NICE National Institute for Health and Care Excellence

Public Health England

Local adaption for Gloucestershire April 2023 v1.0
https://www.bnf.org/news/2021/07/29/bnf-hosts-antimicrobial-summary-guidance-on-behalf-of-nice-and-phe/

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

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
▼ Gastrointestinal tract infections						
Oral candidiasis Public Health England Last updated: Oct 2018	**Topical azoles** are more effective than topical nystatin.[1A+] Oral candidiasis is rare in immunocompetent adults;[2D] consider undiagnosed risk factors, including HIV.[2D] Use 50mg fluconazole if extensive/severe candidiasis;[3D,4D] if HIV or immunocompromised, use 100mg fluconazole.[3D,4D]	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]	*Not available. Access supporting evidence and rationales on the PHE website*
		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]	
		fluconazole capsules[6D,7A-]	50mg/100mg OD[3D,6D,8A-]	BNF for children	7 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 *E. coli* 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 250mg to 500mg BD for 5 to 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+] *Access the supporting evidence and rationales on the PHE website.*					
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:** azithromycin	500mg OD[1D,3A+]	-	1 to 3 days[1D,2D,3A+]	*Not available. Access supporting evidence and rationales on the PHE website*
		Prophylaxis/treatment: bismuth subsalicylate	2 tablets QDS[1D,2D]	-	2 days[1D,2D,4A-]	

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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-]	BNF for children	1 dose;[3B-] repeat in 2 weeks if persistent[3B-]	*Not available. Access supporting evidence and rationales on the PHE website*
		Child <6 months or pregnant (at least in first trimester): only hygiene measure for 6 weeks[1D]	-	-	-	

Clostridioides (Clostridium) difficile infection

The below guidance is based on NICE/PHE guidance plus recommendations from local consultant microbiologists and the published American College of Gastroenterologists (ACG) Clinical Guidelines: Prevention, Diagnosis, and Treatment of Clostridioides difficile Infections June 2021 - Volume 116 - Issue 6 - p 1124-1147 https://journals.lww.com/ajg/fulltext/2021/06000/acg_clinical_guidelines__prevention,_diagnosis,.12.aspx

***Fidaxomicin is expensive and not likely to be routinely stocked by community pharmacies, therefore four community pharmacies in Gloucestershire have been commissioned to hold stock. Full details of these pharmacies and their opening hours can be found here.

Suspected *Clostridioides (Clostridium) difficile* infection – pending laboratory confirmation	Send stool sample for testing as soon as possible. If stool results are negative for *Clostridioides difficile* stop the empirical treatment. Consider the possibility of other causes of diarrhoea (eg. other enteric infections, and non-infective causes)	**First episode - suspected:** Oral vancomycin	125 mg QDS	Children and young people see below in Key points section *	10 days	
***Clostridioides (Clostridium) difficile* infection – laboratory confirmed** *Continued below*	For all episodes of laboratory-confirmed CDI do a **severity assessment**: - • Measure temperature • Check U+Es, CRP and WCC • Stool frequency Mild cases (<4 episodes of stool/day) may respond without specific antibiotic treatment;	**First episode – Mild, Moderate or Severe – First Line:** Oral vancomycin	125 mg QDS	Children and young people see below in Key points section *	10 days	*Access supporting evidence and rationales on the PHE website*

(continued from above) ***Clostridioides (Clostridium) difficile* infection – laboratory confirmed**	**If severe (T>38.5, or CRP >200, or WCC>15, rising creatinine, or signs/symptoms of severe colitis)**: • if life-threatening infection consider urgent hospital referral • review progress closely Review need for antibiotics, PPIs, anti-peristaltic agents and medicines that may cause problems if people are dehydrated (such as NSAIDs) and discontinue use where possible Advise patient on: • Drinking enough fluids to avoid dehydration • Preventing the spread of infection • Seeking medical help if symptoms worsen rapidly or significantly at any time *** For children and young people,** treatment should be started only after discussion with a consultant paediatrician	**First episode – Moderate to Severe - Second line (if poor response to oral vancomycin within 7 days):** Oral fidaxomicin***	200 mg BD	-	10 days	
		Second episode within 12 weeks of symptom resolution (relapse): Oral fidaxomicin***	200 mg BD	-	10 days	
		Second episode after more than 12 weeks after symptom resolution (recurrence): Oral vancomycin	125 mg QDS	-	10 days	
		Recurrent (3 or more lab confirmed episodes) **: Oral vancomycin (tapering dose)	125mg QDS for 14 days 125mg TDS for 7 days 125mg BD for 7 days 125 mg OD for 7 days 125mg every 48 hours for 7 days 125mg twice weekly for 7 days	-	49 days	

****Recurrent laboratory confirmed infection despite tapering dose vancomycin** - discuss with Consultant Microbiologist. Faecal Microbiota Transplant may need to be considered

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Helicobacter pylori Public Health England See PHE quick reference guide for diagnostic advice: PHE H. pylori Last updated: Feb 2019	Always test for *H. pylori* 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 **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 *H. pylori*:** post DU/GU, or relapse after second-line therapy,[1A+] using UBT or SAT,[10A+,11A+] consider referral for endoscopy and culture.[2D]	**Always use PPI**[2D,3D,5A+,12A+] **First line and first relapse and no penicillin allergy** PPI **PLUS** 2 antibiotics	-	BNF for children	7 days[2D] MALToma 14 days[7A+,16A+]	*Not available. Access supporting evidence and rationales on the PHE website*
	amoxicillin[2D,6B+] **PLUS**	1000mg BD[14A+]	BNF for children			
	clarithromycin[2D,6B+] **OR**	500mg BD[8A-]	BNF for children			
	metronidazole[2D,6B+]	400mg BD[2D]	BNF for children			
	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]	BNF for children			
	tetracycline[2D]	500mg QDS[15D]				
	Relapse and previous metronidazole and clarithromycin: PPI **PLUS** 2 antibiotics	-	-			
	amoxicillin[2D,7A+] **PLUS**	1000mg BD[14A+]	BNF for children			
	tetracycline[2D,7A+] **OR**	500mg QDS[15D]				
	levofloxacin (if tetracycline cannot be used)[2D,7A+]	250mg BD[7A+]				
	Third line on advice: PPI **WITH**	-	-		10 days	
	bismuth subsalicylate **PLUS**	525mg QDS[15D]	-			
	2 antibiotics as above not previously used **OR**	-	-			
	rifabutin[14A+] **OR**	150mg BD	-			
	furazolidone[17A+]	200mg BD	-			

Infection	Key points	Medicine	Doses		Length	Visual summary
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Acute diverticulitis NICE Last updated: Nov 2019	**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 complicated acute diverticulitis. Give IV antibiotics if admitted to hospital with suspected or confirmed complicated acute diverticulitis (including diverticular abscess). If CT-confirmed uncomplicated acute diverticulitis, review the need for antibiotics. * A longer course may be needed based on clinical assessment.	**First-choice (uncomplicated acute diverticulitis):** co-amoxiclav	500/125mg TDS	-	5 days*	
		Penicillin allergy or co-amoxiclav unsuitable: cefalexin (caution in penicillin allergy) **AND** metronidazole **OR**	cefalexin: 500mg BD or TDS (up to 1g to 1.5g TDS or QDS for severe infections) metronidazole: 400mg TDS	-		
		trimethoprim **AND** metronidazole **OR**	trimethoprim: 200mg BD metronidazole: 400mg TDS	-		
		ciprofloxacin (only if switching from IV ciprofloxacin with specialist advice; consider safety issues) **AND** metronidazole	ciprofloxacin: 500mg BD metronidazole: 400mg TDS			
		For IV antibiotics in complicated acute diverticulitis (including diverticular abscess) see visual summary				