**Principles of treatment:**

1. This guidance is based on the best available evidence, but use professional judgement and involve patients in management decisions.
2. This guidance should not be used in isolation; it should be supported with patient information about safety netting, delayed-back-up antibiotics, self-care, infection severity and usual duration, clinical staff education, and audits. Materials are available on the RCGP TARGET website.
3. Prescribe an antibiotic only when there is likely to be clear clinical benefit, giving alternative, non-antibiotic self-care advice, where appropriate.
4. Consider a ‘no’ or ‘delayed/back-up’ antibiotic strategy for acute self-limiting upper respiratory tract infections and mild UTI symptoms.
5. In severe infection, or immunocompromised, it is important to initiate antibiotics as soon as possible, particularly if sepsis is suspected. If patient is not at moderate to high risk for sepsis, give information about symptom monitoring, and how to access medical care if they are concerned.
6. Where an empirical therapy has failed or special circumstances exist, microbiological advice can be obtained from your local acute hospital.
7. Limit prescribing over the telephone to exceptional cases. Any remote prescribing must be backed up by electronic confirmation (e.g. e-mail or entry in CareNotes).
8. Use simple, generic antibiotics if possible. Avoid broad spectrum antibiotics (eg co-amoxiclav, quinolones and cephalosporins) as they increase the risk of *Clostridium difficile*, MRSA and resistant unlike the narrow spectrum antibiotics.
10. A dose and duration of treatment for adults is usually suggested, but may need modification for age, weight, renal function, or if immunocompromised. In severe or recurrent cases, consider a larger dose or longer course.
11. Refer to the BNF for further dosing and interaction information (eg the interaction between macrolides and statins), and check for hypersensitivity.
12. Have a lower threshold for antibiotics in immunocompromised, or in those with multiple morbidities; consider culture/specimens, and seek advice.
13. Avoid widespread use of topical antibiotics, especially in those agents also available systemically; in most cases, topical use should be limited.
14. In pregnancy, take specimens to inform treatment. Where possible, avoid tetracyclines, aminoglycosides, quinolones, azithromycin (except in chlamydial infection), clarithromycin, and high dose metronidazole (2g stat), unless the benefits outweigh the risks. Penicillins, cephalosporins, and erythromycin are safe in pregnancy. Short-term use of nitrofurantoin is not expected to cause foetal problems (theoretical risk of neonatal haemolysis). *Trimethoprim* is also unlikely to cause problems unless poor dietary folate intake, or taking another folate antagonist.
15. This guidance is developed alongside the NHS England Antibiotic Quality Premium. The required performance in 2017/19 is: a 10% reduction (or greater) in the number of *E. coli* blood stream infections across the whole health economy; a 10% reduction (or greater) in the *trimethoprim* nitrofurantoin prescribing ratio for UTI in primary care, and a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater; sustained reduction of inappropriate prescribing in primary care.

### Summary table Management & Treatment of Common Infections & Infestations

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>GOOD PRACTICE POINTS</th>
<th>TREATMENT</th>
<th>ADULT DOSE</th>
<th>COURSE DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UPPER RESPIRATORY TRACT INFECTIONS</strong> (consider no antibiotic or delayed prescription)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **INFLUENZA**<br>PHE Influenza<br>NICE Influenza | Follow **PHE influenza** guidance.<br>Annual vaccination is essential for all those “at risk”** of influenza. **

**Older people, the very young, pregnant women, immunocompromised patients and those with underlying diseases, particularly chronic respiratory or cardiac disease.** | | | |
| **Acute sore throat**<br>NICE NG84<br>FeverPAIN<br>CKS sore throat | **Avoid antibiotics** as 82% of cases resolve in 7 days and pain is only reduced by 16 hours. **Use FeverPAIN Score:**

- **Fever** in last 24 hours, Purulence; *Attends rapidly within 3 days; Inflamed tonsils; No cough or coryza.*
- **Score 0-1:** 13-18% streptococci - no antibiotic.
- **Score 2-3:** 34-40% streptococci - 3 day delayed antibiotic.
- **Score 4-5:** 62-65% streptococci - if severe, immediate antibiotic or 48-hour delayed antibiotic.

**Advise paracetamol, self-care, and safety net.** Complications are rare: antibiotics to prevent quinsy NNT>4000; otitis media NNT200. 10 days penicillin has lower relapse than five days in patients under 18 years of age. | Phenoxymethylpenicillin | 500mg QDS OR 1g BD | 5-10 days |
| Acute Otitis Externa<br>CKS otitis externa | **First use analgesia**<br>Cure rates similar at 7 days for topical acetic acid or antibiotic +/- steroid<br>It cellulitis/disease extending outside ear canal, start oral antibiotics & refer to exclude malignant otitis externa | **First line:**

- EarCalm spray (acetic acid 2%, prescribe brand name)<br>
- **Second Line:** neomycin sulphate with corticosteroid | 1 Spray TDS | 7 days |
| | | 3 drops TDS | 7-14 days |
### Acute Rhinosinusitis
- **Avoid antibiotics** as 80% resolve in 14 days without, and they only offer marginal benefit after 7 days (NNT15).
- **Use adequate analgesia**
  - Consider 7-day delayed or immediate antibiotic when purulent nasal discharge (NNT8)
  - In persistent infections, use an agent with anti-anaerobic activity.

<table>
<thead>
<tr>
<th>Phenoxyemthylpenicillin <strong>OR</strong> doxycycline</th>
<th>500mg QDS OR 1g BD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For severe and persistent symptoms:</strong> Co-amoxiclav</td>
<td>200mg STAT then 100mg OD</td>
</tr>
<tr>
<td>500/125mg TDS</td>
<td><strong>COURSE DURATION</strong> 5 days all treatments</td>
</tr>
</tbody>
</table>

### Cough, bronchitis
- **Acute cough, bronchitis**
  - Antibiotic little benefit if no co-morbidity.
  - Symptom resolution can take 3 weeks.
  - Consider 7 day delayed antibiotic with symptomatic advice/leaflet.
  - Consider immediate antibiotics if:
    - Over 80 years old with ONE of below:
      - Hospitalisation in past year
      - Oral steroids
      - Diabetic
      - Congestive heart failure
      - OR over 65 years old with 2 of above

<table>
<thead>
<tr>
<th>Amoxicillin <strong>OR</strong> doxycycline</th>
<th>500mg TDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>200mg STAT then 100mg OD</td>
<td><strong>COURSE DURATION</strong> 5 days all treatments</td>
</tr>
</tbody>
</table>

### Acute exacerbation of COPD
- **NICE CG114 GOLD COPD**
  - Treat exacerbations promptly with antibiotics if purulent sputum and increased shortness of breath and/or increased sputum volume.
  - Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations and antibiotic treatments in the last 3 months.

<table>
<thead>
<tr>
<th><strong>First line:</strong> Amoxicillin</th>
<th>500mg TDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>200mg STAT then 100mg OD</td>
<td><strong>COURSE DURATION</strong> 5 days all treatments</td>
</tr>
</tbody>
</table>

### Community-acquired pneumonia - treatment in the community
- **BTA 2009 NICE CG191**
  - Use CRB65 score to help guide and review:
    - Each scores 1:
      - Confusion (AMT < 8)
      - Respiratory rate > 30/min
      - BP systolic < 90 or diastolic ≤ 60
    - Age 65
      - Score 0: suitable for treatment in mental health ward
      - Score 1-2: intermediate risk consider acute hospital assessment
      - Score 3-4: urgent acute hospital admission
      - Always give safety net advice and likely duration of treatment. Mycoplasma infection is rare in over 65 years old.

<table>
<thead>
<tr>
<th>If CRB65= 0 Amoxicillin <strong>OR</strong> doxycycline</th>
<th>500mg TDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>200mg STAT then 100mg OD</td>
<td><strong>COURSE DURATION</strong> 5 days all treatments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If CRB65= 1 or 2 suitable for treatment on Mental Health ward Amoxicillin and Clarythromycin <strong>OR</strong> doxycycline alone</th>
<th>500mg TDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>500mg BD</td>
<td>200mg STAT then 100mg OD</td>
</tr>
</tbody>
</table>

### Meningitis
- **Prevention of secondary cases of meningitis:** Only prescribe following advice from Public Health.
- Contact local HPA on 03442253861 Option 1 or if out of hours on 08449670069

<table>
<thead>
<tr>
<th>Suspected meningococcal disease</th>
<th><strong>TRANSFER ALL PATIENTS TO AN ACUTE HOSPITAL IMMEDIATELY.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If time before admission, and non-blanching rash, give IV benzylpenicillin or cefotaxime unless definite history of hypersensitivity Recommended treatment is for information only as there are no IV antibiotics stocked in wards</td>
<td>Benzylpenicillin IV or IM <strong>OR</strong> Cefotaxime IV or IM</td>
</tr>
<tr>
<td><strong>Age10+ years:</strong> 1200mg</td>
<td><strong>Age 12+ years:</strong> 1000mg</td>
</tr>
<tr>
<td><strong>GIVE IM IF VEIN CANNOT BE FOUND</strong></td>
<td><strong>COURSE DURATION</strong></td>
</tr>
</tbody>
</table>
### Management and Treatment of Common Infections and Infestations

#### URINARY TRACT INFECTIONS

*As E.coli bacteremia and antimicrobial resistance is increasing use nitrofurantoin first line, always give safety net and self-care advice and consider risk of resistance. Give TARGET UTI leaflet.*

**Catheter in situ:** antibiotics will not eradicate asymptomatic bacteriuria; only treat if systemically unwell or pyelonephritis likely. Do not use prophylactic antibiotics for catheter changes unless history of catheter-change-associated UTI or trauma. Take sample if new onset of delirium, or two or more symptoms of UTI.

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>GOOD PRACTICE POINTS</th>
<th>TREATMENT</th>
<th>ADULT DOSE</th>
<th>COURSE DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower UTI in adults</td>
<td><strong>NICE NG109</strong>&lt;br&gt;PHE Urine&lt;br&gt;PHE diagnosis of UTI&lt;br&gt;SIGN&lt;br&gt;CKS women&lt;br&gt;CKS men&lt;br&gt;RCGP UTI&lt;br&gt;Clinical module&lt;br&gt;SAPG UTI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UTI in pregnancy</td>
<td><strong>PHE Urine CKS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute pyelonephritis</td>
<td><strong>NICE NG111</strong>&lt;br&gt;CKS pyelonephritis&lt;br&gt;EMA Oct 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent UTI in non-pregnant women ≥ 3 UTIs/year</td>
<td><strong>NICE NG112</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute prostatitis</td>
<td><strong>NICE NG110</strong>&lt;br&gt;CKS prostatitis&lt;br&gt;EMA Oct 18</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**First line:**

- Nitrofurantoin *if GFR* ≥ 45

**If first line option unsuitable:**

- **If low risk of resistance:**
  - Trimethoprim
  - If GFR >45mls/min
- Pivmecillinam **

**If penicillin allergy:**

- Fosfomycin

**NB:** If increased resistance risk, send culture with FIRST presentation for susceptibility testing & give safety net advice.

- *Low risk of resistance:* younger women with acute UTI & no resistance risks.
- **This is a penicillin**

**Risk factors for increased resistance include:**

- Care home resident, recurrent UTI (2 in 6 months, ≥3 in 12 months), hospitalisation for >7 days in the last 6 months, unresolved urinary symptoms, recent travel to a country with increased resistance, previous UTI resistant to trimethoprim, cephalosporins, or quinolones.

**TO REDUCE REOCURRENCE FIRST ADVISE SIMPLE MEASURES INCLUDING HYDRATION AND CRANBERRY PRODUCTS:**

- Ongoing prophylaxis is not encouraged and may drive resistance.
- If must use, choice should be driven by cultures

**Choice driven by cultures**

- Nitrofurantoin *if GFR* ≥ 45
- Trimethoprim

**Follow advice EMA Oct 18**

- Ciprofloxacin
- Ofloxacin

**If quinolone not appropriate:**

- Do not use quinolones to treat acute prostatitis

### TREATMENTS

<table>
<thead>
<tr>
<th>UTI in pregnancy</th>
<th>PHE Urine CKS</th>
<th>PHE Urine CKS</th>
<th>Acute pyelonephritis</th>
<th>NICE NG111</th>
<th>CKS pyelonephritis</th>
<th>EMA Oct 18</th>
<th>Recurrent UTI in non-pregnant women ≥ 3 UTIs/year</th>
<th>NICE NG112</th>
<th>Acute prostatitis</th>
<th>NICE NG110</th>
<th>CKS prostatitis</th>
<th>EMA Oct 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrofurantoin</td>
<td>Pivmecillinam</td>
<td>Fosfomycin</td>
<td>Cefalexin</td>
<td>Cefalexin</td>
<td>Co-amoxiclav ___</td>
<td>Ciprofloxacin ___</td>
<td>Choice driven by cultures</td>
<td>Nitrofurantoin</td>
<td>Ofloxacin</td>
<td>Ciprofloxacin</td>
<td>Ofloxacin</td>
<td></td>
</tr>
<tr>
<td>100mg MR BD</td>
<td>400mg STAT</td>
<td>500mg BD</td>
<td>500mg BD</td>
<td>500mg BD</td>
<td>500/125mg TDS</td>
<td>500mg BD</td>
<td>Nitrofurantoin <em>if GFR</em> ≥ 45</td>
<td>100mg MR OD @ night</td>
<td>200mg BD</td>
<td>500mg BD</td>
<td>14 days then review and stop or continue for further 14 days</td>
<td></td>
</tr>
</tbody>
</table>

**If treatment failure: always perform culture**

- Send MSU for culture & sensitivity and start antibiotics.
- If admission to an acute hospital not needed, send MSU for culture & sensitivities and start antibiotics. If no response within 24 hours, seek advice.
- If there is risk of contamination with extended spectrum β- lactamase producing bacteria and with microbiology advice consider IV antibiotics via outpatient parenteral antimicrobial therapy (OPAT) service.

- To reduce reoccurrence first advise simple measures including hydration and cranberry products.
- Ongoing prophylaxis is not encouraged and may drive resistance.
- If must use, choice should be driven by cultures.

- Send MSU for cultures and start antibiotics.
- 4 weeks course may prevent chronic prostatitis.
- Quinolones achieve high prostate concentrations.

**Follow advice EMA Oct 18**

- Ciprofloxacin
- Ofloxacin

**If quinolone not appropriate:**

- Do not use quinolones to treat acute prostatitis

**Follow advice EMA Oct 18**

- Ciprofloxacin
- Ofloxacin

**If quinolone not appropriate:**

- Do not use quinolones to treat acute prostatitis

**Follow advice EMA Oct 18**

- Ciprofloxacin
- Ofloxacin

**If quinolone not appropriate:**

- Do not use quinolones to treat acute prostatitis

**Follow advice EMA Oct 18**

- Ciprofloxacin
- Ofloxacin
| Vaginal candidiasis CKS Vag. candidiasis | Only topical preparations are appropriate in pregnancy with recommended course duration of 7 days | Fluconazole oral Clotrimazole pessary Clotrimazole 10% cream | 150mg STAT 500mg STAT 5g applicator full STAT | Repeat in 3 days in severe cases |

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>GOOD PRACTICE POINTS</th>
<th>TREATMENT</th>
<th>ADULT DOSE</th>
<th>COURSE DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>GASTRO-INTESTINAL TRACT INFECTIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eradication of Helicobacter pylori</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICE CG184 PHE H.pylori CKS dyspepsia</td>
<td>Eradication is beneficial in known DU, GU or low grade maltaoma</td>
<td>Always use PPI (BD) First line: PPI with amoxicillin and metronidazole (MZ)</td>
<td>Twice daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider test and treat in persistent uninvestigated dyspepsia</td>
<td>Second line: (intolerant to MZ) PPI with amoxicillin and clarithromycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not offer eradication for GORD</td>
<td>Penicillin Allergy: PPI with clarithromycin and metronidazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not use clarithromycin or metronidazole if used in the past year for any infection</td>
<td>If previous clarithromycin use and not had exposure to a quinolone: PPI with metronidazole and levofloxacin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If patient fits outside this guideline, please refer to microbiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In relapse see NICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Candidiasis CKS oral candida</td>
<td>Oral candidiasis rare in immunocompetent adults; consider undiagnosed risk factors including HIV.</td>
<td>Mild-moderate miconazole oral gel OR Nystatin suspens. 100 .000 IU Moderate- severe fluconazole oral tablets</td>
<td>2.5mL **“for 7 days after asymptomatic” 1ml QDS ** “for 2 days after asymptomatic” 50mg OD OR 100mg OD if extensive, severe, HIV or immunocompromised</td>
<td>7 days **</td>
</tr>
<tr>
<td>Abdominal sepsis e.g.diverticulitis CKS diverticulitis</td>
<td>Assess the need for admission. If treated at home, use broad spectrum antibiotics.</td>
<td>co-amoxiclav Penicillin Allergy: ciprofloxacin and metronidazole 500/125mg TDS</td>
<td>500mg BD 400mg TDS</td>
<td>7 days all treatments</td>
</tr>
<tr>
<td>Threadworm CKS threadworm</td>
<td>Treat all household contacts at the same time PLUS advise hygiene measures for 2 weeks (hand hygiene, pants at night, morning shower) PLUS wash sleepwear, bed linen, dust, and vacuum on day one</td>
<td>mebendazole</td>
<td>100mg STAT</td>
<td>Repeat in 2 weeks if infestation persists</td>
</tr>
<tr>
<td>Infectious diarrhoea PHE diarrhoea</td>
<td>Antibiotic therapy not indicated unless systemically unwell. If very sick and Campylobacter suspected (e.g. undercooked meat and abdominal pain) Consider recent antibiotics / hospital admission and risk of Clostridium difficile</td>
<td>Clarithromycin</td>
<td>500mg</td>
<td>5 days</td>
</tr>
<tr>
<td>Clostridium difficile PHE C. diff</td>
<td>Stop unnecessary antibiotics and/or PPIs. Admit to an acute hospital if severe: T &gt;38.5; WCC &gt;15, rising creatinine or signs/symptoms of severe colitis</td>
<td>No Hx of CDI or &gt; 30 days ago Metronidazole CDI within 30 days (Severe / recurrent) Vancomycin (oral)</td>
<td>400-500mg TDS 125mg QDS</td>
<td>10-14 days</td>
</tr>
</tbody>
</table>

| SKIN INFECTIONS | | | | |
| Eczema CKS eczema | If no visible signs of infection use of antibiotics (alone or with steroids) encourages resistance and does not improve healing. In cases with visible signs of infection, use treatment as in impetigo. | | | |

** Produced: January 2019  Adapted by the South Central Antimicrobial Network Group from the Public Heath England “Management of Infection: Guidance for Primary Care”**
## Management and Treatment of Common Infections and Infestations

### Impetigo

| CKS impetigo | For extensive, severe, or bullous impetigo use oral antibiotics. Reserve local antibiotics for very localized lesions. Discuss with Micro if MRSA positive. | Flucloxacillin<br>
If penicillin allergy: Clarithromycin<br>
Topical fusidic acid 2% | 500mg QDS | 7 days | 500mg BD TDS |
|--------------|-------------------------------------------------------------------------------------------------|-----------------------------------|------------------|-----------------|------------------|

### Cellulitis

| CKS cellulitis | Class I: If patient afebrile and healthy other than cellulitis, use oral fluclouxacinil alone. Class II: If febrile and ill, or comorbidly, consider IV treatment by community team. Class III: Toxic appearance, admit to acute hospital. If river or sea water exposure discuss with microbiologist. | Flucloxacillin<br>
If penicillin allergy: Clarithromycin<br>
If penicillin allergy & on statins: Doxycycline<br>
If not resolving: Clindamycin<br>
If facial: Co-amoxiclav | 500mg QDS | 7 days | 200mg STAT then 100mg OD 300mg - 450mg QDS 500/125mg TDS |

### Leg ulcers

| CKS leg ulcers PHE VLU | Ulcers are always colonised. Antibiotics do not improve healing unless active infection (cellulitis, increased pain, pyrexia, purulent exudate, odour) If active infection, send pre-treatment swab. Review antibiotics after culture results. | Flucloxacillin<br>
If penicillin allergy: Clarithromycin | 500mg QDS | 7 days | 500mg BD |

### Bites Human:

| Cat or dog: CKS bites | Review at 24 & 48 hours | Prophylaxis or treatment: Co-amoxiclav<br>
If penicillin Allergy: Cat/dog bites Metronidazole and doxycycline<br>
Human bites as cat/dog above Or alternatively use Metronidazole and Clarithromycin | 500/125mg TDS | 7 days | 400mg TDS 100mg BD 200 - 400mg TDS 250 - 500mg BD |

### Contaminated Lacerations

| Co-amoxiclav 500/125<br>
If penicillin allergy: Clarithromycin and Metronidazole | 500/125 mg TDS | 7 days | 500mg BD 400mg TDS |

### Scabies

| CKS scabies NHS scabies | Treat all home & sexual contacts within 24h. Treat whole body from ear/chin downwards and under nails. If elderly, also face & scalp. | Permethrin 5% cream<br>
If allergy: Malathion 0.5% aqueous liquid 2 applications 1 week apart | 7 - 14 days | 3 courses For 1 – 12 days after healing |

### Dermatophyte infection – skin

| CKS body & groin CKS foot CKS scalp PHE nail & skin | Terbinafine is fungicidal, so treatment time shorter than with fungistatic azoles. If scalp affected: discuss with dermatology. | Topical terbinafine 1% OR Topical azole 1% OR Alternative for athlete's foot only: Topical undecanoates (Mycota®) | Apply BD | 7 - 14 days | Finger 6 months Toes 12 months Fingers 6 weeks Toes 12 weeks Fingers 2 courses Toes 3 courses |

### Dermatophyte infection – fingernail or toenail

| CKS nail PHE nail & skin | Take nail clippings: start therapy only if infection is confirmed by laboratory. Oral terbinafine is more effective than oral azole. Liver reactions rare with oral antifungals. If candida or non-dermatophyte infection confirmed, use oral Itraconazole. 1 course equals to 7 consecutive days of treatment per month. | If superficial: Amorolfine 5% nail lacquer First line: Terbinafine Second line: Itraconazole | 1-2 weekly 50mg OD 200mg BD | 7 - 14 days | Finger 6 months Toes 12 months Fingers 6 weeks Toes 12 weeks Fingers 2 courses Toes 3 courses |
### Dental Infections

<table>
<thead>
<tr>
<th>Illness</th>
<th>Good Practice Points</th>
<th>Treatment</th>
<th>Adult Dose</th>
<th>Course Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental abscess</td>
<td>Solar Antimicrobial Network Group</td>
<td>Metronidazole</td>
<td>500mg BD</td>
<td>Review after 3 days</td>
</tr>
<tr>
<td></td>
<td>PCDS dental abscess</td>
<td>Amoxicillin</td>
<td>500mg TDS</td>
<td>5 days all treatments</td>
</tr>
<tr>
<td></td>
<td>SDCEP dental problems</td>
<td>For 6 weeks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Regular analgesia should be first option until a dentist can be seen for urgent drainage, as repeated courses of antibiotics for abscess without drainage are inappropriate as are ineffective in preventing spread of infection.**
- **Antibiotics are only recommended if there are signs of severe infection, systemic symptoms or high risk of complications.**
- **Severe odontogenic infections; defined as cellulitis plus signs of sepsis, difficulty in swallowing, impending airway obstruction, Ludwig’s angina. Refer urgently for admission to protect airway, achieve surgical drainage and IV antibiotics**
- **The empirical use of cephalosporins, co-amoxiclav, clarithromycin, and clindamycin 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.**

### EYE INFECTIONS

<table>
<thead>
<tr>
<th>Illness</th>
<th>Good Practice Points</th>
<th>Treatment</th>
<th>Adult Dose</th>
<th>Course Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>KS conjunctivitis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AAO conjunctivitis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blepharitis</strong></td>
<td>It is a chronic condition. Treatment can control symptoms preventing complications although, periodic relapses and exacerbations may occur. Successful management is dependent on treatment compliance and good eye lid hygiene**.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Surgical site infection

<table>
<thead>
<tr>
<th>Illness</th>
<th>Good Practice Points</th>
<th>Treatment</th>
<th>Adult Dose</th>
<th>Course Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella zoster/chicken pox</td>
<td>If severe refer to an acute hospital</td>
<td>Aciclovir</td>
<td>800mg five times a day</td>
<td>7 days</td>
</tr>
<tr>
<td><strong>CKS chickenpox</strong></td>
<td>If signs of airways obstruction, refer urgently to hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHA varicella</strong></td>
<td>If pus, drain by incision, tooth extraction or root canal. Send pus to microbiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Herpes zoster/shingles</strong></td>
<td>If pus, drain by incision, tooth extraction or root canal. Send pus to microbiology</td>
<td>Aciclovir</td>
<td>800mg five times a day</td>
<td>7 days all treatments</td>
</tr>
<tr>
<td><strong>PCDS herpes Zoster</strong></td>
<td>If spreading infection (lymph involvement or systemic signs such as fever/malaise) ADD metronidazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CKS shingles</strong></td>
<td>If signs of airways obstruction, refer urgently to hospital</td>
<td>Add metronidazole</td>
<td>400mg TDS</td>
<td>5 days all treatments</td>
</tr>
<tr>
<td><strong>Pilonidal sinus</strong></td>
<td>If spreading infection (lymph involvement or systemic signs such as fever/malaise) ADD metronidazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CKS pilonidal sinus</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insect bites</td>
<td>Consider antibiotic treatment if cellulitis is suspected and “wait and watch” approach for asymptomatic patients recommending meticulous hygiene with regular baths/showers. Refer for consideration of surgery if discharge</td>
<td>Flucloxacillin</td>
<td>500mg QDS</td>
<td>7 days all treatments</td>
</tr>
</tbody>
</table>

### NICE CG74

- Not all SSI require antibiotic treatment, minor infections may respond to drainage of pus and topical antiseptics
- Consider local resistance patterns and microbiological test to ensure appropriate treatment as antibiotic therapy carries the risk of adverse reaction and the development of resistant bacteria and *Clostridium difficile*. 

### EYE INFECTIONS

- **Varicella zoster/chicken pox**
- **CKS chickenpox**
- **PHA varicella**
- **Herpes zoster/shingles**
- **PCDS herpes Zoster**
- **CKS shingles**
- **Pilonidal sinus**
- **CKS pilonidal sinus**
- **Insect bites**
- **CKS insect bites**
- **Conjunctivitis**
- **KS conjunctivitis**
- **AAO conjunctivitis**
- **Blepharitis**
- **KS blepharitis**

### Dentistry and Treatment of Common Infections and Infestations

**KSconjunctivitis**

- Aciclovir 800mg five times a day for 7 days
- **Flucloxacillin If penicillin allergy:**
  - Clarithromycin 500mg BD
- **Flucloxacillin If penicillin allergy:**
  - Clarithromycin and Metronidazole 500mg QDS

**Blepharitis**

- Aciclovir 800mg five times a day
- **Chloramphenicol 0.5% drops and chloramphenicol 1% ointment**
- **Chloramphenicol 1% ointment**

**Conjunctivitis**

- Aciclovir 800mg five times a day
- **Chloramphenicol 0.5% drops and chloramphenicol 1% ointment**
- **Clarithromycin**

**Blepharitis**

- Aciclovir 800mg five times a day
- **Chloramphenicol 0.5% drops and chloramphenicol 1% ointment**
- **Clarithromycin and Metronidazole**

**Blepharitis**

- Aciclovir 800mg five times a day
- **Valaciclovir (10 times the cost)**

**Blepharitis**

- Aciclovir 800mg five times a day
- **Valaciclovir (10 times the cost)**

**Blepharitis**

- Aciclovir 800mg five times a day