

Antimicrobial Prescribing guidance – quick desktop guide



West Essex

Clinical Commissioning Group

Produced by West Essex CCG Medicines Optimisation Team

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This document is an extract from the antimicrobial prescribing guidance in primary care for Herts and West Essex

All doses included are for adults; for doses in children please refer to the relevant NICE visual summary or the [BNF for Children](#).

Upper Respiratory Tract Infections				
Give TARGET RTI leaflet				
Acute Sore Throat NICE Visual Summary	Advise paracetamol, or if preferred and suitable, ibuprofen for pain. Medicated lozenges may help pain in adults. 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.	First choice: phenoxymethylpenicillin	500mg QDS OR 1000mg BD	5 to 10 days*
		Penicillin allergy: clarithromycin OR	250mg to 500mg BD	5 days
		erythromycin (preferred if pregnant)	250 to 500mg QDS 500 mg to 1000 mg BD	5 days
		For dosing in children and young people under 18 years please see visual summary		
		*5 days of phenoxymethylpenicillin may be enough for symptomatic cure; but a 10-day course may increase the chance of microbiological cure.		
Acute Otitis Media NICE Visual Summary	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. Otherwise: no or back-up antibiotic. Systemically very unwell or high risk of complications: immediate antibiotic	First choice: amoxicillin	For dosing in children and young people under 18 years please see visual summary	5 to 7 days
		Penicillin Allergy: clarithromycin OR		
		erythromycin (preferred if pregnant)		
		Second choice: co-amoxiclav		
Acute Otitis Externa	First line: analgesia for pain relief, and apply localised heat (such as a warm flannel). Second line: topical acetic acid or topical antibiotic +/- steroid: similar cure at 7 days. If cellulitis or disease extends outside ear canal, or systemic signs of infection, start oral flucloxacillin and refer to exclude malignant otitis externa.	Second line: Topical acetic acid 2% OR	1 spray TDS	7 days
		Topical neomycin sulphate with corticosteroid (consider safety issues if perforated tympanic membrane)	3 drops TDS	7 days (min) to 14 days (max)
		If cellulitis: flucloxacillin	250mg QDS If severe: 500mg QDS	7 days
Sinusitis NICE Visual Summary	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.	First choice: phenoxymethylpenicillin	500mg QDS	5 days
		Penicillin allergy: doxycycline (not in under 12s) OR	200mg on day 1, then 100mg OD	
		clarithromycin OR	500mg BD	
		erythromycin (preferred if pregnant)	250 to 500mg QDS or 500 to 1000mg BD	
		Second choice or first choice if systemically very unwell or high risk of complications: co-amoxiclav	500/125mg TDS	
Lower Respiratory Tract Infections				
Acute exacerbation of COPD NICE Visual Summary	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.	First choice: amoxicillin OR	500mg TDS (see BNF for severe infection)	5 days
		doxycycline OR	200mg on day 1, then 100mg OD (see BNF for severe infection)	
		clarithromycin	500mg BD	
		Second choice: use alternative first choice		
Alternative choice (if person at higher risk of treatment failure) please refer to full guidelines				
Acute cough, NICE Visual Summary	Acute cough with upper respiratory tract infection: no antibiotic. Acute bronchitis: no routine antibiotic. Acute cough and higher risk of complications (at face-to-face examination): immediate or back-up antibiotic. Acute cough and systemically very unwell (at face to face examination): immediate antibiotic 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.	Adults first choice: doxycycline	200 mg on day 1, then 100 mg OD	5 days
		Adults alternative first choices: amoxicillin (preferred if pregnant) OR clarithromycin OR erythromycin (preferred if pregnant)	500mg TDS 250mg to 500mg BD 250mg to 500mg QDS or 500mg to 1000mg BD	
		For children and young people under 18 years please see visual summary.		
Community acquired pneumonia NICE Visual Summary	Assess severity in adults based on clinical judgement guided by mortality risk score (CRB65 or CURB65). See the NICE guideline on pneumonia for full details: low severity – CRB65 0 or CURB65 0 or 1 moderate severity – CRB65 1 or 2 or CURB65 2 high severity – CRB65 3 or 4 or CURB65 3 to 5. 1 point for each parameter: confusion , (urea >7 mmol/l), respiratory rate ≥30/min, low systolic (<90 mm Hg) or diastolic (≤60 mm Hg) blood pressure, age ≥65. Assess severity in children based on clinical judgement. Offer an antibiotic. Start treatment as soon as possible after diagnosis, within 4 hours (within 1 hour if sepsis suspected and person meets any high risk criteria – see the NICE guideline on sepsis). When choosing an antibiotic, take account of severity, risk of complications, local antimicrobial resistance and surveillance data, recent antibiotic use and microbiological results. * Stop antibiotics after 5 days unless microbiological results suggest a longer course is needed or the person is not clinically stable.	First choice (low severity in adults or non-severe in children): amoxicillin	500mg TDS (higher doses can be used, see BNF)	*5 Days
		Alternative first choice (low severity in adults or non-severe in children): doxycycline (not in under 12s) OR	200mg on day 1, then 100mg OD	
		clarithromycin OR	500mg BD	
		erythromycin (in pregnancy)	500mg QDS	
		First choice (moderate severity in adults): amoxicillin AND (if atypical pathogens suspected)	500mg TDS (higher doses can be used, see BNF)	
		clarithromycin OR	500mg BD	
		erythromycin (in pregnancy)	500mg QDS	
Alternative first choice (moderate severity in adults): doxycycline OR	200mg on day 1, then 100mg OD			

	For detailed information click on the visual summary. See also the NICE guideline on pneumonia .	clarithromycin	500mg BD	*5 Days
		First choice (high severity in adults or severe in children): co-amoxiclav AND (if atypical pathogens suspected)	500/125mg TDS	
		clarithromycin OR	500mg BD	
		erythromycin (in pregnancy)	500mg QDS	
		Alternative first choice (high severity in adults): levofloxacin (consider safety issues)	500mg BD	

Skin and soft tissue infections

Cellulitis and Erysipelas NICE Visual Summary	Exclude other causes of skin redness (inflammatory reactions or non-infectious causes). Consider marking extent of infection with a single use surgical marker pen. Offer an antibiotic. Take account of severity, site of infection, risk of uncommon pathogens, any microbiological results and MRSA status. Infection around eyes or nose is more concerning because of serious intracranial complications. *A longer course (up to 14 days in total) may be needed but skin takes time to return to normal, and full resolution at 5 to 7 days is not expected. Do not routinely offer antibiotics to prevent recurrent cellulitis or erysipelas.	First choice: flucloxacillin	500mg to 1g QDS	5 to 7 days*	
		Penicillin allergy or if flucloxacillin unsuitable: clarithromycin OR erythromycin (in pregnancy) OR doxycycline (adults only)	500 mg BD 500mg QDS 200 mg on day 1, then 100 mg OD		
		If infection near eyes or nose: co-amoxiclav	500/125 mg TDS		7 days*
		For children, infection near eyes or nose (penicillin allergy), alternative choice antibiotics for severe infection, and suspected or confirmed MRSA infection please see visual summary			

Urinary Tract Infection

Give [TARGET UTI leaflet](#), and refer to [PHE UTI](#) guidance for diagnostic information.

Lower urinary tract infection NICE Visual Summary	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. If people have symptoms of pyelonephritis (such as fever) or a complicated UTI, see acute pyelonephritis (upper urinary tract infection) for antibiotic choices.	Non-pregnant women first choice: nitrofurantoin (if eGFR \geq 45 ml/minute) OR trimethoprim (if low risk of resistance)	100mg m/r BD (or if unavailable 50mg QDS) 200mg BD	3 days	
		Pregnant women first choice: nitrofurantoin (avoid at term) (if eGFR \geq 45 ml/minute)	100mg m/r BD (or if unavailable 50mg QDS)	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: trimethoprim OR nitrofurantoin (if eGFR \geq 45 ml/minute)	200mg BD 100mg m/r BD (or if unavailable 50mg QDS)	7 days	
		Children and young people (3 months and over) first choice: trimethoprim (if low risk of resistance) OR nitrofurantoin (if eGFR \geq 45 ml/minute)	For dosing in children and young people under 16 years please see visual summary		
		Second choice: please see full guidelines			

Acute prostatitis NICE Visual Summary	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).	First choice (guided susceptibilities when available): ciprofloxacin (consider safety issues) OR ofloxacin (consider safety issues) OR trimethoprim (if fluoroquinolone not appropriate; seek specialist advice)	500 mg BD 200 mg BD 200 mg BD	14 days then review	
		Second choice: please see full guidelines			

Acute pyelonephritis (upper urinary tract) NICE Visual Summary	Advise paracetamol (+/- low-dose weak opioid) for pain for people over 12. Offer an antibiotic. When prescribing 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. Avoid antibiotics that don't achieve adequate levels in renal tissue, such as nitrofurantoin. For pregnant women, and children and young people please see visual summary	Non-pregnant women and men first choice: cefalexin OR co-amoxiclav (only if culture results available and susceptible) OR trimethoprim (only if culture results available and susceptible) OR ciprofloxacin (consider safety issues)	500mg BD or TDS (up to 1g to 1.5g TDS or QDS for severe infections) 500/125mg TDS 200mg BD 500mg BD	7 to 10 days 7 to 10 days 14 days 7 days
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Recurrent urinary tract infection NICE Visual Summary	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 (review within 12 months). For non-pregnant women, if no improvement, consider single-dose antibiotic prophylaxis for exposure to a trigger (review within 6 months). For non-pregnant women (if no improvement or no identifiable trigger) or with specialist advice for pregnant women, men, children or young people, consider a trial of daily antibiotic prophylaxis (review within 6 months).	First choice antibiotic prophylaxis: trimethoprim (avoid in pregnancy) OR nitrofurantoin (avoid at term) - if eGFR \geq 45 ml/minute	200mg single dose when exposed to a trigger or 100mg at night 100mg single dose when exposed to a trigger or 50 to 100mg at night
		Second choice antibiotic prophylaxis: amoxicillin OR cefalexin	500mg single dose when exposed to a trigger or 250mg at night 500mg single dose when exposed to a trigger or 125mg at night

Catheter-associated UTI NICE Visual Summary	Antibiotic treatment is not routinely needed for asymptomatic bacteriuria in people with a urinary catheter. Consider removing or, if not possible, changing the catheter if it has been in place for more than 7 days. But do not delay antibiotic treatment. Advise paracetamol for pain. Advise drinking enough fluids to avoid dehydration. Offer an antibiotic for a symptomatic infection. Please refer to full guidelines for antibiotic choice.
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Gastrointestinal tract infections

Acute diverticulitis NICE Visual Summary	Acute diverticulitis and systemically well: Consider no antibiotics, offer simple analgesia (for example paracetamol), advise to re-present if symptoms persist or worsen. Acute diverticulitis and systemically unwell, immunosuppressed or significant comorbidity: offer an antibiotic. Give oral antibiotics if person not referred to hospital for suspected	First-choice (uncomplicated acute diverticulitis): co-amoxiclav	500/125mg TDS	5 days*
		For penicillin allergy or if co amoxiclav unsuitable please see visual summary		

	complicated acute diverticulitis. * A longer course may be needed based on clinical assessment.			
Genital Tract Infections				
Pelvic inflammatory disease	<p>Refer women and sexual contacts to GUM.</p> <p>Raised CRP supports diagnosis, absent pus cells in HVS smear good negative predictive value.</p> <p>Exclude: ectopic, appendicitis, endometriosis, UTI, irritable bowel, complicated ovarian cyst, functional pain.</p>	<p>First line therapy: ceftriaxone PLUS metronidazole PLUS doxycycline</p> <p>Second line therapy: Metronidazole PLUS Ofloxacin</p>	<p>1000mg IM 400mg BD 100mg BD</p> <p>400mg BD 400mg BD</p>	<p>Stat 14 days 14 days</p> <p>14 days 14 days</p>