



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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Lead Author:	Pamela Innes & Laura Pelan
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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

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 the NHSGGC Clinical Guideline Platform.

Disease codes linked to the guideline choices (synonyms) are available for most common indications (indicated where applicable in brackets).

UPPER RESPIRATORY TRACT	LOWER RESPIRATORY TRACT	URINARY TRACT	SKIN / SOFT TISSUE
<p>Consider delayed antibiotic prescriptions.</p>	<p>Do not use quinolones (ciprofloxacin, ofloxacin) first line due to poor pneumococcal activity.</p>	<p>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)</p>	<p>Impetigo (.IMPETIGO) Reserve topical antibiotics for very localised lesions. Fusidic acid 2% apply topically TDS for 5 days If extensive, severe or bullous impetigo Flucloxacillin 500 mg QDS or if true penicillin allergy Clarithromycin 500mg BD for 5 days</p> <p>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 5 days for treatment BUT review at 24 and 48 hours.</p>
<p>Pharyngitis / sore throat / tonsillitis (.TONSILLITIS) • SELF-LIMITING ILLNESS lasting around 1 week • Check FeverPAIN score (Fever, Purulent tonsils, Attending rapidly, Infamed 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 Group A Strep) or if true penicillin allergy • Clarithromycin 500mg BD Duration 5 days</p>	<p>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</p>	<p>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</p>	<p>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)</p>
<p>Otitis media (.OTITIS MEDIA) • SELF-LIMITING ILLNESS lasting around 3-7 days • Optimise analgesia • Consider 2 or 3 day delayed prescribing or immediate antibiotics if otorrhoea (see also Paediatric Guideline) • Amoxicillin 500mg - TDS (1g if severe) or if true penicillin allergy • Clarithromycin 500mg BD Duration 5 days</p>	<p>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</p>	<p>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</p>	<p>*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.</p>
<p>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</p>		<p>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 Or *Cefalexin 500mg TDS Duration 7 days</p>	<p>Acne Vulgaris (.ACNE) Mild to moderate - topical benzoyl peroxide with topical clindamycin gel (Duac) or topical adapalene with topical benzoyl peroxide (Epiduo) or topical tretinoin with topical clindamycin (Trecin), apply once daily Moderate to severe - consider oral antibiotic PLUS topical adapalene with topical benzoyl peroxide (Epiduo) apply once daily or Topical azelaic acid apply twice daily. Oral Antibiotic Lymecycline 408mg OD or Doxycycline 100mg OD Assess effect after 12 weeks. Review ongoing treatment at least every 3 months and stop oral antibiotic as soon as possible. Only continue oral antibiotics for more than 6 months in exceptional circumstances.</p>
<p>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'</p>		<p>Acute prostatitis (.PROSTATE) Always perform culture *Ciprofloxacin 500mg BD or Trimethoprim 200 mg BD Duration 14 days then review</p>	<p>*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</p>