prophylaxis of animal bites because it is a broad-spectrum antibiotic that is effective against the most commonly isolated organisms from animal bites (including Pasteurella). Macrolides are not recommended for animal bites because they do not adequately cover Pasteurella.

**References**
Skin & Soft Tissue Infections – Human Bite

When to treat\(^1,2\)
Prescribe prophylactic antibiotics for all human bite wounds less than 72 hours old, even if there is no sign of infection. Refer to A&E for further assessment and management if wound closure is necessary. Admit anyone who has severe infection or who is systemically unwell as IV antibiotics may be required.

Assess risk of tetanus, HIV, Hepatitis B&C: Seek immediate advice from a consultant in microbiology or infectious diseases for anyone considered to be at risk of HIV, hepatitis B or C. Consider all people to be at risk unless the current status of the biter is known (rare). Consider if tetanus prophylaxis is required.

When to investigate\(^1\)
Where infection suspected, send a pus or deep wound swab for culture before cleaning the wound and starting antibiotics (state on form that swab is from an infected human bite.) Advise all patients to attend urgently for review if the infection worsens or if they feel increasingly unwell. For infected wounds, review at 24 and 48 hours to ensure that infection is responding to treatment (particularly for penicillin allergic regimens – see below).

How to respond to a positive lab result
Alter treatment in response to culture and sensitivity results.

General advice\(^1\)
If the wound has just occurred remove any foreign bodies from the wound and encourage it to bleed. Clean and irrigate the wound thoroughly with warm running water.

Treatment choices\(^2\)

<table>
<thead>
<tr>
<th>Prophylaxis or treatment</th>
<th>Prophylaxis or treatment if penicillin allergic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-amoxiclav 375-625mg tds for 7 days</td>
<td>Metronidazole 200-400mg tds PLUS Doxycycline 100mg bd for 7 days OR Metronidazole 200-400mg tds PLUS Clarithromycin 250-500mg bd for 7 days</td>
</tr>
</tbody>
</table>

Penicillin allergy: reassess at 24 and 48 hours after starting a course of antibiotic treatment because the recommended regimen (above) covers the majority, but not all, of the likely pathogens from a human bite.

Cautions
Antiseptic cleansers are not necessary and there is some concern that they damage tissue and delay wound healing.

Evidence\(^2\)
Co-amoxiclav recommended first line for treatment or prophylaxis of human bites because it is a broad-spectrum antibiotic that is effective against the most commonly isolated organisms from human bites. Doxycycline, but not clarithromycin is active against *Eikenella* species, which is commonly isolated from human mouths.

References
**Skin & Soft Tissue Infections – Scabies**

| When to treat | The main symptom is generalised itch – especially at night. Characteristic silvery lines may be seen in the skin where mites have burrowed. Erythematous papular or vesicular lesions are often associated with the burrows.¹ Typical sites include the interdigital folds, wrists, elbows and around the nipples in women.² Simultaneously (within 24 hours) treat the infected person and all members of the household, close contacts and sexual contacts even in the absence of symptoms.¹ Scabies persists indefinitely if not treated.¹ Treat scabies that has become infected with an antibiotic.¹ Scabies is rare in children under 2 months of age. Seek specialist advice (e.g. from a paediatric dermatologist) if treatment is required for this age group.¹ |
| When to investigate | Finding the mite or its products confirms, but is not necessary for making a diagnosis of scabies.¹ Review if symptoms have not cleared within 6 weeks after the first application of treatment.¹ Refer institutionalised outbreaks of scabies (e.g. schools, long-stay nursing homes) to the PHE.¹ |
| Treatment choices | **Permethrin**<sup>+</sup> 5% cream. Apply as described below, in two applications, 7 days apart.³ Wash off after 8-12 hours.¹ **If allergy: Malathion**: 0.5% aqueous liquid. Apply as described below, in two applications, 7 days apart.³ Wash off after 24 hours.¹ |
| General advice | Itch may persist for several weeks.¹ Consider symptomatic treatment for itching (e.g. crotamiton 10% cream).¹ Machine wash (at 50°C or above) clothes, towels, and bed linen, on the day of application of the first treatment.¹ If recurrence occurs where all contacts were treated simultaneously and treatment was applied correctly, give a course of a different insecticide.¹ |
| Evidence | There is more evidence for the effectiveness of permethrin than malathion.¹ Benzyl benzoate is regarded as too irritant, and crotamiton is ineffective compared to the recommended options.² Crusted scabies usually only occurs in people who are immunocompromised or who have other risk factors and does not present in the same way as classic scabies.¹ There are hyperkeratotic, warty crusts, which are usually on the hands and feet but all areas of the skin may be involved.¹ Seek specialist advice from a consultant dermatologist for the management of anyone presenting with crusted scabies; admission may be required.¹ |
## Skin & Soft Tissue Infections – Fungal Infection – Skin

### When to treat

Treat fungal skin infections with topical or oral antifungals depending on their severity and location (see below).⁴

Scalp infections: discuss with specialist.²

### When to investigate

Samples are not needed for uncomplicated athlete’s foot, mild infections of the groin and mild skin ringworm.²

Take samples if oral treatment is being considered; in severe or extensive skin fungal infections; for skin infections refractory to initial treatment or when the diagnosis is uncertain.²

Scrape skin from the advancing edge of lesion. Use a blunt scalpel blade or similar. 5mm² of skin flakes are needed for microscopy and culture. Do not refrigerate.²

### How to respond to a positive lab result

Treat if positive lab cultures. Susceptibility testing of dermatophytes is not required, as antifungal resistance is unusual and there is no known correlation between antifungal susceptibilities and outcome.²

For non-dermatophyte moulds other than Candida sp, seek the advice of a microbiologist or dermatologist.²

### General advice

Wash the affected skin daily and dry thoroughly afterwards, wash clothes and bed linen frequently, don’t share towels and wash them frequently, wear loose-fitting clothes made of cotton.¹

### Treatment choices

#### Dermatophyte infection:

**Skin or foot:**
- Topical 1% Terbinafine⁴ od - bd for 7-14 days
- **Groin or foot:**
  - Use a 1% Azole cream od - bd for 4-6 weeks
  - **Alternative for foot only:**³
    - Topical Undecanoates (Mycota®)²+ bd continued for 1-2 weeks after healing

#### Candida infection:

- **Azole** cream 1% od - bd continued for 1-2 weeks after healing¹

If intractable, send skin scrapings before starting oral treatment:³
- **Terbinafine** 250mg oral od⁴
- **Skin:** 4 weeks  
  - **Groin:** 2-4 weeks  
  - **Foot:** 2-6 weeks  
- **OR Itraconazole**⁴*
  - **Skin or groin:** either 100mg oral daily for 15 days, or 200mg od for 7 days⁴
  - **Foot:** either 100mg oral once daily for 30 days or 200mg twice daily for 7 days⁴

#### Cautions

* Following reports of heart failure, caution is advised when prescribing itraconazole to patients at high risk of heart failure.⁴
Do not give a corticosteroid preparation alone.¹

#### Evidence

As terbinafine is fungicidal, one week is as effective as 4 weeks azole which is fungistatic.⁴⁺

A Cochrane review found little difference between terbinafine and azoles in standard courses at 2 weeks after baseline however at 6 weeks, treatment failure was lower with terbinafine.³

### References

2. PHE Fungal skin and nail infections 2011.
## Skin & Soft Tissue Infections – Fungal Infection – Fingernail or Toenail

### When to treat
Start therapy only if infection is confirmed by laboratory. Only 50% of nail dystrophy are fungal. Self-care alone may be appropriate for people who are not bothered by the infected nail or who wish to avoid the possible adverse effects of drug treatment.

### When to investigate
Always send samples before starting lengthy treatment. Send specimens of nail clippings or scrapings for fungal microscopy and culture. False-negative rates are high (about 30%). Therefore repeat the test if the result is negative, and there is high clinical suspicion that the nail is infected.

### How to respond to a positive lab result
For infections with dermatophytes use oral terbinafine or intraconazole. Terbinafine is more effective than azoles. If candida or non-dermatophyte infection confirmed, use oral itraconazole.

### General advice
Liver reactions rare with oral antifungals. For children, seek specialist advice as fungal nail infection is rare in children, and the preferred treatments are not licensed for use in children.

### Treatment choices

<table>
<thead>
<tr>
<th>Choice</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Superficial only:</strong></td>
<td>Amorolfine 5% nail lacquer B- 1-2x / weekly</td>
</tr>
<tr>
<td><strong>Fingernails:</strong></td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Toenails:</strong></td>
<td>12 months</td>
</tr>
<tr>
<td><strong>First line:</strong></td>
<td>Terbinafine A+ 250mg oral od</td>
</tr>
<tr>
<td><strong>Fingernails:</strong></td>
<td>6-12 weeks</td>
</tr>
<tr>
<td><strong>Toenails:</strong></td>
<td>3-6 months</td>
</tr>
<tr>
<td><strong>Second line:</strong></td>
<td>Itraconazole A+ 200mg oral bd for 7 days each month.</td>
</tr>
<tr>
<td><strong>Fingernails:</strong></td>
<td>2 courses</td>
</tr>
<tr>
<td><strong>Toenails:</strong></td>
<td>3 courses</td>
</tr>
</tbody>
</table>

### Evidence
Treatment does not always cure the infection. Cure rates range between approximately 60–80%. The PHE Mycology Reference Laboratory recommends itraconazole for non-dermatophyte infections because although some of the infecting organisms are not particularly susceptible to this agent in vitro, it does reach high concentrations in nail tissue. It can be given as a pulse therapy regimen rather than continuous treatment.

### References
# Skin & Soft Tissue Infections – Varicella Zoster (chicken pox), Herpes Zoster (shingles) & Cold Sores

## When to treat

**Chicken pox:** If started <24h of rash onset & >14 years old or severe pain, dense/oral rash, 2° household case, steroids or smoker consider treatment. In a review in children and adolescents, aciclovir within 24h of rash onset shortened fever by approximately one day and reduced the maximum number of lesions but did not reduce the complication rate.  

**Shingles:** Treat if <72 h of rash onset and >50 years old or if non-truncal involvement or moderate/severe pain or rash. Treat and/or urgently refer patients with ophthalmic involvement. Immunocompetent children: antivirals not recommended.  

**Cold sore:** Resolve after 7-10d without treatment. Topical antivirals applied prodromally reduce duration by 12-24hrs.

## When to test

**Chicken pox:** Laboratory tests can be used for confirmation but are rarely required.  

**Shingles:** Seek specialist advice for anyone who is thought to be immunocompetent and has had two episodes of shingles or if there is diagnostic uncertainty.

## General advice

Prescribe appropriate analgesia where necessary.

## Treatment choices

**First line chicken pox/shingles:**

- **Aciclovir**<sup>A+</sup> 800mg five times a day for 7 days<sup>1B+</sup>  
- **Cold sore:**
  - **Topical Aciclovir** 5% 4-hourly for 5-10 days<sup>4</sup>

**Second line for shingles if compliance a problem (as more expensive)**

- **Valaciclovir**<sup>B+</sup> 1g tds 7 days<sup>8+</sup>  
- **Famciclovir**<sup>B+</sup> 250mg tds 7 days<sup>8+</sup>

## Evidence<sup>1</sup>

Evidence from RCTs supports treatment for all those over 50 years to prevent the incidence of post-herpetic neuralgia. Pregnant women are at greater risk of varicella pneumonia, and there is a risk to the foetus of congenital varicella syndrome if exposure occurs during the first 20 weeks of pregnancy, and severe disease in the neonate if varicella is contracted a week before delivery.

## References

Skin & Soft Tissue Infections – Acne vulgaris

When to treat

**Mild acne:** Predominantly consists of non-inflammatory comedones (open and closed)

**Moderate acne:** Consists of a mixture of non-inflammatory comedones and predominating inflammatory papules and pustules.

**Severe acne:** Characterized by presence of widespread nodules and cysts together with preponderance of papules and pustules. Complications include scarring, (although rare in mild acne), psychological problems and hyperpigmentation. Treatment should be started early to avoid scarring.

When to investigate

- Refer to psychiatry people who have severe psychosocial problems, including a morbid fear of deformity
- Refer to dermatology: 1) Severe acne: urgently people with severe variant with systemic symptoms (i.e. acne fulminans), refer (soon) all other people 2) Moderate acne: features that make the diagnosis uncertain; those at risk of developing scarring despite treatment; acne that has failed to respond adequately to treatment (over a period of at least 6 months).
- Refer to endocrinology or gynaecology, women suspected of having an underlying endocrinological cause of acne.

General advice

Advise not to wash more than twice a day, use a mild soap or cleanser and lukewarm water, not to use vigorous scrubbing when washing acne-affected skin and not to attempt to ‘clean’ blackheads. Treatments are effective but take time to work (typically 8 - 12 weeks) and may irritate the skin, especially at the start of treatment.

Treatment choices

**Topical Treatment**

- **Mild/moderate:** First line: Topical Retinoid OR Benzoyl Peroxide
- Second line: Azelaic Acid

- **Moderate acne (at risk of scarring):** Topical antibiotic PLUS Benzoyl Peroxide OR Topical Retinoid

- **Moderate (if extensive/significant risk of scarring)/severe (awaiting referral):**

  - First line: (Oxy)tetracycline 500mg bd
  - Second line: Lymecycline 408mg od OR
    - Doxycycline 100mg od
  - Alternative regimen: Erythromycin 500mg bd

  **PLUS Topical Retinoid OR Benzoyl Peroxide**

Treatment notes: **Oral antibiotics:** follow up at 6-8 weeks: i) Good response- continue for additional 4-6 months (consider halving dose for latter half of treatment period) then stop ii) Inadequate response- Continue for a minimum of 3 months before assuming treatment ineffective (consider referral at this stage). Continue topical treatment after stopping oral antibiotic; also consider combination of topical retinoid plus benzoyl peroxide (though may be poorly tolerated). Do not use oral antibiotic treatment alone. Do not combine topical and oral antibiotic treatments. Topical antibiotics should be limited to 12 weeks treatment where possible. Topical retinoids are contraindicated in pregnancy.

Consider prescribing a standard combined oral contraceptive or co-cyprindiol (Dianette) for women who require contraception.

**Evidence**

Topical antibiotics are no more effective than benzoyl peroxide and heavy reliance on them, particularly with erythromycin, has caused significant emergence of resistant strains of bacteria. A Cochrane review has found minocycline not to be superior to other commonly used therapies and there are concerns about its safety; and lymecycline was not found to be superior to minocycline (Garner SE et al 2012).

**References**

### Skin & Soft Tissue Infections – Surgical Site Infection (SSI)

#### When to treat

Any SSI may cause redness, delayed healing, fever, pain, tenderness, warmth, or swelling. These are the additional signs and symptoms for specific types of SSI:
- A superficial incisional SSI may produce purulent discharge from the wound site but may not need antibiotic treatment.
- A deep incisional SSI may also produce pus. The wound site may reopen on its own.
- An organ or space SSI may show a discharge of pus coming from a drain placed through the skin into a body space or organ(abscess).

#### General advice

Not all SSIs require antibiotic treatment: minor infections may respond to drainage of pus (for example, by removal of sutures) and topical antisepsis. Antibiotic therapy carries with it the risk of adverse drug reactions and the development of resistant bacteria with the associated risk of *C. difficile* diarrhoea. Send culture to microbiology.

#### Treatment choices

**First line:**
- **Flucloxacillin** 500mg *qds* for 7 days
  - If clean/contaminated surgery involving mucosal surfaces:
    - **Metronidazole** 400mg *tds* for 7 days
    - **Co-Amoxiclav** 500/125 *tds* for 7 days

**At risk of MRSA:**
- **Rifampicin** 300mg *bd*
  - **PLUS**
  - **Doxycycline** 100mg *bd* for 7 days
  - **Clindamycin** 450mg *qds* for 7 days

#### References

3. Health Protection Agency 2009 MRSA screening and suppression.
4. BNF June 14
Skin & Soft Tissue Infections – Scarlet Fever (Scarletina)

<table>
<thead>
<tr>
<th>When to treat²</th>
<th>Prompt treatment with antibiotics significantly reduces complications such as an ear infection, throat abscess (quinsy), pneumonia, sinusitis or meningitis in the early stages and acute glomerulonephritis and acute rheumatic fever at a later stage. Symptoms include: • sore throat, headache, fever, nausea and vomiting. After 12 to 48 hours the characteristic fine red rash develops (feels like sandpaper). Typically, it first appears on the chest and stomach, rapidly spreading to other parts of the body. On more darkly-pigmented skin, the scarlet rash may be harder to spot, although the ‘sandpaper’ feel should be present. • Fever over 38.3°C (101°F) or higher is common. • White coating on the tongue, which peels a few days later, leaving the tongue looking red and swollen (known as ‘strawberry tongue’). • Swollen glands in the neck. • Feeling tired and unwell. • Flushed red face, but pale around the mouth. The flushed face may appear more ‘sunburnt’ on darker skin. • Peeling skin on the fingertips, toes and groin area, as the rash fades.²</th>
</tr>
</thead>
<tbody>
<tr>
<td>When to admit¹</td>
<td>• Have pre-existing valvular disease. • Are significantly immunocompromised (for example with clinically-apparent HIV infection). • Have a severe complication of scarlet fever (for example evidence of acute rheumatic fever or an invasive suppurative complication). • Have a severe form of scarlet fever, such as ‘septic’ or ‘toxic’ scarlet fever (characterized by high fever and marked systemic toxicity, possibly including arthritis and jaundice).</td>
</tr>
<tr>
<td>General advice¹</td>
<td>Scarlet fever is a notifiable infectious disease caused by a particular strain of the group A streptococcus bacterium (Streptococcus pyogenes). Scarlet fever is characterised by a rash, which usually accompanies a sore throat, and is sometimes confused with the measles’ rash. The bacteria which cause the infection produce toxins (poisons), which cause a rash, a red and swollen tongue and flushed cheeks.² The primary site of infection with S. pyogenes is usually the throat, where it causes symptoms of pharyngitis. In rare circumstances, scarlet fever can also originate from other sites (for example an infected wound).¹ Reassure the person that scarlet fever is no longer a serious condition and that symptoms usually last for 1 week. Advise the person to: stay away from school or work for 1 day after starting antibiotic treatment, wash their hands frequently, avoid sharing eating utensils and towels, dispose of handkerchiefs promptly, and avoid contact with anyone at particular risk of infection (e.g. people with valvular disease or who are immunocompromised). Offer Ibuprofen or paracetamol for symptom relief. Encourage the person to rest and drink adequate fluids. Advise to return for follow up if symptoms have not improved or have worsened after 7 days.</td>
</tr>
<tr>
<td>Treatment choices</td>
<td><strong>First line:</strong> Phenoxyemethylpenicillin 500mg every 6 hours, increased up to 1g every 6 hours if necessary; Child up to 1 year: 62.5mg every 6 hours, increased up to 12.5mg/kg every 6 hours if necessary; 1-6 years: 125mg every 6 hours, increased up to 12.5mg/kg every 6 hours if necessary; 6-12 years: 250mg every 6 hours, increased up to 12.5mg/kg every 6 hours if necessary³</td>
</tr>
<tr>
<td></td>
<td><strong>Second line (if allergic to penicillin):</strong> Erythromycin (doses may be doubled in severe infection): Adult and child over 8 years: 250-500mg every 6 hours OR 0.5-1g every 12 hours; Child 1 month-2 years: 125mg every 6 hours OR 250mg every 12 hours, 2-8 years: 250mg every 6 hours OR 500mg every 12 hours. <strong>OR Clarithromycin</strong> (doses may be doubled in severe infection) Adult and child over 12 years: 250mg every 12 hours. Child body-weight under 8kg: 7.5mg/kg twice daily; 8-11kg: 6.25mg twice daily; 12-19kg: 125mg twice daily; 20-29kg: 187.5mg twice daily; 30-40kg: 250mg twice daily³</td>
</tr>
</tbody>
</table>

References
**Eye infections – Infective Conjunctivitis**

| When to treat | Acute infective conjunctivitis may affect one or both eyes. It usually presents with eye irritation or a vague foreign body sensation accompanied by tear production, discharge (which may stick the eyelids together upon waking) and red eye. Infective conjunctivitis may be viral or bacterial – it is difficult to clinically distinguish between the two. Acute infective conjunctivitis is usually self-limiting therefore a ‘wait and see’ or delayed prescribing approach is likely to be most appropriate. Consider starting treatment if no improvement after 3 days. Consider offering a topical antibiotic if the conjunctivitis is severe (consider to be severe when the person considers the symptoms to be distressing or the signs are judged to be severe from clinical experience). Clinical resolution occurs within 2-5 days in 65% of confirmed bacterial conjunctivitis cases treated with placebo. |
| When to investigate | If any of the following symptoms are present, refer the patient for specialist same-day assessment to exclude acute glaucoma, keratitis, iritis or orbital cellulitis: Significant photophobia; reduced visual acuity; pain deep in the eye; recent eye surgery; absent or sluggish pupil response; irregular pupils; corneal damage or opacity on fluorescein staining; restricted or painful eye movements; history of head/eye trauma. Swab the eye to identify the infective cause when infective conjunctivitis is hyper-acute or persistent. This is not usually considered useful for people with acute infective conjunctivitis. Patients should be advised to seek medical advice if symptoms do not settle within 7 days, or if there is visual disturbance, significant eyelid swelling, photophobia or pain in the eye. |
| Treatment choices | **First line:** Chloramphenicol\(^b\) 0.5% drop 2-hourly for 2 days then 4-hourly (whilst awake). Add 1% ointment at night for severe infections or if slow to respond\(^d\) (incurs additional prescription charge). Continue for 48h after symptom resolution.  
**Second line:** Fusidic acid 1% gel \(bd^\) Continue for 48h after symptom resolution. |
| General advice | Self-management: Bathe eyes with tepid water, wiping away from the bridge of the nose to the side. Avoid contact lenses until symptoms have cleared. Exercise hand hygiene and avoid sharing towels or pillows. |
| Evidence | Fusidic acid has less Gram-negative activity than chloramphenicol. A double-blind placebo-controlled RCT in children showed, at day 7, 83% clinical cure with placebo compared with 86% with chloramphenicol. Minimum difference in duration of moderate symptoms was observed between patients given immediate and treatment delayed by 3 days. Delayed prescribing of antibiotics appears to reduce antibiotic use (almost 50%) with similar symptom control to immediate prescribing. |
2. [http://cks.nice.org.uk/conjunctivitis-infective#references/A31179](http://cks.nice.org.uk/conjunctivitis-infective#references/A31179) (last accessed May 2014)  
3. Management of Infection Guidance for Primary Care, PHE & BIA, Jan 2012  
Dental Infections
# Dental Infections – Mucosal Ulceration and Inflammation (Simple Gingivitis)

## When to treat
Where possible manage precipitating factors.
Offer symptomatic treatment for pain, discomfort, and swelling, especially when ulcers are causing problems with eating.
If ulcers are infrequent, mild, and not interfering with daily activities (for example eating), treatment may not be needed.

## When to refer
Referral is recommended for people with a suspected underlying cause of aphthous-like ulceration, to identify and manage any underlying disease.

### Refer urgently anyone with:
- Unexplained ulceration of the oral mucosa or mass persisting for more than 3 weeks.
- Unexplained red and white patches (including suspected lichen planus) of the mucosa which are painful, swollen, or bleeding. Symptoms or signs related to the oral cavity that persist for >6 weeks if a definitive diagnosis of a benign lesion cannot be made.

### Make a non-urgent referral for anyone with:
- Unexplained red and white patches (including suspected lichen planus) of the mucosa that are not painful, swollen, bleeding. A suspected underlying cause of aphthous-like ulceration, suggested by history, examination, or results of investigations particularly painful and disabling aphthous ulceration or if recurrences are frequent and severe and not adequately relieved by symptomatic treatments.

## General advice
Temporary pain and swelling relief can be attained with saline mouthwash.
Use antiseptic mouthwash if more severe pain limits oral hygiene or to prevent secondary infection.

## Treatment choices

<table>
<thead>
<tr>
<th>Simple saline mouthwash</th>
<th>Chlorhexidine 0.2% mouthwash</th>
<th>Hydrogen peroxide mouthwash 6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>½ tsp salt dissolved in glass warm water</td>
<td>(Do not use within 30mins of toothpaste) Rinse mouth with 10ml for 1 minute bd. Can be diluted 1:1 with water with no loss in efficacy.</td>
<td>Rinse mouth for 2-3 minutes with 15ml diluted in half a glass of warm water tds.</td>
</tr>
</tbody>
</table>

**Spit out mouthwash after rinsing.** Use until lesions have resolved or less pain allows oral hygiene.

## Evidence
Evidence on antimicrobial mouthwashes for the management of aphthous ulcers is poor. The quality of studies is poor and results are not consistent. Antimicrobial mouthwashes may reduce the duration and severity (degree of pain) of an ulcer episode, and increase the number of ulcer-free days between episodes. However, antimicrobial mouthwashes do not seem to reduce the incidence of ulceration (number of new ulcers).

## References
2. BNF 67, March 2014
### Dental Infections – Acute Necrotising Ulcerative Gingivitis (ANG) and Pericoronitis (PC)

| When to treat | Professional scaling and polishing, root surface instrumentation, and sometimes surgical procedures, are required.¹  
**ANG:** The mainstay of treatment is local antiseptics and hygiene measures; adjunctive antibiotics are only required in cases of systemic involvement or where there is failure to improve following primary dental management.¹,²  
Commence antibiotics and refer urgently to dentist for scaling and oral hygiene advice.¹  
**PC:** Refer to dentist urgently for irrigation and debridement.²  Antibacterial treatment required only in presence of systemic features of infection, or of triasmus or persistent swelling despite local treatment.²,³ |
| --- | --- |
| General advice² | During the acute phase the person should, if possible, use a soft toothbrush to clean their teeth.¹  
While the patient is waiting for referral to a dentist prescribe analgesia for pain relief.¹ |
| Treatment choices | **First line:**²,³  
**Metronidazole** 400mg tds for 3 days in conjunction with dental treatment.  
**Second line:**²,³  
**Amoxicillin** 500mg tds for 3 days in conjunction with dental treatment (irrigation or incision and debridement). |
| Evidence | Trials or systematic reviews on the treatment of ANUG are awaited; therefore the recommendations are based on formal expert opinion from the Scottish Dental Clinical Effectiveness Programme 2011.  
Obligate anaerobes were isolated in 91% of cases, in a study of 35 patients with pericoronitis, and resistance to metronidazole was not evident in any species. Amoxicillin was highly active against 91.5% of aerobes and anaerobes isolated and therefore in severe infections amoxicillin can be added to metronidazole.⁴  CKS found no evidence that metronidazole is more (or less) effective than amoxicillin.¹ |
³. BNF 67, March 2014  
# Dental Infections – Dental Abscess

## When to treat
Systemic signs of acute dental abscess include: pyrexia, trismus, lymphadenopathy, gross facial or ocular oedema, dysphagia, tachycardia or rigors. Refer urgently to dentist – dental abscesses should be treated with local measures in the first instance.\(^1\)

Interim treatment while waiting to see a dentist may consist of advice about self-care and analgesia, with or without an antibiotic prescription.\(^2\)

Antibiotics are only recommended (in conjunction with urgent dental referral) if there are signs of severe infection, with cellulitis or systemic symptoms or high risk of complications.\(^2,3\) Otherwise, regular analgesia should be first option until a dentist can be seen.\(^4\) Definitive surgical treatment to drain the abscess (through incision, extraction or removal of necrotic pulp) by a dentist is the primary management of a dentoalveolar abscess.\(^4\)

## General advice\(^2\)
Provide advice regarding food and drink to reduce the pressure and pain of the dental abscess: avoid food or drink that may be too hot or cold; consume cool, soft foods.

Encourage regular use of analgesics (ibuprofen and/or paracetamol is recommended if no contra-indications). Warn the individual not to exceed the recommended or prescribed dose. Analgesics should not be used to delay appropriate dental treatment.

Advise the patient that antibiotic therapy is prescribed to reduce the spread of infection; NOT a substitute for dental treatment.

## Treatment choices

### First line:\(^2,4\)
- **Amoxicillin** 500mg tds OR **Phenoxymethylpenicillin** 500mg - 1g qds for up to 5 days, review at 3 days\(^5\)
- If spreading infection (lymph node involvement, or systemic signs, i.e. fever or malaise) **ADD Metronidazole**\(^4c\) 400mg tds for 5 days\(^1,2\)

### Penicillin Allergy: First line:
- **Metronidazole** 400mg tds for 5 days

### Penicillin Allergy: Second line
- **Clarithromycin** 500mg bd for up to 5 days, review at 3 days\(^5\)
  - **ADD Metronidazole**\(^4c\) 400mg tds for 5 days\(^1,2\)

### If severe infection:
- **Clindamycin** 300mg gds for 5 days\(^5\) *

## Cautions
Do not routinely provide repeat prescriptions or switch antibiotics in people who fail to respond to first-line treatment. Instead advise the person to see a dental practitioner urgently.\(^2\) The failure of the antibiotic is not usually due to microbial resistance.\(^2\) *High risk for *C. difficile* infections

## Evidence
Amoxicillin and metronidazole are generally considered to be the antibiotics of choice for the management of dental abscesses. CKS found very little evidence to provide clear advice on which of the two antibiotics should be considered first-line.\(^2\)

An audit in Cardiff of 112 patients with dentoalveolar infection concluded that incisional drainage appeared to produce a more rapid improvement compared to drainage by opening of the root canal. The presence of penicillin-resistant bacteria did not adversely affect the outcome of treatment. The observations made support surgical drainage as the first principle of management and question the value of prescribing penicillin as part of treatment.\(^4\)

The empirical use of clindamycin, clarithromycin, cephalosporins and co-amoxiclav do not offer any advantage for most dental patients and should only be used if no response to first line drugs when referral is the preferred option.\(^4c\)

## References
3. BNF 67, March 2014
IV/IM Drugs in the Community
| **When to treat** | It is beyond the scope of these guidelines to make recommendations for IV/IM antibiotic use. However in some community rapid response teams, doses of IM antibiotics such as ceftriaxone are given as part of an enhanced service to prevent hospital admissions. **In these cases the locally approved guideline should be followed.** |
# Fosfomycin Indication and Licensing

## When is Fosfomycin indicated?
Lower UTI due to ESBL-producing micro-organisms or on recommendation of consultant medical microbiologist. Fosfomycin is not indicated for the treatment of ESBL pyelonephritis or peri-nephric abscess (admit to hospital for IV antibiotics).

## What is an ESBL?
Extended-spectrum beta-lactamases (ESBLs) are bacterial enzymes (usually plasmid-mediated) that confer resistance to a broad range of beta-lactam antibiotics including co-amoxiclav and cephalosporins.

## What is Fosfomycin’s licensing status in the UK?
Fosfomycin is licensed in the UK. However no UK-packaged product is currently available and thus all supplies must be obtained from abroad.

## Where is Fosfomycin licensed?
Fosfomycin is currently licensed and can be sourced from Germany, France, Italy and Spain.

# Fosfomycin Prescribing Information

## Mode of action
Fosfomycin is a bactericidal antibacterial. Fosfomycin inactivates the enzyme pyruvyl transferase required for the biosynthesis of peptidoglycan in bacterial cell walls. Fosfomycin is concentrated in the bladder and is active against E. coli, Proteus sp. and Enterococci.

## Pregnancy
Animal data show no teratogenic effects. Several published reports studied the efficacy and safety of oral fosfomycin in all stages of pregnancy. In these studies fosfomycin did not cause harm to a foetus.

## Contraindications
- Hypersensitivity to fosfomycin.
- Suspected bacteraemia.
- GFR <10mL/min.

## Dosing: Uncomplicated UTI in females
Fosfomycin 3 gram sachet as a single oral dose is effective in the treatment of uncomplicated lower urinary tract infections in adult females. Single dose therapy (3 gram) was equivalent to 7-day course of norfloxacin in a randomised, blinded study. (de Jong Z et al. 1991 Urol Int).

## Dosing: Complicated UTI or male patients
Fosfomycin calcium 500mg capsules are licensed at 500mg-1gram every 8 hours. Fosfomycin 3g sachets have been administered once every 48 hours. A 7-day course (minimum) is recommended for male patients and for complicated lower urinary tract infections (e.g. catheter-associated UTI) without bacteraemia (Moroni M 1987 Eur Urol).

## Interactions
- No significant drug-drug interactions.
- Food intake can slow down the absorption of fosfomycin with, as a result, lower concentrations in the urine. Fosfomycin should, therefore, be administered while fasting or 2 or 3 hours before meals.

## Dosing in renal impairment
GFR 10-50mL/min: 3gram single dose or 3grams every third day.

## Side Effects

### More common than 1%:
- Diarrhoea/Abdominal pain (10%)
- Nausea/Indigestion (5%)
- Headache (3-10%)
- Skin rashes (1%)
- Vaginitis (5%)
- Asthenia (1%)

### Rare Serious Reactions:
- Serious hypersensitivity reactions
- Impairment of hepatic function
- Aplastic anaemia
Fosfomycin Supplies

Fosfomycin is not available commercially as a licensed product in the UK. Currently the only means of obtaining fosfomycin is to order from a ‘specials’ supplier. There will be a delay in obtaining the product in the community setting and careful consideration needs to be given when prescribing and supplying to patients who may need treatment more urgently. The patient should be advised to consult GP if symptoms worsen whilst awaiting supply.

Brands: These include – MONURIL® (Zambon – Italy; Netherlands) and MONUROL® (Pharmazam – Spain, USA, Hong Kong).

Fosfomycin can be imported via IDIS World Medicines. There is usually a delay of 48 hours between order and delivery.

IDIS World Medicines: IDIS House, Churchfield Road, Weybridge, Surrey KT13 8DB; Tel: 01932 824000; Fax: 01932 824226; Web: www.idispharma.com