NICE National Institute for Health and Care Excellence

Public Health England

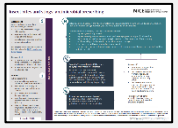
Local adaption for Gloucestershire Aug 2021 vs1

https://www.bnf.org/news/2021/07/29/bnf-hosts-antimicrobial-summary-guidance-on-behalf-of-nice-and-phe/

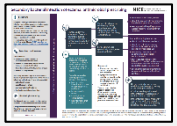
Summary of antimicrobial prescribing guidance – managing common infections

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

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
▼ Skin and soft tissue infections						
Note: Refer to RCGP Skin Infections online training.[1D] For MRSA, discuss therapy with microbiologist.[1D]						
Cold sores Public Health England Last updated: Nov 2017	**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+] Access supporting evidence and rationales on the PHE website.					
PVL-SA Public Health England Last updated: Nov 2017	Panton-Valentine leukocidin (PVL) is a toxin produced by 20.8 to 46% of *S. aureus* 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-] Access the supporting evidence and rationales on the PHE website.					
Insect bites and stings NICE Public Health England Last updated: Sep 2020	*Most insect bites or stings will not need antibiotics.* *Do not offer an antibiotic if there are no symptoms or signs of infection.* *If there are symptoms or signs of infection, see cellulitis and erysipelas.*	-	-	-	-	

Adapted from: Summary of antimicrobial prescribing guidance – managing common infections (July 2021)

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Eczema (bacterial infection) NICE Public Health England Last updated: Mar 2021	Manage underlying eczema and flares with treatments such as emollients and topical corticosteroids, whether antibiotics are given or not. Symptoms and signs of secondary bacterial infection can include: weeping, pustules, crusts, no response to treatment, rapidly worsening eczema, fever and malaise. Not all flares are caused by a bacterial infection, so will not respond to antibiotics. Eczema is often colonised with bacteria but may not be clinically infected. Do not routinely take a skin swab. **Not systemically unwell:** Do not routinely offer either a topical or oral antibiotic. If an antibiotic is offered, when choosing between a topical or oral antibiotic, take account of patient preferences, extent and severity of symptoms or signs, possible adverse effects, and previous use of topical antibiotics because antimicrobial resistance can develop rapidly with extended or repeated use. **Systemically unwell:** Offer an oral antibiotic. If there are symptoms or signs of cellulitis, see cellulitis and erysipelas. *For detailed information click on the visual summary.*	**If not systemically unwell, do not routinely offer either a topical or oral antibiotic**				
		Topical antibiotic (if a topical is appropriate). For localised infections only:				
		First choice: fusidic acid 2%	TDS		5 to 7 days	
		Oral antibiotic:				
		First choice: flucloxacillin	500mg QDS		5 to 7 days	
		Penicillin allergy or flucloxacillin unsuitable: clarithromycin **OR**	250mg BD (can be increased to 500mg BD for severe infections)			
		erythromycin (in pregnancy)	250mg to 500mg QDS			
		If MRSA suspected or confirmed – consult local microbiologist				

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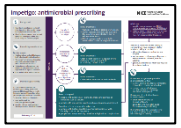
			Adult	Child		
Impetigo NICE Public Health England Last updated: Feb 2020	**Localised non-bullous impetigo:** Hydrogen peroxide 1% cream (other topical antiseptics are available but no evidence for impetigo). If hydrogen peroxide unsuitable or ineffective, short-course topical antibiotic. **Widespread non-bullous impetigo:** Short-course topical or oral antibiotic. Take account of person's preferences, practicalities of administration, previous use of topical antibiotics because antimicrobial resistance can develop rapidly with extended or repeated use, and local antimicrobial resistance data. **Bullous impetigo, systemically unwell, or high risk of complications:** Short-course oral antibiotic. Do not offer combination treatment with a topical and oral antibiotic to treat impetigo. *5 days is appropriate for most, can be increased to 7 days based on clinical judgement. *For detailed information click on the visual summary.*	**Topical antiseptic:**				
		hydrogen peroxide 1%	BD or TDS		5 days*	
		Topical antibiotic:				
		First choice: fusidic acid 2%	TDS		5 days*	
		Fusidic acid resistance suspected or confirmed: mupirocin 2%	TDS			
		Oral antibiotic:				
		First choice: flucloxacillin	500mg QDS		5 days*	
		Penicillin allergy or flucloxacillin unsuitable: clarithromycin **OR**	250mg BD			
		erythromycin (in pregnancy)	250 to 500mg QDS			
		If MRSA suspected or confirmed – consult local microbiologist				
Mastitis Public Health England Last updated: Nov 2017	*S. aureus* 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]	-	10 to 14 days[2D]	Not available. Access supporting evidence and rationales on the PHE website
		Penicillin allergy: erythromycin[2D] **OR**	250mg to 500mg QDS[2D]			
		clarithromycin[2D]	500mg BD[2D]			

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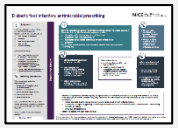
			Adult	Child		
Cellulitis and erysipelas NICE Public Health England Last updated: Sept 2019	Exclude other causes of skin redness (inflammatory reactions or non-infectious causes). Consider marking extent of infection with a single-use surgical marker pen. Offer an antibiotic. Take account of severity, 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. *For detailed information click on the visual summary.*	**First choice:**				
		flucloxacillin	500mg to 1g QDS		5 to 7 days*	
		Penicillin allergy or if flucloxacillin unsuitable:				
		clarithromycin **OR**	500mg BD		5 to 7 days*	
		erythromycin (in pregnancy) **OR**	500mg QDS			
		doxycycline (adults only) **OR**	200mg on day 1, then 100mg OD	-		
		co-amoxiclav (children only: not in penicillin allergy)	-			
		If infection near eyes or nose:				
		co-amoxiclav	500/125mg TDS		7 days*	
		If infection near eyes or nose (penicillin allergy):				
		clarithromycin **AND**	500mg BD		7 days*	
		metronidazole (only add in children if anaerobes suspected)	400mg TDS			
		For alternative choice antibiotics for severe infection, suspected or confirmed MRSA infection and IV antibiotics click on the visual summary				

Continued below

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Scabies 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]	BNF for children	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]	BNF for children		
Leg ulcer infection NICE Public Health England Last updated: Feb 2020	Manage any underlying conditions to promote ulcer healing. Only offer an antibiotic when there are symptoms or signs of infection (such as redness or swelling spreading beyond the ulcer, localised warmth, increased pain or fever). Few leg ulcers are clinically infected but most are colonised by bacteria. When prescribing antibiotics, take account of severity, risk of complications and previous antibiotic use. *For detailed information click on the visual summary.*	**First-choice:**				
		flucloxacillin	500mg to 1g QDS	-	7 days	
		Penicillin allergy or if flucloxacillin unsuitable:				
		doxycycline **OR**	200mg on day 1, then 100mg OD (can be increased to 200mg daily)	-	7 days	
		clarithromycin **OR**	500mg BD			
		erythromycin (in pregnancy)	500mg QDS			
		Second choice:				
		co-amoxiclav **OR**	500/125mg TDS	-	7 days	
		co-trimoxazole (in penicillin allergy)	960mg BD			
		For antibiotic choices if severely unwell or MRSA suspected or confirmed, click on the visual summary				
Tick bites (Lyme disease) Public Health England Last updated: Feb 2020	**Treatment**: Treat erythema migrans **empirically**; serology is often negative early in infection.[1D] For other suspected Lyme disease such as neuroborreliosis (CN palsy, radiculopathy) seek advice.[1D]	**Treatment**: doxycycline[1D]	100mg BD[1D]	BNF for children	21 days[1D]	*Not available. Access supporting evidence and rationales on the PHE website*
		Alternative: amoxicillin[1D]	1,000mg TDS[1D]	BNF for children		

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Diabetic foot infection NICE Public Health England Last updated: Oct 2019	In diabetes, all foot wounds are likely to be colonised with bacteria. Diabetic foot infection has at least 2 of: local swelling or induration; erythema; local tenderness or pain; local warmth; purulent discharge. Severity is classified as: **Mild**: local infection with 0.5 to less than 2cm erythema **Moderate**: local infection with more than 2cm erythema or involving deeper structures (such as abscess, osteomyelitis, septic arthritis or fasciitis) **Severe**: local infection with signs of a systemic inflammatory response. Start antibiotic treatment as soon as possible. Take samples for microbiological testing before, or as close as possible to, the start of treatment When choosing an antibiotic, take account of severity, risk of complications, previous microbiological results and antibiotic use, and patient preference. *A longer course (up to a further 7 days) may be needed based on clinical assessment. However, skin does take time to return to normal, and full resolution at 7 days is not expected. Do not offer antibiotics to prevent diabetic foot infection. *For detailed information click on the visual summary.*	**Mild infection: first choice**				
		flucloxacillin	500mg to 1g QDS	-	7 days*	
		Mild infection (penicillin allergy):				
		clarithromycin **OR**	500mg BD	-	7 days*	
		erythromycin (in pregnancy) **OR**	500mg QDS			
		doxycycline	200mg on day 1, then 100mg OD (can be increased to 200mg daily)			
		For antibiotic choices for moderate or severe infection, infections where *Pseudomonas aeruginosa* or MRSA is suspected or confirmed, and IV antibiotics click on the visual summary				

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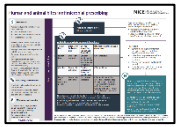
			Adult	Child		
Human and animal bites NICE Public Health England Last updated: Nov 2020	Offer an antibiotic for a human or animal bite if there are symptoms or signs of infection, such as increased pain, inflammation, fever, discharge or an unpleasant smell. Take a swab for microbiological testing if there is discharge (purulent or non-purulent) from the wound. Do not offer antibiotic prophylaxis if a human or animal bite has not broken the skin. **Human bite:** Offer antibiotic prophylaxis if the human bite has broken the skin and drawn blood. Consider antibiotic prophylaxis if the human bite has broken the skin but not drawn blood if it is in a high-risk area or person at high risk. **Cat bite:** Offer antibiotic prophylaxis if the cat bite has broken the skin and drawn blood. Consider antibiotic prophylaxis if the cat bite has broken the skin but not drawn blood if the wound could be deep. **Dog or other traditional pet bite (excluding cat bite)** Do not offer antibiotic prophylaxis if the bite has broken the skin but not drawn blood. Offer antibiotic prophylaxis if the bite has broken the skin and drawn blood if it has caused considerable, deep tissue damage or is visibly contaminated (for example, with dirt or a tooth). Consider antibiotic prophylaxis if the bite has broken the skin and drawn blood if it is in a high-risk area or person at high risk. *course length can be increased to 7 days (with review) based on clinical assessment of the wound.	**First choice:**				
		co-amoxiclav	250/125mg or 500/125mg TDS		3 days for prophylaxis 5 days for treatment*	
		Penicillin allergy or co-amoxiclav unsuitable:				
		doxycycline **AND**	200mg on day 1, then 100mg or 200mg daily		3 days for prophylaxis 5 days for treatment*	
		metronidazole	400mg TDS			
		seek specialist advice in pregnancy				
		IV antibiotics *(click on visual summary)*				

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Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Dermatophyte infection: skin Public Health England Last updated: Feb 2019	**Most cases**: use terbinafine as fungicidal, treatment time shorter and more effective than with fungistatic imidazoles or 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]	topical terbinafine[3A+,4D] **OR**	1% OD to BD[2A+]	BNF for children	1 to 4 weeks[3A+]	*Not available. Access supporting evidence and rationales on the PHE website*
		topical imidazole[2A+,3A+]	1% OD to BD[2A+]	BNF for children	4 to 6 weeks[2A+,3A+]	
		Alternative in athlete's foot: topical undecenoates [2A+] (such as Mycota®) [2A+]	OD to BD[2A+]	BNF for children		
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]	BNF for children	Fingers: 6 weeks[1D,6D] Toes: 12 weeks[1D,6D]	*Not available. Access supporting evidence and rationales on the PHE website*
		Second line: itraconazole[1D,3A+,4D,6D]	200mg BD[1D,4D]	BNF for children	1 week a month[1D] Fingers: 2 courses[1D] Toes: 3 courses[1D]	
		Stop treatment when continual, new, healthy, proximal nail growth.[6D]				

Continued below

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Acne vulgaris NICE Last updated: Jun 2021	**First-line treatment options**: offer a course of 1 of the options, taking account of severity, preferences, and advantages/disadvantages of each option. Completing the course is important because positive effects can take 6 to 8 weeks. Consider topical benzoyl peroxide monotherapy as an alternative if first-line treatment options are contraindicated, or to avoid topical retinoids or an antibiotic (topical or oral). **Do not use:** monotherapy with a topical antibiotic, monotherapy with an oral antibiotic, or a combination of a topical antibiotic and an oral antibiotic. Review first-line treatment at 12 weeks. Only continue a topical or oral antibiotic for more than 6 months in exceptional circumstances. Review at 3 monthly intervals, and stop the antibiotic as soon as possible. For detailed information see the NICE guideline on acne vulgaris. *Continued below*	**First line**: fixed combination of topical adapalene with topical benzoyl peroxide (for any acne severity, not in under 9s) **OR**	0.1% adapalene/ 2.5% benzoyl peroxide **OR** 0.3% adapalene/2.5% benzoyl peroxide OD (thinly in the evening)	BNF for children	12 weeks	Not available. See the NICE guideline on acne vulgaris.
		fixed combination of topical tretinoin with topical clindamycin (for any acne severity, not in under 12s) **OR**	0.025% tretinoin/ 1% clindamycin OD (thinly in the evening)	BNF for children		
		fixed combination of topical benzoyl peroxide with topical clindamycin (for mild to moderate acne, not in under 12s) **OR**	3% benzoyl peroxide/1% clindamycin OR 5% benzoyl peroxide/1% clindamycin OD (in the evening)	BNF for children		
		fixed combination of topical adapalene with topical benzoyl peroxide **AND** either oral lymecycline or oral doxycycline (for moderate to severe acne, not in under 12s) **OR** *(continued below)*	0.1% adapalene/ 2.5% benzoyl peroxide **OR** 0.3% adapalene/2.5% benzoyl peroxide OD (in the evening) **AND** lymecycline 408mg OD **OR** doxycycline 100mg OD	BNF for children BNF for children		

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Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Acne vulgaris continued		topical azelaic acid **AND** either oral lymecycline or oral doxycycline (for moderate to severe acne, not in under 12s)	15% or 20% azelaic acid BD **AND** lymecycline 408mg OD **OR** doxycycline 100mg OD	BNF for children BNF for children		
		Alternative: topical benzoyl peroxide	5% benzoyl peroxide OD to BD	BNF for children		
Varicella zoster/ chickenpox **Herpes zoster/ shingles** Public Health England Last updated: Oct 2018	**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] **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] 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+] immuno-compromised;[4D] or severe pain.[7D,11B+]	**First line for chicken pox and shingles**: aciclovir[3A+,7A+,10A+,13B+,14A-,15A+]	800mg 5 times daily[16A-]	BNF for children	7 days[14A-,16A-]	*Not available. Access supporting evidence and rationales on the PHE website*
		Second line for shingles if poor compliance: *not for children:* famciclovir[8D,14A-, 16A-] **OR**	250mg to 500mg TDS[15A+] **OR** 750mg BD[15A+]	-		
		valaciclovir[8D,10A+,14A-]	1g TDS[14A-]	BNF for children		

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