

Summary of antimicrobial prescribing guidance – managing common infections





- For all PHE guidance, follow [PHE's principles of treatment](#).
- See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breastfeeding.

Key: Click to access doses for children Click to access NICE's printable visual summary

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Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
▼ Upper respiratory tract infections						
Acute sore throat TARGET Treating Your	Advise paracetamol, or if preferred and suitable, ibuprofen for pain. Medicated lozenges may help pain in adults.	First choice: phenoxymethylpenicillin	500mg QDS		10 days	
		Penicillin allergy: clarithromycin OR	500mg BD		5 days	

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Infection RTI leaflet NICE Last updated: Jan 2018	Use FeverPAIN or Centor to assess symptoms: FeverPAIN 0-1 or Centor 0-2: no antibiotic; FeverPAIN 2-3: no or back-up antibiotic; FeverPAIN 4-5 or Centor 3-4: immediate or back-up antibiotic. Systemically very unwell or high risk of complications: immediate antibiotic. <i>For detailed information click the visual summary icon.</i>	erythromycin (preferred if pregnant)	500mg QDS		5 days	
Influenza Public Health England Last updated: Feb 2019	Annual vaccination is essential for all those 'at risk' of influenza. ^{1D} Antivirals are not recommended for healthy adults. ^{1D,2A+} Treat 'at risk' patients with 5 days oseltamivir 75mg BD, ^{1D} when influenza is circulating in the community, and ideally within 48 hours of onset (36 hours for zanamivir treatment in children), ^{1D,3D} or in a care home where influenza is likely. ^{1D,2A+} At risk: pregnant (and up to 2 weeks post-partum); children under 6 months; adults 65 years or older; chronic respiratory disease (including COPD and asthma); significant cardiovascular disease (not hypertension); severe immunosuppression; chronic neurological, renal or liver disease; diabetes mellitus; morbid obesity (BMI>40). ^{4D} See the PHE Influenza guidance for the treatment of patients under 13 years. ^{4D} In severe immunosuppression, or oseltamivir resistance, use zanamivir 10mg BD ^{5A+,6A+} (2 inhalations twice daily by diskhaler for up to 10 days) and seek advice. ^{4D} <i>Access supporting evidence and rationales on the PHE website.</i>					
Scarlet fever (GAS) Public Health England Last updated: Oct 2018	Prompt treatment with appropriate antibiotics significantly reduces the risk of complications. ^{1D} Vulnerable individuals (immunocompromised, the comorbid, or those with skin disease) are at increased risk of developing complications. ^{1D}	Phenoxyethylpenicillin ^{2D}	500mg QDS ^{2D}		10 days ^{3A+,4A+,5A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
Penicillin allergy: clarithromycin ^{2D}		500mg BD ^{2D}		5 days ^{2D,5A+}		
Optimise analgesia ^{2D} and give safety netting advice						
Acute otitis media	Regular paracetamol or ibuprofen for pain (right dose for age or weight at the right time and maximum doses for severe pain). Otorrhoea or under 2 years with infection in both ears: no, back-up or immediate antibiotic.	First choice: amoxicillin	500mg TDS		7 days	
Penicillin allergy: clarithromycin OR		500mg BD	7 days			
erythromycin (preferred if pregnant)		500mg QDS	7 days			



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NICE Last updated: Feb 2018	Otherwise: no or back-up antibiotic. Systemically very unwell or high risk of complications: immediate antibiotic. <i>For detailed information click on the visual summary.</i>	Second choice: co-amoxiclav	500/125mg TDS		7 days	
Acute otitis externa Public Health England Last updated: Nov 2017	First line: analgesia for pain relief, ^{1D,2D} and apply localised heat (such as a warm flannel). ^{2D} Second line: topical acetic acid or topical antibiotic +/- steroid: similar cure at 7 days. ^{2D,3A+,4B-} If cellulitis or disease extends outside ear canal, or systemic signs of infection, start oral flucloxacillin and refer to exclude malignant otitis externa. ^{1D}	Second line: topical acetic acid 2% ^{2D,4B-} OR	1 spray TDS ^{5A-}		7 days ^{5A}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		topical neomycin sulphate with corticosteroid ^{2D,5A-}	3 drops TDS ^{5A-}		7 days (min) to 14 days (max) ^{3A+}	
		If cellulitis: flucloxacillin ^{6B+}	500mg QDS ^{2D}		7 days ^{2D}	
Sinusitis TARGET Treating Your Infection RTI leaflet NICE Last updated: Oct 2017	Advise paracetamol or ibuprofen for pain. Little evidence that nasal saline or nasal decongestants help, but people may want to try them. Symptoms for 10 days or less: no antibiotic. Symptoms with no improvement for more than 10 days: no antibiotic or back-up antibiotic depending on likelihood of bacterial cause. Consider high-dose nasal corticosteroid (if over 12 years). Systemically very unwell or high risk of complications: immediate antibiotic. <i>For detailed information click on the visual summary.</i>	First choice: phenoxymethylpenicillin	500mg QDS		5 days	
		Penicillin allergy: doxycycline (not in under 12s) OR	200mg on day 1, then 100mg OD		5 days	
		clarithromycin OR	500mg BD		5 days	
		erythromycin (preferred if pregnant)	500mg QDS		5 days	
		Second choice or first choice if systemically very unwell or high risk of complications: co-amoxiclav	500/125mg TDS		5 days	


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			Adult	Child			
▼ Lower respiratory tract infections							
Note: Low doses of penicillins are more likely to select for resistance. ^{1D} Do not use fluoroquinolones (ciprofloxacin, ofloxacin) first line because they may have long-term side effects (small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects) and there is poor pneumococcal activity. ^{2B--3D-} Reserve all fluoroquinolones (including levofloxacin) for proven resistant organisms. ^{1D}							
Acute exacerbation of COPD NICE Last updated: Dec 2018	Many exacerbations are not caused by bacterial infections so will not respond to antibiotics. Consider an antibiotic, but only after taking into account severity of symptoms (particularly sputum colour changes and increases in volume or thickness), need for hospitalisation, previous exacerbations, hospitalisations and risk of complications, previous sputum culture and susceptibility results, and risk of resistance with repeated courses. Some people at risk of exacerbations may have antibiotics to keep at home as part of their exacerbation action plan. <i>For detailed information click on the visual summary. See also the NICE guideline on COPD in over 16s.</i>	First choice: amoxicillin OR	500mg TDS	-	5 days		
		doxycycline OR	200mg on day 1, then 100mg OD	-			
		clarithromycin	500mg BD	-			
		Second choice: use alternative first choice					5 days
		Alternative choice (if person at higher risk of treatment failure): co-amoxiclav OR	500/125mg TDS	-			
		co-trimoxazole (consider safety issues)	960mg BD	-			
IV antibiotics (click on visual summary)							
Acute cough TARGET Treating Your Infection RTI leaflet	Some people may wish to try honey (in over 1s), the herbal medicine pelargonium (in over 12s), cough medicines containing the expectorant guaifenesin (in over 12s) or cough medicines containing cough suppressants, except codeine, (in over 12s). These self-care treatments have limited evidence for the relief of cough symptoms. Acute cough with upper respiratory tract infection: no antibiotic. Consider back-up prescription for no more than 5 days.	Adults first choice: doxycycline	200mg on day 1, then 100mg OD	-	5 days		
		Adults alternative first choices: amoxicillin OR	500mg TDS	-			
		clarithromycin OR	500mg BD	-			
		erythromycin (preferred if pregnant)	500mg QDS	-			

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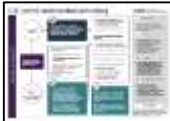
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			Adult	Child		
NICE	<p>Acute bronchitis: no routine antibiotic.</p> <p>Acute cough and higher risk of complications (at face-to-face examination): immediate or back-up antibiotic.</p> <p>Acute cough and systemically very unwell (at face to face examination): immediate antibiotic.</p> <p>Higher risk of complications includes people with pre-existing comorbidity; young children born prematurely; people over 65 with 2 or more of, or over 80 with 1 or more of: hospitalisation in previous year, type 1 or 2 diabetes, history of congestive heart failure, current use of oral corticosteroids.</p> <p>Do not offer a mucolytic, an oral or inhaled bronchodilator, or an oral or inhaled corticosteroid unless otherwise indicated.</p> <p><i>For detailed information click on the visual summary.</i></p>	<p>Children first choice: amoxicillin</p>	-			
		<p>Children alternative first choices: clarithromycin OR</p>	-			
		<p>erythromycin OR</p>	-			
		<p>doxycycline (not in under 12s)</p>	-			
Last updated: Feb 2019						

Community-acquired pneumonia	<p>BAAG update: NICE COVID19 rapid Community acquired guideline [NG165] has superseded the NICE CAP guideline [NG138] for antimicrobial prescribing in adults. We have updated our antimicrobial choices to align our guidance with the most current NICE recommendations. There are no changes to recommendations in children.</p> <p>Use CRB65 score to guide mortality risk, place of care, and antibiotics.^{1D} Each CRB65 parameter scores one: Confusion (AMT<8 or new disorientation in person, place or time);</p>	CRB65=0:			5 days (review at 3 days); ^{1D} 7 days if poor response ^{1D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		doxycycline ^{2A+,4D}	200mg stat then 100mg OD ^{6A-}			
		amoxicillin ^{1D,4D} OR	500mg TDS ^{5A+}			
		clarithromycin ^{2A+,4D,5A+} OR	500mg BD ^{5A+}			

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Public Health England Last updated: Nov 2017	Respiratory rate >30/minute; BP systolic <90, or diastolic <60; age >65. Score 0: low risk, consider home-based care; 1–2: intermediate risk, consider hospital assessment; 3–4: urgent hospital admission. ^{1D} Give safety net advice^{1D} and likely duration of different symptoms, such as cough 6 weeks. ^{1D} Clinically assess need for dual therapy for atypicals. Mycoplasma infection is rare in over 65s. ^{2A+,3C}	CRB65 = 1–2 and at home: Clinically assess need for dual therapy for atypicals: amoxicillin ^{1D, 4D} AND clarithromycin ^{2A+,4D,5A+} OR doxycycline alone ^{4D}	500mg TDS ^{5A+} 500mg BD ^{5A+} 200mg stat then 100mg OD ^{6A-}	 	7 days ^{1D}	

▼ Urinary tract infections

Lower urinary tract infection TARGET Treating Your Infection UTI leaflet NICE Summary of antimicrobial prescribing guidance – managing common infections (February 2019) adapted by BAAG	Advise paracetamol or ibuprofen for pain. Non-pregnant women: back up antibiotic (to use if no improvement in 48 hours or symptoms worsen at any time) or immediate antibiotic. Pregnant women, men, children or young people: immediate antibiotic. When considering antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data. <i>For detailed information click on the visual summary. See also the NICE guideline on urinary tract infection in under 16s: diagnosis and management.</i>	See choice for MEN below. Non-pregnant women first choice: nitrofurantoin (if eGFR ≥45 ml/minute) OR	100mg m/r BD (if m/r is not available, use standard release 50mg QDS)	-	3 days	
		trimethoprim (if no known risk of resistance and no recent exposure to trimethoprim)	200mg BD	-	3 days	
		Non-pregnant women second choice: pivmecillinam (a penicillin) OR	400mg initial dose, then 200mg TDS	-	3 days	
		fosfomicin	3g single dose			

sachet


-

single dose

Infection	Key points	Medicine	Doses		Length	Visual summary		
			Adult	Child				
Last updated: Oct 2018	+++ add urine sampling method ++++	Pregnant women first choice: nitrofurantoin (avoid at term) – if eGFR ≥ 45 ml/minute OR Trimethoprim if no known risk of resistance and no recent exposure to trimethoprim) in 2nd & 3rd trimester (BAAG opinion)	100mg m/r BD (if m/r is not available, use standard release 50mg QDS)	-	7 days			
		200mg BD						
		Pregnant women second choice: cefalexin OR amoxicillin (only if culture results available and susceptible)	500mg BD	-	7 days			
		500mg BD	-	7 days				
		Treatment of asymptomatic bacteriuria in pregnant women: choose from nitrofurantoin (avoid at term), amoxicillin or cefalexin based on recent culture and susceptibility results						
		Men first choice: nitrofurantoin (if eGFR ≥ 45 ml/minute) OR trimethoprim if no known risk of resistance and no recent exposure to trimethoprim)	100mg m/r BD (if m/r is not available, use standard release 50mg QDS)	-	7 days			
		200mg BD	-	7 days				
Men second choice: consider alternative diagnoses basing antibiotic choice on recent culture and susceptibility results								





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			Adult	Child		
		<p>Children and young people (3 months and over) first choice: trimethoprim if no known risk of resistance and no recent exposure to trimethoprim) OR</p> <p>nitrofurantoin (if eGFR ≥45 ml/minute)</p> <p>Children and young people (3 months and over) second choice: nitrofurantoin (if eGFR ≥45 ml/minute and not used as first choice) OR</p> <p>amoxicillin (only if culture results available and susceptible) OR</p> <p>cefalexin</p>			-	
Acute pyelonephritis (upper urinary tract)	<p>Advise paracetamol (+/- low-dose weak opioid) for pain for people over 12. Offer an antibiotic.</p> <p>When prescribing antibiotics, take account of severity of symptoms including suprapubic/flank pain, recurrent dysuria, history of fevers, risk of complications (history of immunosuppression), previous urine culture and susceptibility results, previous antibiotic use which may have led to</p>	<p>Non-pregnant women and men first choice:</p>			-	
		<p>co-amoxiclav (only if culture results available and susceptible) OR</p>	500/125mg TDS	-	7	
					-	

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			Adult	Child		
NICE Last updated: Oct 2018	resistant bacteria and local antimicrobial resistance data. <i>For detailed information click on the visual summary. See also the NICE guideline on urinary tract infection in under 16s: diagnosis and management.</i>	ciprofloxacin (consider safety issues– small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects)	500mg BD	-	7 days	
		Pregnant women first choice: Refer to secondary care - BAAG opinion		-		
		Children and young people (3 months and over) first choice: cefalexin OR	-		-	
		co-amoxiclav (only if culture results available and susceptible)	-	-	-	
		IV antibiotics (<i>click on visual summary</i>)	-	-	-	
Recurrent urinary tract infection	First advise about behavioural and personal hygiene measures, and self-care (with D-mannose or cranberry products) to reduce the risk of UTI. For postmenopausal women, if no improvement, consider vaginal oestrogen	First choice antibiotic prophylaxis non-pregnant: trimethoprim OR	200mg single dose when exposed to a trigger or 100mg at night		Review in 3 months (BAAG opinion)	
		nitrofurantoin (avoid at term) - if eGFR ≥45 ml/minute	100mg single dose when exposed to a trigger or 100mg at night		Review in 3 months (BAAG opinion)	






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			Adult	Child		
Last updated: Nov 2018	<p>previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data.</p> <p>Do not routinely offer antibiotic prophylaxis to people with a short-term or long-term catheter.- MAKE BOLD</p> <p><i>For detailed information click on the visual summary.</i></p>	<p>Non-pregnant women and men first choice if upper UTI symptoms: cefalexin OR</p>	<p><i>Non - severe</i> 500mg TDS</p> <p><i>Severe</i> 1.5g TDS</p>	-	<p>10 days</p> <p>7 days</p>	
		<p>co-amoxiclav (only if culture results available and susceptible) OR</p>	500/125mg TDS	-	7 DAYS	
		<p>trimethoprim (only if culture results available and susceptible) OR</p>	200mg BD	-	14 days	
		<p>ciprofloxacin (consider safety issues– small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects)</p>	500mg BD	-	7 days	
		<p>IV antibiotics (click on visual summary)</p>	-	-		

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			Adult	Child		
		Pregnant women first choice: cefalexin Non - severe 500mg TDS Severe 1.5g TDS		-	10 days 7 days	
		Children and young people (3 months and over) first choice: trimethoprim if no known risk of resistance and no recent exposure to trimethoprim) OR				
		amoxicillin (only if culture results available and susceptible) OR				
		cefalexin OR				
		co-amoxiclav (only if culture results available and susceptible)				
Acute prostatitis	Advise paracetamol (+/- low-dose weak opioid) for pain, or ibuprofen if preferred and suitable. Offer antibiotic. Review antibiotic treatment after 14 days and either stop antibiotics or continue for a further 14 days if needed (based on assessment of history, symptoms, clinical examination, urine and blood tests). For detailed information click on the visual summary.	First choice (guided susceptibilities when available): ciprofloxacin (consider safety issues– small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects)	500mg BD	-	14 days then review	
NICE						

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Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Last updated: Oct 2018				-		
				-		
		Second choice co-trimoxazole	960MG BD	-	14 days, then review	
				-		
▼ Meningitis						
Suspected meningococcal disease Public Health England Last updated: Feb 2019	Transfer all patients to hospital immediately. ^{1D} If time before hospital admission, ^{2D,3A+} if suspected meningococcal septicaemia or non-blanching rash, ^{2D,4D} give IV benzylpenicillin ^{1D,2D,4D} as soon as possible. ^{2D} Do not give IV antibiotics if there is a definite history of anaphylaxis; ^{1D} rash is not a contraindication. ^{1D}	IV or IM benzylpenicillin ^{1D,2D}	Child <1 year: 300mg ^{5D} Child 1–9 years: 600mg ^{5D} Adult/child 10+ years: 1.2g ^{5D}		Stat dose; ^{1D} give IM, if vein cannot be accessed ^{1D}	<i>Not available. Access the supporting evidence and rationales on the PHE website</i>
Prevention of secondary case of meningitis Public Health England Last updated: Nov 2017	Only prescribe following advice from your local health protection specialist/consultant: ☎ [INSERT PHONE NUMBER] Out of hours: contact on-call doctor: ☎ [INSERT PHONE NUMBER] <i>Access the supporting evidence and rationales on the PHE website.</i>					
▼ Gastrointestinal tract infections						
Oral candidiasis Public Health England	Topical azoles are more effective than topical nystatin. ^{1A+} Oral candidiasis is rare in immunocompetent adults; ^{2D} consider undiagnosed risk factors, including HIV. ^{2D}	Miconazole oral gel ^{1A+,4D,5A-}	2.5ml of 24mg/ml QDS (hold in mouth after food) ^{4D}		7 days; continue for 7 days after resolved ^{4D,6D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		If not tolerated: nystatin suspension ^{2D,6D,7A-}	1ml; 100,000units/mL QDS (half in each side) ^{2D,4D,7A-}		7 days; continue for 2 days after resolved ^{4D}	

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			Adult	Child		
Last updated: Oct 2018		fluconazole capsules ^{6D,7A-}	100mg OD ^{3D,6D,8A-}		7 days (except HIV / immunocompromised) to 14 days ^{6D,7A-,8A-}	
Infectious diarrhoea Public Health England Last updated: Oct 2018	Refer previously healthy children with acute painful or bloody diarrhoea, to exclude <i>E. coli</i> O157 infection. ^{1D} Antibiotic therapy is not usually indicated unless patient is systemically unwell. ^{2D} If systemically unwell and campylobacter suspected (such as undercooked meat and abdominal pain), ^{3D} consider clarithromycin 250–500mg BD for 5–7 days, if treated early (within 3 days). ^{3D,4A+} If giardia is confirmed or suspected – tinidazole 2g single dose is the treatment of choice. ^{5A+} <i>Access the supporting evidence and rationales on the PHE website.</i>					
Helicobacter pylori Public Health England See PHE quick reference guide for diagnostic advice: PHE H. pylori	Always test for <i>H. pylori</i> before giving antibiotics. Treat all positives, if known DU, GU, ^{1A+} or low-grade MALToma. ^{2D,3D} NNT in non-ulcer dyspepsia: 14. ^{4A+} Do not offer eradication for GORD. ^{3D} Do not use clarithromycin, metronidazole or quinolone if used in the past year for any infection. ^{5A+,6B+,7A+} Penicillin allergy: use PPI PLUS clarithromycin PLUS metronidazole. ^{2D} If previous clarithromycin, use PPI PLUS bismuth salt PLUS metronidazole PLUS tetracycline hydrochloride. ^{2D,8A-,9D} Relapse and no penicillin allergy use PPI PLUS amoxicillin PLUS clarithromycin or metronidazole (whichever was not used first line) ^{2D} Relapse and previous metronidazole and clarithromycin: use PPI PLUS amoxicillin	Always use PPI ^{2D,3D,5A+,12A+} First line and first relapse and no penicillin allergy PPI PLUS 2 antibiotics	-		7 days ^{2D} MALToma 14 days ^{7A+,16A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		amoxicillin ^{2D,6B+} PLUS	1000mg BD ^{14A+}			
		clarithromycin ^{2D,6B+} OR	500mg BD ^{8A-}			
		metronidazole ^{2D,6B+}	400mg BD ^{2D}			
		Penicillin allergy and previous clarithromycin: PPI WITH bismuth subsalicylate PLUS 2 antibiotics	-	-		
		bismuth subsalicylate ^{13A+} PLUS	525mg QDS ^{15D}			
		metronidazole ^{2D} PLUS	400mg BD ^{2D}			
		tetracycline ^{2D}	500mg QDS ^{15D}			


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<p>Last updated: Feb 2019</p>	<p>PLUS either tetracycline OR levofloxacin (if tetracycline not tolerated).^{2D,7A+} Relapse and penicillin allergy (no exposure to quinolone): use PPI PLUS metronidazole PLUS levofloxacin.^{2D} Relapse and penicillin allergy (with exposure to quinolone): use PPI PLUS bismuth salt PLUS metronidazole PLUS tetracycline.^{2D} Retest for <i>H. pylori</i>: post DU/GU, or relapse after second-line therapy,^{1A+} use <i>H.pylori</i> stool antigen testing only</p>	<p>Relapse and previous metronidazole and clarithromycin: PPI PLUS 2 antibiotics</p>	-	-		
		<p>amoxicillin^{2D,7A+} PLUS</p>	1000mg BD ^{14A+}			
		<p>tetracycline^{2D,7A+} OR</p>	500mg QDS ^{15D}			
		<p>levofloxacin^{2D,7A+} (consider safety issues– small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects)</p>	250mg BD ^{7A+}			
		<p>Third line seek specialist advice</p>	-	-		
<p><i>Clostridium difficile</i></p> <p>Public Health England</p> <p>Last updated: Oct 2018</p>	<p>Review need for antibiotics,^{1D,2D} PPIs,^{3B-} and antiperistaltic agents and discontinue use where possible.^{2D} Mild cases (<4 episodes of stool/day) may respond without metronidazole;^{2D} 70% respond to metronidazole in 5 days; 92% respond to metronidazole in 14 days.^{4B-}</p> <p>Insert BAAG pathway</p>	<p>First episode: metronidazole^{2D,4B-}</p> <p>Severe, or recurrent seek specialist advice</p>	400mg TDS ^{1D,2D}		14 days ^{1D,4B-}	<p><i>Not available. Access supporting evidence and rationales on the PHE website</i></p>

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Traveller's diarrhoea Public Health England Last updated: Oct 2018	Prophylaxis rarely, if ever, indicated. ^{1D} Consider standby antimicrobial only for patients at high risk of severe illness, ^{2D} or visiting high-risk areas. ^{1D,2D}	Standby private prescription azithromycin	500mg OD ^{1D,3A+}	-	3 days ^{1D,2D,3A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		Prophylaxis/treatment: private prescription or OTC bismuth subsalicylate	2 tablets QDS ^{1D,2D}	-	2 days ^{1D,2D,4A-}	
Threadworm Public Health England Last updated: Nov 2017	Treat all household contacts at the same time. ^{1D} Advise hygiene measures for 2 weeks ^{1D} (hand hygiene; ^{2D} pants at night; morning shower, including perianal area). ^{1D,2D} Wash sleepwear, bed linen, and dust and vacuum. ^{1D} Child <6 months , add perianal wet wiping or washes 3 hourly. ^{1D}	Child >6 months: mebendazole ^{1D,3B-}	100mg stat ^{3B-}		1 dose; ^{3B-} repeat in 2 weeks if persistent ^{3B-}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		Child <6 months or pregnant (at least in first trimester): only hygiene measure for 6 weeks ^{1D}	-	-	-	
▼ Genital tract infections						
STI screening Public Health England Last updated: Nov 2017	People with risk factors should be screened for chlamydia, gonorrhoea, HIV and syphilis. ^{1D} Refer individual and partners to GUM. ^{1D} Risk factors: <25 years; no condom use; recent/frequent change of partner; symptomatic or infected partner; area of high HIV. ^{2B-} <i>Access the supporting evidence and rationales on the PHE website.</i>					
Chlamydia trachomatis/ urethritis	Opportunistically screen all sexually active patients aged 15 to 24 years for <i>chlamydia</i> annually and on change of sexual partner. ^{1B-}	First line: doxycycline ^{4A+,11A-,12A+}	100mg BD ^{4A+,11A-,12A+}	-	7 days ^{4A+,11A-,12A+}	<i>Not available. Access supporting evidence and</i>

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Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
<p>Public Health England</p> <p>Last updated: Feb 2019</p>	<p>If positive, treat index case, refer to GUM and initiate partner notification, testing and treatment.^{2D,3A+}</p> <p>As single dose azithromycin has led to increased resistance in GU infections, doxycycline should be used first line for <i>chlamydia</i> and urethritis.^{4A+} Advise patient to abstain from sexual intercourse for 7 days after treatment.^{3A+,4A+}</p> <p>Test positives for reinfection at 3 months following treatment.^{1B-,5B-}</p> <p>Second line, pregnant, breastfeeding, allergy, or intolerance: azithromycin is most effective.^{6A+,7D,8A+,9A+,10D} As lower cure rate in pregnancy, test for cure at least 3 weeks after end of treatment.^{3A+}</p> <p>Consider referring all patients with symptomatic urethritis to GUM as testing should include <i>Mycoplasma genitalium</i> and <i>Gonorrhoea</i>.^{11A-}</p> <p>If <i>M.genitalium</i> is proven, use doxycycline followed by azithromycin using the same dosing regimen.^{11A-,12A+}</p>	<p>Second line/ pregnant/breastfeeding/ allergy/intolerance: azithromycin^{4A+,11A-,12A+}</p>	<p>1000mg^{4A+,11A-,12A+} then 500mg OD^{4A+,11A-,12A+}</p>		<p>Stat^{4A+,11A-,12A+}</p> <p>2 days^{4A+,11A-,12A+} (total 3 days)</p>	<p>rationales on the PHE website</p>
<p>Epididymitis</p> <p>Public Health England</p> <p>Last updated: Nov 2017</p>	<p>Usually due to Gram-negative enteric bacteria in men over 35 years with low risk of STI.^{1A+,2D}</p> <p>If under 35 years or STI risk, refer to GUM.^{1A+,2D}</p>	<p>Doxycycline^{1A+,2D} OR</p> <p>ciprofloxacin^{1A+,2D} (consider safety issues– small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects)</p>	<p>100mg BD^{1A+,2D}</p> <p>500mg BD^{1A+,2D,3A+}</p>	-	<p>14 days^{1A+,2D}</p> <p>10 days^{1A+,2D,3A+}</p>	<p>Not available. Access supporting evidence and rationales on the PHE website</p>



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Vaginal candidiasis Public Health England Last updated: Oct 2018	All topical and oral azoles give over 80% cure. ^{1A+,2A+} Pregnant: avoid oral azoles, the 7 day courses are more effective than shorter ones. ^{1A+,3D,4A+} Recurrent (>4 episodes per year): ^{1A+} 150mg oral fluconazole every 72 hours for 3 doses induction, ^{1A+} followed by 1 dose once a week for 6 months maintenance. ^{1A+}	Clotrimazole ^{1A+,5D} OR	500mg pessary ^{1A+}	-	Stat ^{1A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
					Stat ^{1A+}	
		oral fluconazole ^{1A+,3D}	150mg ^{1A+,3D}		Stat ^{1A+}	
		If recurrent: fluconazole (induction/maintenance) ^{1A+}	150mg every 72 hours THEN 150mg once a week ^{1A+,3D}		3 doses 6 months ^{1A+}	
Bacterial vaginosis Public Health England Last updated: Nov 2017	Oral metronidazole is as effective as topical treatment, ^{1A+} and is cheaper. ^{2D} 7 days results in fewer relapses than 2g stat at 4 weeks. ^{1A+,2D} Pregnant/breastfeeding: avoid 2g dose. ^{3A+,4D} Treating partners does not reduce relapse. ^{5A+}	Oral metronidazole ^{1A+,3A+} OR	400mg BD ^{1A+,3A+} OR 2000mg ^{1A+,2D}	-	7 days ^{1A+} OR Stat ^{2D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		clindamycin 2% cream ^{1A+,2D}	5g applicator at night ^{1A+,2D}		7 nights ^{1A+,2D,3A+}	
Genital herpes Public Health England Last updated: Nov 2017	Advise: saline bathing, ^{1A+} analgesia, ^{1A+} or topical lidocaine for pain, ^{1A+} and discuss transmission. ^{1A+} First episode: treat within 5 days if new lesions or systemic symptoms, ^{1A+,2D} and refer to GUM. ^{2D} Recurrent: self-care if mild, ^{2D} or immediate short course antiviral treatment, ^{1A+,2D} or suppressive therapy if more than 6 episodes per year. ^{1A+,2D}	Oral aciclovir ^{1A+,2D,3A+,4A+} OR	400mg TDS ^{1A+,3A+} 800mg TDS (if recurrent) ^{1A+}	-	5 days ^{1A+} 2 days ^{1A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		valaciclovir ^{1A+,3A+,4A+} OR	500mg BD ^{1A+}		5 days ^{1A+}	
Gonorrhoea Public Health England Last updated: Feb 2019	Antibiotic resistance is now very high. ^{1D,2D} Use IM ceftriaxone if susceptibility not known prior to treatment ^{2D} . Refer to GUM. ^{3B-} Test of cure is essential. ^{2D}	Ceftriaxone ^{2D} WHERE POSSIBLE + REFER TO GUM	1000mg IM ^{2D}	-	Stat ^{2D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>





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Trichomoniasis Public Health England Last updated: Nov 2017	Oral treatment needed as extrvaginal infection common. ^{1D} Treat partners, ^{1D} and refer to GUM for other STIs. ^{1D} Pregnant/breastfeeding: avoid 2g single dose metronidazole; ^{2A+,3D} clotrimazole for symptom relief (not cure) if metronidazole declined. ^{2A+,4A-5D}	Metronidazole ^{1A+,2A+,3D,6A+} Pregnancy to treat symptoms: clotrimazole ^{2A+,4A-,5D}	400mg BD ^{1A+,6A+} Or 2g (more adverse effects) ^{6A+} 100mg pessary at night ^{5D}	-	7 day ^{1A+} Stat ^{1A+,6A+} 6 nights ^{5D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
Pelvic inflammatory disease Public Health England Last updated: Feb 2019	Refer women and sexual contacts to GUM. ^{1A+} Raised CRP supports diagnosis, absent pus cells in HVS smear good negative predictive value. ^{1A+} Exclude: ectopic pregnancy, appendicitis, endometriosis, UTI, irritable bowel, complicated ovarian cyst, functional pain. Moxifloxacin has greater activity against likely pathogens, but always test for gonorrhoea, chlamydia, and <i>M. genitalium</i> . ^{1A+} <i>If M. genitalium</i> tests positive contact GUM.	First line therapy: Ceftriaxone ^{1A+,3C,4C} PLUS metronidazole ^{1A+,5A+} PLUS doxycycline ^{1A+,5A+} Second line therapy: metronidazole ^{1A+,5A+} PLUS ofloxacin ^{1A+,2A-,5A+} (consider safety issues— small increased risk of aortic aneurysm and dissection or potentially long lasting or irreversible side effects)	1000mg IM ^{1A+,3C} 400mg BD ^{1A+} 100mg BD ^{1A+} 400mg BD ^{1A+} 400mg BD ^{1A+,2A-}	-	Stat ^{1A+,3C} 14 days ^{1A+} 14 days ^{1A+} 14 days ^{1A+} 14 days ^{1A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
▼ Skin and soft tissue infections						
<i>Note: Refer to RCGP Skin Infections online training.^{1D} For MRSA, discuss therapy with microbiologist.^{1D}</i>						
Impetigo	Reserve topical antibiotics for very localised lesions to reduce risk of bacteria becoming resistant. ^{1D,2B+} Only use mupirocin if caused by MRSA. ^{1D,3A+}	Topical fusidic acid ^{2D,3A+} If MRSA: topical mupirocin ^{3A+}	Thinly TDS ^{4D} 2% ointment TDS ^{3A+}	 	5 days ^{1D,2D} 5 days ^{1D,2D,3A+}	<i>Not available. Access supporting evidence and</i>








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Public Health England Last updated: Nov 2017	Extensive, severe, or bullous: oral antibiotics. ^{4D}	More severe: oral flucloxacillin ^{1D,3A+} OR oral clarithromycin ^{1D,4D}	500mg QDS ^{3A+} 500mg BD ^{1D,4D}	 	7 days ^{3A+} 7 days ^{4D}	<i>rationales on the PHE website</i>
Cold sores Public Health England Last updated: Nov 2017	TREAT AS OTC Most resolve after 5 days without treatment. ^{1A-,2A-} Topical antivirals applied prodromally can reduce duration by 12 to 18 hours. ^{1A-,2A-,3A-} If frequent, severe, and predictable triggers: consider oral prophylaxis: ^{4D,5A+} aciclovir 400mg, twice daily, for 5 to 7 days. ^{5A+,6A+} <i>Access supporting evidence and rationales on the PHE website</i>					
PVL-SA Public Health England Last updated: Nov 2017	Panton-Valentine leukocidin (PVL) is a toxin produced by 20.8 to 46% of <i>S. aureus</i> from boils/abscesses. ^{1B+,2B+,3B-} PVL strains are rare in healthy people, but severe. ^{2B+} Suppression therapy should only be started after primary infection has resolved, as ineffective if lesions are still leaking. ^{4D} Risk factors for PVL: recurrent skin infections; ^{2B+} invasive infections; ^{2B+} MSM; ^{3B-} if there is more than one case in a home or close community ^{2B+,3B-} (school children; ^{3B-} military personnel; ^{3B-} nursing home residents; ^{3B-} household contacts). ^{3B-} <i>Access the supporting evidence and rationales on the PHE website.</i>					
Eczema Public Health England Last updated: Nov 2017	No visible signs of infection: antibiotic use (alone or with steroids) ^{1A+} encourages resistance and does not improve healing. ^{1A+} With visible signs of infection: use oral flucloxacillin ^{2D} or clarithromycin, ^{2D} or topical treatment (as in impetigo). ^{2D} <i>Access the supporting evidence and rationales on the PHE website.</i>					
Leg ulcer Public Health England Last updated: Feb 2019	Ulcers are always colonised. ^{1C,2A+} Antibiotics do not improve healing unless active infection ^{2A+} (only consider if purulent exudate/odour; increased pain; cellulitis; pyrexia). ^{3D}	Flucloxacillin ^{5D} OR clarithromycin ^{5D}	500mg QDS ^{5D} BMI > 30 use 1g QDS 500mg BD ^{5D}	 	7 days If slow response continue for another 7 days ^{5D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
Acne	Mild (open and closed comedones) ^{1D} or moderate (inflammatory lesions): ^{1D}	Second line: topical retinoid ^{1D,2D,3A+} OR benzoyl peroxide ^{1A-,2D,3A+,4A-}	Thinly OD ^{3A+} 5% cream OD-BD ^{3A+}		6–8 weeks ^{1D} 6–8 weeks ^{1D}	<i>Not available. Access supporting</i>

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Public Health England Last updated: Nov 2017	First line: self-care ^{1D} (wash with mild soap; do not scrub; avoid make-up). ^{1D} Second line: topical retinoid or benzoyl peroxide. ^{2D} Third-line: add topical antibiotic, ^{1D,3A+} or consider addition of oral antibiotic. ^{1D} Severe (nodules and cysts): ^{1D} add oral antibiotic (for 3 months max) ^{1D,3A+} and refer. ^{1D,2D}	Third-line: topical clindamycin ^{3A+}	1% cream, thinly BD ^{3A+}		12 weeks ^{1A-,2D}	evidence and rationales on the PHE website
		If treatment failure/severe: oral tetracycline ^{1A-,3A+} OR	500mg BD ^{3A+}		6–12 weeks ^{3A+}	
		oral doxycycline ^{3A+,4A-}	100mg OD ^{3A+}		6–12 weeks ^{3A+}	
Cellulitis and erysipelas Public Health England Last updated: Oct 2018	Class I: patient afebrile and healthy other than cellulitis, use oral flucloxacillin alone. ^{1D,2D,3A+} If river or sea water exposure: seek advice. ^{1D} Class II: patient febrile and ill, or comorbidity, admit for IV treatment, ^{1D} or use outpatient parenteral antimicrobial therapy. ^{1D} Class III: if toxic appearance, admit. ^{1D} Adding clindamycin does not improve outcomes ^{4B+} Erysipelas: often facial and unilateral. ^{5B+} Use flucloxacillin for non-facial erysipelas. ^{1D,2D,3A+}	Flucloxacillin ^{1D,2D,3A+}	500mg QDS ^{1D,2D} BMI > 30 1g qds		7 days; ^{1D} if slow response, continue for a further 7 days ^{1D}	Not available. Access supporting evidence and rationales on the PHE website
		Penicillin allergy: clarithromycin ^{1D,2D,3A+,6A+}	500mg BD ^{1D,2D}			
		Penicillin allergy and taking statins: doxycycline ^{2D}	200mg stat then 100mg OD ^{2D}			
		Facial (non-dental): co-amoxiclav ^{7B-}	500/125mg TDS ^{1D}			
Bites Public Health England	Human: thorough irrigation is important. ^{1A+,2D} Antibiotic prophylaxis is advised. ^{1A+,2D,3D} Assess risk of tetanus, rabies, ^{1A+} HIV, and hepatitis B and C. ^{3D} Cat: always give prophylaxis. ^{1A+,3D} Dog: give prophylaxis if: puncture wound; ^{1A+,3D} bite to hand, foot, face, joint, tendon, or ligament; ^{1A+} immunocompromised; cirrhotic;	Prophylaxis/treatment all: co-amoxiclav ^{2D,3D}	625mg TDS ^{3D}		7 days ^{3D}	Not available. Access supporting evidence and rationales on the PHE website
		Human bite: penicillin allergy: metronidazole ^{3D,4A+} AND	400mg TDS ^{2D}		7 days ^{3D}	
		clarithromycin ^{3D,4A+}	500mg BD ^{2D}			

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Last updated: Oct 2018	asplenic; or presence of prosthetic valve/joint. ^{2D,4A+} Penicillin allergy: Review all at 24 and 48 hours, ^{3D} as not all pathogens are covered. ^{2D,3}	Animal bite: penicillin allergy: metronidazole ^{3D,4A+} AND	400mg TDS ^{2D}		7 days ^{3D}	
		doxycycline ^{3D}	100mg BD ^{2D}			
		If pregnant seek specialist advice.		-		
Public Health England Last updated: Oct 2018	First choice permethrin: Treat whole body from ear/chin downwards, ^{1D,2D} and under nails. ^{1D,2D} If using permethrin and patient is under 2 years, elderly or immunosuppressed, or if treating with malathion: also treat face and scalp. ^{1D,2D} Home/sexual contacts: treat within 24 hours. ^{1D}	Permethrin ^{1D,2D,3A+}	5% cream ^{1D,2D}		2 applications, 1 week apart ^{1D}	Not available. Access supporting evidence and rationales on the PHE website
		Permethrin allergy: malathion ^{1D}	0.5% aqueous liquid ^{1D}			
Public Health England Last updated: Nov 2017	<i>S. aureus</i> is the most common infecting pathogen. ^{1D} Suspect if woman has: a painful breast; ^{2D} fever and/or general malaise; ^{2D} a tender, red breast. ^{2D} Breastfeeding: oral antibiotics are appropriate, where indicated. ^{2D,3A+} Women should continue feeding, ^{1D,2D} including from the affected breast. ^{2D}	Flucloxacillin ^{2D}	500mg QDS ^{2D}	-	14 days ^{2D}	Not available. Access supporting evidence and rationales on the PHE website
		Penicillin allergy: erythromycin ^{2D} OR	500mg QDS ^{2D}			
		clarithromycin ^{2D}	500mg BD ^{2D}			
Dermatophyte infection: skin	Most cases: use terbinafine as fungicidal, treatment time shorter and more effective than with fungistatic imidazoles or	Topical terbinafine ^{3A+,4D} OR	1% OD to BD ^{2A+}		1–4 weeks ^{3A+}	Not available. Access supporting evidence and
		topical imidazole ^{2A+,3A+}	1% OD to BD ^{2A+}		4–6 weeks ^{2A+,3A+}	





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Public Health England Last updated: Feb 2019	undecenoates. ^{1D,2A+} If candida possible, use imidazole. ^{4D} If intractable, or scalp: send skin scrapings, ^{1D} and if infection confirmed: use oral terbinafine ^{1D,3A+,4D} or itraconazole. ^{2A+,3A+,5D} Scalp: oral therapy, ^{6D} and discuss with specialist. ^{1D}	Alternative in athlete's foot: topical undecenoates ^{2A+} , (such as Mycota®) ^{2A+}	OD to BD ^{2A+}			<i>rationales on the PHE website</i>
Dermatophyte infection: nail Public Health England Last updated: Oct 2018	Take nail clippings; ^{1D} start therapy only if infection is confirmed. ^{1D} Oral terbinafine is more effective than oral azole. ^{1D,2A+,3A+,4D} Liver reactions 0.1 to 1% with oral antifungals. ^{3A+} If candida or non-dermatophyte infection is confirmed, use oral itraconazole. ^{1D,3A+,4D} Topical nail lacquer is not as effective. ^{1D,5A+,6D} To prevent recurrence: apply weekly 1% topical antifungal cream to entire toe area. ^{6D} Children: seek specialist advice. ^{4D}	First line: terbinafine ^{1D,2A+,3A+,4D,6D}	250mg OD ^{1D,2A+,6D}		Fingers: 6 weeks ^{1D,6D} Toes: 12 weeks ^{1D,6D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		Second line: itraconazole ^{1D,3A+,4D,6D}	200mg BD ^{1D,4D}		1 week a month ^{1D} Fingers: 2 courses ^{1D} Toes: 3 courses ^{1D}	
		Stop treatment when continual, new, healthy, proximal nail growth. ^{6D}				
Varicella zoster/ chickenpox Herpes zoster/ shingles	Pregnant/immunocompromised/ neonate: seek urgent specialist advice. ^{1D} Chickenpox: consider aciclovir ^{2A+,3A+,4D} if: onset of rash <24 hours, ^{3A+} and 1 of the following: >14 years of age, ^{4D} severe pain, ^{4D} dense/oral rash; ^{4D,5B+} taking steroids; ^{4D} smoker. ^{4D,5B+} Give paracetamol for pain relief. ^{6C}	First line for chicken pox and shingles: aciclovir ^{3A+,7A+,10A+,13B+,14A-,15A+}	800mg 5 times daily ^{16A-}		7 days ^{14A-,16A-}	<i>Not available. Access supporting evidence and</i>
Second line for shingles if poor compliance: <i>not for children:</i>		-				

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Public Health England Last updated: Oct 2018	<p>Shingles: treat if >50 years^{7A+,8D} (PHN rare if <50 years)^{9B+} and within 72 hours of rash,^{10A+} or if 1 of the following: active ophthalmic;^{11D} Ramsey Hunt;^{4D} eczema;^{4D} non-truncal involvement;^{8D} moderate or severe pain;^{8D} moderate or severe rash.^{5B+,8D}</p> <p>Shingles treatment if not within 72 hours: consider starting antiviral drug up to 1 week after rash onset,^{12B+} if high risk of severe shingles^{12B+} or continued vesicle formation;^{4D} older age;^{7A+,8D,12B+} immunocompromised;^{4D} or severe pain.^{7D,11B+}</p>	valaciclovir ^{8D,10A+,14A-}	1g TDS ^{14A-}			<i>rationales on the PHE website</i>
Public Health England Last updated: Oct 2018	<p>Prophylaxis:^{1A+} not routinely recommended in Europe.^{2D} In pregnancy, consider amoxicillin.^{2D}</p> <p>If immunocompromised, consider prophylactic doxycycline.^{2D} Risk increased if high prevalence area and the longer tick is attached to the skin.^{3D}</p> <p>Only give prophylaxis within 72 hours of tick removal.^{1A+,2D,4A-} Give safety net advice about erythema migrans^{2D} and other possible symptoms^{2D} that may occur within 1 month of tick removal.^{2D}</p>	Prophylaxis: ^{1A+} doxycycline ^{2D,4A-,5D}	200mg ^{2D,4A,5D}		Stat ^{2D,4A-,5D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
	<p>Treatment: Treat erythema migrans empirically; serology is often negative early in infection.^{3D}</p> <p>For other suspected Lyme disease such as neuroborreliosis (CN palsy, radiculopathy) seek advice.^{3D}</p>	<p>Treatment: doxycycline^{2D,3D,5D}</p> <p>First alternative: amoxicillin^{2D,3D,5D}</p>	100mg BD ^{2D,3D,5D}		21 days ^{2D,3D,5D}	
▼ Eye infections						
Public Health England	<p>First line: bath/clean eyelids with cotton wool dipped in sterile saline or boiled (cooled) water, to remove crusting.^{1D}</p> <p>Treat only if severe,^{2A+} as most cases are viral^{3D} or self-limiting.^{2A+}</p>	<p>Second line: chloramphenicol^{1D,2A+,4A-,5A+} 0.5% eye drop^{1D,2A+}</p> <p>OR 1% ointment^{1D,5A+}</p>	2 hourly for 2 days, ^{1D,2A+} then reduce frequency ^{1D} to 3–4 times daily, ^{1D} or just at night if using eye ointment ^{1D}		48 hours after resolution ^{2A+,7D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>

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Last updated: Oct 2018	Bacterial conjunctivitis: usually unilateral and also self-limiting. ^{2A+,3D} It is characterised by red eye with mucopurulent, not watery discharge. ^{3D} 65% and 74% resolve on placebo by days 5 and 7. ^{4A-,5A+} Third line: fusidic acid as it has less Gram-negative activity. ^{6A-,7D}	Third line: fusidic acid 1% gel ^{2A+,5A+,6A-}	BD ^{1D,7D}			
Blepharitis Public Health England Last updated: Nov 2017	First line: lid hygiene ^{1D,2A+} for symptom control, ^{1D} including: warm compresses; ^{1D,2A+} lid massage and scrubs; ^{1D} gentle washing; ^{1D} avoiding cosmetics. ^{1D} Blepharitis self-help advice Second line: topical antibiotics if hygiene measures are ineffective after 2 weeks. ^{1D,3A+} Signs of meibomian gland dysfunction, ^{3D} or acne rosacea: ^{3D} consider oral antibiotics. ^{1D}	Second line: topical chloramphenicol ^{1D,2A+,3A-}	1% ointment BD ^{2A+,3D}		6-week trial ^{3D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		oral doxycycline ^{1D,2A+,3D}	100mg OD ^{3D} 50mg OD ^{3D}		4 weeks (initial) ^{3D} 8 weeks (maint) ^{3D}	
▼ Suspected dental infections in primary care (outside dental settings)						
Derived from the Scottish Dental Clinical Effectiveness Programme (SDCEP) 2013 Guidelines. This guidance is not designed to be a definitive guide to oral conditions, as GPs should not be involved in dental treatment. Patients presenting to non-dental primary care services with dental problems should be directed to their regular dentist, or if this is not possible, to the NHS 111 service (in England), who will be able to provide details of how to access emergency dental care.						
<i>Note: Antibiotics do not cure toothache.^{1D} First-line treatment is with paracetamol^{1D} and/or ibuprofen;^{1D} codeine is not effective for toothache.^{1D}</i>						
Mucosal ulceration and inflammation (simple gingivitis) Public Health England Last updated: Nov 2017	Temporary pain and swelling relief can be attained with saline mouthwash (½ tsp salt in warm water) ^{1D} . Use antiseptic mouthwash if more severe, ^{1D} and if pain limits oral hygiene to treat or prevent secondary infection. ^{1D,2A-} The primary cause for mucosal ulceration or inflammation (aphthous ulcers; ^{1D} oral lichen planus; ^{1D} herpes simplex infection; ^{1D} oral cancer) ^{1D} needs to be evaluated and treated. ^{1D}	Chlorhexidine 0.12 to 0.2% ^{1D, 2A-,3A+,4A+} (do not use within 30 minutes of toothpaste) ^{1D} OR	1 minute BD with 10 ml ^{1D}	 	Always spit out after use. ^{1D} Use until lesions resolve or less pain allows for oral hygiene ^{1D}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		hydrogen peroxide 6% ^{5A-, 1D}	2 to 3 minutes BD/TDS with 15ml in ½ glass warm water ^{1D}			
Acute necrotising ulcerative gingivitis	Refer to dentist for scaling and hygiene advice. ^{1D,2D}	Chlorhexidine 0.12 to 0.2% (do not use within 30 minutes of toothpaste) ^{1D} OR	1 minute BD with 10ml ^{1D}		Until pain allows for oral hygiene ^{6D}	<i>Not available. Access supporting evidence and</i>

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Public Health England Last updated: Nov 2017	Antiseptic mouthwash if pain limits oral hygiene. ^{1D} Commence metronidazole if systemic signs and symptoms. ^{1D,2D,3B-,4B+,5A-}	hydrogen peroxide 6% ^{1D}	2 to 3 minutes BD/TDS with 15ml in ½ glass warm water		3 days ^{1D,2D}	<i>rationales on the PHE website</i>
		metronidazole ^{1D,3B-,4B+,5A-}	400mg TDS ^{1D,2D}			
Pericoronitis Public Health England Last updated: Nov 2017	Refer to dentist for irrigation and debridement. ^{1D} If persistent swelling or systemic symptoms, ^{1D} use metronidazole ^{1D,2A+,3B+} or amoxicillin. ^{1D,3B+} Use antiseptic mouthwash if pain and trismus limit oral hygiene. ^{1D}	Metronidazole ^{1D,2A+,3B+} OR	400mg TDS ^{1D}		3 days ^{1D,2A+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		amoxicillin ^{1D,3B+}	500mg TDS ^{1D}		3 days ^{1D}	
		chlorhexidine 0.2% (do not use within 30 minutes of toothpaste) ^{1D} OR	1 minute BD with 10ml ^{1D}		Until less pain allows for oral hygiene ^{1D}	
		hydrogen peroxide 6% ^{1D}	2 to 3 minutes BD/TDS with 15ml in ½ glass warm water ^{1D}			
Dental abscess Public Health England Last updated: Oct 2018	Regular analgesia should be the first option ^{1A+} until a dentist can be seen for urgent drainage, ^{1A+,2B-,3A+} as repeated courses of antibiotics for abscesses are not appropriate. ^{1A+,4A+} Repeated antibiotics alone, without drainage, are ineffective in preventing the spread of infection. ^{1A+,5C} Antibiotics are only recommended if there are signs of severe infection, ^{3A+} systemic symptoms, ^{1A+,2B-,4A+} or a high risk of complications. ^{1A+} Patients with severe odontogenic infections (cellulitis, ^{1A+,3A+} plus signs of sepsis, ^{3A+,4A+} difficulty in swallowing, ^{6D} impending airway obstruction) ^{6D} should be referred urgently for hospital admission to protect airway, ^{6D} for surgical drainage ^{3A+} and for IV antibiotics. ^{3A+} The empirical use of cephalosporins, ^{6D} co-amoxiclav, ^{6D} clarithromycin, ^{6D} and clindamycin ^{6D} do not offer any advantage for most dental patients, ^{6D} and should only be used if there is no response to first-line drugs. ^{6D}					
	If pus is present, refer for drainage, ^{1A+,2B-} tooth extraction, ^{2B-} or root canal. ^{2B-} Send pus for investigation. ^{1A+} If spreading infection ^{1A+} (lymph node involvement ^{1A+,4A+} or systemic signs, ^{1A+,2B-,4A+} that is, fever ^{1A+} or malaise) ^{4A+} ADD metronidazole. ^{6D,7B+} Use clarithromycin in true penicillin allergy ^{6D} and, if severe, refer to hospital. ^{3A+,6D}	Amoxicillin ^{6D,8B+,9C,10B+} OR	1000mg TDS ^{6D}		Up to 5 days; ^{6D,10B+} review at 3 days ^{9C,10B+}	<i>Not available. Access supporting evidence and rationales on the PHE website</i>
		phenoxymethylpenicillin ^{11B-}	1000mg QDS ^{6D}			
		metronidazole ^{6D,8B+,9C}	400mg TDS ^{6D}			
		Penicillin allergy: clarithromycin ^{6D}	500mg BD ^{6D}			

Summary of antimicrobial prescribing guidance – managing common infections (February 2019)adapted by BAAG

Approved by APC May 2019. Review May 2021

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
▼ Abbreviations						
BD, twice a day; eGFR, estimated glomerular filtration rate; IM, intramuscular; IV, intravenous; MALToma, mucosa-associated lymphoid tissue lymphoma; m/r, modified release; MRSA, methicillin-resistant <i>Staphylococcus aureus</i> ; MSM, men who have sex with men; stat, given immediately; OD, once daily; TDS, 3 times a day; QDS, 4 times a day.						