NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Infection Management in Adults Guidance for Primary Care Poster

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Primary Care Adult Infection Management Guidelines

Quick Reference Summary (see www.ggcprescribing.org.uk for full guideline)

AIMS
- to provide a simple, best guess 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

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This guidance is based on the best available evidence but its application should be modified by professional judgement.
Where a 'best guess' therapy has failed or special circumstances exist, microbiological advice can be obtained via your local hospital or from the Infectious Diseases Unit, Ward 5c, Queen Elizabeth University Hospital (tel; 0141 201 1100 page 15295). For additional indications and information see **full Adult Infection Management Guidelines** and **Paediatric Infection Management Guidelines** on Staffnet.
Disease codes linked to the guideline choices (synonyms) are available for most common indications (indicated where applicable in brackets).

UPPER RESPIRATORY TRACT

Consider delayed antibiotic prescriptions.

Pharyngitis / sore throat / tonsillitis (.TONSILLITIS)
- **SELF-LIMITING ILLNESS** lasting around 1 week
- Check **FeverPAIN** score (**Fever**, **P**urulent tonsils, **A**ttending rapidly, Inflammed tonsils, **No** cough/ coryza) 0-1 = No antibiotic; 2-3=delayed; ≥4 delayed/ give if severe
- Pen V **500mg QDS** for 5 days (10 days if high risk of GAS)

or if true penicillin allergy
- **Clarithromycin** 500mg BD

Duration 5 days

Otitis media (.OTITIS MEDIA)
- **SELF-LIMITING ILLNESS** lasting around 3-7 days amoxicillin 1g to be used in severe infections
- Consider 2 or 3 day delayed prescribing or immediate antibiotics if ottorhoea (see also Paediatric Guideline)
- **Amoxicillin** 500mg - TDS (1g if severe) ***or***

if true penicillin allergy
- **Clarithromycin** 500mg BD

Duration 5 days

Acute Rhinosinusitis (.SINUSITIS)
- **SELF-LIMITING ILLNESS** lasting around 2.5 weeks
- Optimise analgesia +/- xylometazoline 0.1% nasal spray
- Consider 7 day delayed or immediate antibiotic when purulent nasal discharge
- **Doxycycline** 200mg stat/100mg OD ***or***
- **Amoxicillin** 500mg TDS

Duration 5 days

LOWER RESPIRATORY TRACT

Do not uses quinolones (ciprofloxacin, ofloxacin) first line due to poor pneumococcal activity.

Acute bronchitis (.BRONCHITIS)
- **SELF-LIMITING ILLNESS** lasting around 3 weeks. Antibiotics of little benefit in absence of co-morbidity
- Consider 7 day delayed prescribing

COPD Exacerbation (.COPD)
- Treat exacerbations promptly with antibiotics if purulent sputum **and** increased shortness of breath **and/or** increased sputum volume

Do not use dual antibiotic therapy

Doxycycline 200 mg stat then 100 mg OD
or
Amoxicillin 500mg TDS ***or***
Clarithromycin 500mg BD

Duration 5 days

Community Acquired Pneumonia (.PNEUMONIA)

Treatment in the community unless severe or clinical concern. Assess using **CRB65** score.

Each scores 1:
- Confusion (Abbreviated Mental Test<8);
- Respiratory rate >30/min; Age >65;
- BP systolic <90 or diastolic ≤ 60;
- Score 0: suitable for home treatment;
- Score 1-2: hospital assessment or admission
- Score 3-4: urgent hospital admission
- If CRB65=0:

Amoxicillin 500 mg TDS
or if penicillin allergy
Clarithromycin 500 mg BD ***or***
Doxycycline 200mg stat then 100mg OD

Duration 5 days

Clarithromycin **and other macrolides are known to have serious drug interactions and may prolong the QTc interval. Avoid in patients with other risk factors for QTc prolongation. See BNF (appendix 1) for details'**

URINARY TRACT

Do not treat asymptomatic bacteriuria unless pregnant
Consider self management with NSAID / delayed prescribing if only mild UTI symptoms in non-pregnant women.
Amoxicillin resistance is common, therefore ONLY use if culture confirms susceptibility.
In patients with eGFR<30ml/min trimethoprim should be used with caution and nitrofurantoin is contraindicated (use nitrofurantoin with caution at eGFR 30-44ml/min for short term use only)

Uncomplicated lower UTI (.UTI)

in non pregnant women ie no fever or flank pain. Perform culture in all treatment failures

Amoxicillin resistance is common, therefore ONLY use if culture confirms susceptibility.

Treat empirically if ≥ 3 symptoms or dysuria and frequency (consider dipstick testing to guide requirement for treatment if mild/ ≤ 2 symptoms, otherwise well and < 65 years)

Trimethoprim 200mg BD ***or***

Nitrofurantoin 100mg M/R BD ***or*** 50mg QDS

Duration 3 days

Lower UTI in adult men (.UTI)

Always perform culture

Trimethoprim 200 mg BD ***or***

Nitrofurantoin 100mg M/R BD ***or*** 50mg QDS

Duration 7 days

Lower UTI in pregnancy (.UTI)

Always perform culture. Short-term nitrofurantoin is unlikely to cause problems to the foetus

1st line:
Nitrofurantoin (1st or 2nd trimester) 50mg QDS ***or*** 100mg MR BD

2nd line:
Amoxicillin (**ONLY** if susceptible) 500mg TDS

or
***Cefalexin** 500mg TDS

Duration 7 days

Acute prostatitis (.PROSTATE)

Always perform culture

Ciprofloxacin** 500mg BD ***or
Trimethoprim 200 mg BD

Duration 14 days then review

Catheter associated UTI (.UTI)

Antibiotic treatment if one of the following symptoms
- New onset costovertebral tenderness,
- Rigors,
- New-onset delirium,
- Fever > 37.9 degrees C

Change Catheter before antibiotic treatment

Nitrofurantoin 100mg M/R BD 50mg QDS ***or***
Trimethoprim 200 mg BD

Duration 7 days

Upper UTI/Pyelonephritis (men/non-pregant females) (.UTI)

Send MSU for culture and start empiric treatment immediately.

If sepsis or vomiting or if no response within 24 hours admit.

Trimethoprim 200mg BD (if sensitive organism suspected) or

***Co-amoxiclav** 625mg TDS

or if true penicillin allergy

***Ciprofloxacin 500mg BD**

Duration 7 days

Recurrent UTI (≥ 3 a year or 2 in 6 months)

1. lifestyle measures (e.g. hydration, cranberry)
2. post coital / stand by antibiotics
3. trial of nightly prophylaxis for 3-6 months

Nitrofurantoin 50mg at night (or 100mg stat)
or
Trimethoprim 100mg at night (or 200mg stat)
Stat when exposed to trigger or od at night for 3-6 months

SKIN / SOFT TISSUE

Impetigo (.IMPETIGO)

Reserve topical antibiotics for very localised lesions.

Fusidic acid 2% apply topically TDS for 5 days

if more severe for **7 days**
Flucloxacillin 500 mg QDS ***or***

if true penicillin allergy

Clarithromycin 500mg BD
for 5 days

Cellulitis / Mild Surgical Wound Infection

Do not use dual therapy in patients who are afebrile and otherwise well,

Flucloxacillin 500mg QDS ***or***

In true penicillin allergy

Doxycycline 100mg BD

Duration 5 days (continue for further 5 days if slow response)

Clostridioides difficile **infection is associated with prescribing of; 4Cs antibiotics: Cephalosporins, Co-amoxiclav, Clindamycin and Quinolones (Ciprofloxacin, Levofloxacin, Moxifloxacin, Ofloxacin). These agents must be restricted to reduce selection pressure.**

Human or Animal bite (.BITES HUMAN/ .BITES ANIMALS)

Antibiotic prophylaxis advised for puncture wound; bite involving hand, foot, face, joint, tendon, ligament; immunocompromised, diabetics, elderly, asplenic.

Prophylaxis and treatment

*** Co-amoxiclav 625 mg TDS**

or if true penicillin allergy:

Metronidazole 400 mg TDS **plus**

Doxycycline 100 mg BD

Duration 3 days for prophylaxis or 7 days for treatment BUT review at 24 and 48 hours.

Acne Vulgaris (.ACNE)

Try topical benzoyl peroxide or azeleic acid first.
Consider oral antibiotic if topical treatments fail.

Topical

Clindamycin and Benzoyl peroxide Gel (Duac) Apply once daily or Erythromycin and Zinc acetate (Zineryt) twice daily.

Oral

Lymecycline 408mg OD ***or***
Erythromycin 500mg BD

Assess effect after 2-3 months. Review ongoing treatment at least every 6 months.

Maximal benefit usually occurs at 4 to 6 months.

Quinolones** **can very rarely cause long-lasting (up to months or years), disabling, and potentially irreversible side effects, sometimes affecting multiple systems, organ classes, and senses. See MHRA advice on avoiding use in all self-limiting, non-severe infections, and non-bacterial conditions

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