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| --- | --- | --- | --- | --- |
| **Prescribing antimicrobials over the telephone only recommended in exceptional circumstances**  **All doses are for ADULTS unless stated otherwise. Refer to full guidance or BNFC for CHILDREN’s doses.** | | | | |
| **Clinical Diagnosis** |  | **Treatment Advice** | **Days** | **Comments** |
| **Acute Otitis Media (uncomplicated)** | **1st**  2nd  *PA* | **NONE – watch and wait (72hrs)**  Amoxicillin 500mg tds  *Clarithromycin 500mg bd* | 5  *5* | **Usually viral**.  Children with otorrhoea, or <2years with bilateral acute otitis media, have greater benefit but are still eligible for 2 or 3 day delayed prescribing |
| **Sore throat**  **(uncomplicated)** | **1st**  2nd  *PA* | **NONE**  Penicillin V 500mg qds or 1g bd  (1g qds if severe)  *Clarithromycin 250-500mg bd* | 10  *5* | **Usually viral**.  If bacterial usually Group A β-haemolytic streptococcus.  Discuss urgently with microbiology/infectious diseases if diphtheria is suspected. |
| **Acute sinusitis**  **(uncomplicated)** | **1st**  2nd  *PA* | **NONE**  Amoxicillin 500mg -1g tds or  Penicillin V 500mg qds  *Clarithromycin 250- 500mg bd or*  *Doxycycline 200mg stat, then 100mg od* | 7  *7*  *7*  *7* | Often viral. Consider 7-day-delayed or immediate antibiotic when purulent nasal discharge.  **Persistent** rhinosinusitis – anti-anaerobic cover will be required (e.g. Co-amoxiclav 625mg tds for 7 days) |
| **Acute bronchitis** | **1st**  2nd  *PA* | **NONE**  Amoxicillin 500mg tds  *Clarithromycin 500mg bd or*  *Doxycycline 200mg stat, then 100mg od* | 5  *5*  *5* | **Usually viral**  Explanation of likely course of illness recommended. (can consider 7-day-delayed antibiotic). Antibiotics/further investigation recommended when systemically unwell, symptoms of serious illness or at risk due to co-morbidities |
| **Acute exacerbation of COPD** | **1st**  2nd  *PA* | **Amoxicillin 500mg tds**  While awaiting culture results: Doxycycline 200mg stat, then 100mg od or discuss with microbiology  *Clarithromycin 500mg bd* | 5  *5*  *5* | *Streptococcus pneumoniae, Haemophilus influenzae* and *Moraxella catarrhalis* can be associated with exacerbations  Treat exacerbations promptly with antibiotics **if** purulent sputum **and** increased shortness of breath **and/or** increased sputum volume  **Sputum sample if no response to empiric first line** |
| **Community acquired pneumonia (CAP) & CRB = 0** | **1st**  *PA* | **Amoxicillin 500mg tds**  *Clarithromycin 500mg bd or*  *Doxycycline 200mg stat, then 100mg od*  ***Review at day 3 & extend duration to 7 to 10 days if poor response*** | 5  *5*  *5* | Assess patient by CRB-65 protocol  Consider microbiology investigation if no response to empirical treatment after 48 hours |
| **CAP**  **& CRB = 1 or 2 & patient at home** | **1st**  *PA* | **Amoxicillin 500mg tds AND**  **Clarithromycin 500mg bd**  *or*  *Doxycycline 200mg stat, then 100mg od* | 7-10  *7-10* | Assess patient by CRB-65 protocol  Consider microbiology investigation if no response to empirical treatment after 48 hours |
| **Cellulitis** | **1st**  *PA* | **Flucloxacillin 500mg qds**  *Clarithromycin 500mg bd*  *If slow response continue for a further 7 days.* | 7  *7* | If peri-orbital cellulitis refer to hospital for further investigation and treatment.  If sea-water or freshwater exposure, discuss with microbiologist.  If febrile, systemically unwell or with underlying co-morbidities which may complicate infection, refer to hospital for IV treatment. |
| **UTI – catheterised patients** | In the presence of a catheter, antibiotics **will not** eradicate bacteriuria; only treat if systemically unwell or pyelonephritis likely. | | | |
| **Urinary Tract Infection (no fever or flank pain)**  (women and men) | **1st**  2nd | **Nitrofurantoin** **50mg qds or**  **MR 100mg bd, or**  **Trimethoprim 200mg bd, or**  **Pivmecillinam 400mg tds** - swallowed whole with plenty of fluid while sitting or standing  According to microbial culture results  *Course length is gender specific:*  *women 3 days, men 7 days* | ♀ 3  ♂ 7 | Women with severe/ ≥ 3 symptoms: treat  Women with mild/ ≤ 2 symptoms: use dipstick to guide treatment.  Men: send pre-treatment MSU **OR** if symptoms mild/non-specific, use negative nitrite and leucocytes to exclude UTI.  **Obtain culture in all treatment failures** |
| **Urinary Tract Infection in pregnancy.** | **1st**  2nd  3rd | **Nitrofurantoin** (except 3rd trimester) **50mg qds or MR 100mg bd** or  **Amoxicillin 500mg tds** (if susceptible)  Trimethoprim 200mg bd (except 1st trimester)  Cefalexin 500mg bd | 7  7  7  7 | Send MSU for culture & sensitivity and start empirical antibiotics  Discuss with microbiologist if patient unable to take one of the listed options. |
| **See BNF or Summary of Product Characteristics for full prescribing information**  **FOR FULL LOCAL ANTIBIOTIC GUIDANCE SEE** [**http://www.bassetlawccg.nhs.uk/publication/6999-doncaster-and-bassetlaw-antibiotic-guideline-2015**](http://www.bassetlawccg.nhs.uk/publication/6999-doncaster-and-bassetlaw-antibiotic-guideline-2015)  ***PA = Penicillin Allergy*** | | | | |

The following are considered to be safe in pregnancy: penicillins, cephalosporins, erythromycin, trimethoprim in 2nd and 3rd trimester only and nitrofurantoin in 1st and 2nd trimester only. See the BNF for prescribing antibiotics to breast feeding mothers.

This document last reviewed Dec 2015 with minor amendment Sep 2016, for review in Jan 2018 together with full guideline.