


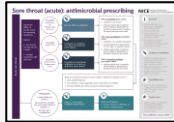


Summary of antimicrobial prescribing guidance – managing common infections

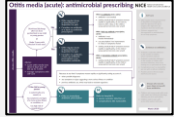






- For all PHE guidance, follow [PHE's principles of treatment](#).
- See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breastfeeding.

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		
▼ Upper respiratory tract infections						
Acute sore throat NICE Public Health England Last updated: Jan 2018	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. *5 days of phenoxymethylpenicillin may be enough for symptomatic cure; but a 10-day course may increase the chance of microbiological cure. <i>For detailed information click the visual summary icon.</i>	First choice: phenoxymethylpenicillin Penicillin allergy: clarithromycin OR erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg QDS or 1000mg BD 250mg to 500mg BD 250mg to 500mg QDS or 500mg to 1000mg BD		5 to 10 days* 5 days 5 days	
Influenza Public Health England Last updated: Feb 2019	Annual vaccination is essential for all those 'at risk' of influenza. ^{1D} Antivirals are not recommended for healthy adults. ^{1D,2A+} Treat 'at risk' patients with 5 days oseltamivir 75mg BD, ^{1D} when influenza is circulating in the community, and ideally within 48 hours of onset (36 hours for zanamivir treatment in children), ^{1D,3D} or in a care home where influenza is likely. ^{1D,2A+} At risk: pregnant (and up to 2 weeks post-partum); children under 6 months; adults 65 years or older; chronic respiratory disease (including COPD and asthma); significant cardiovascular disease (not hypertension); severe immunosuppression; chronic neurological, renal or liver disease; diabetes mellitus; morbid obesity (BMI>40). ^{4D} See the PHE Influenza guidance for the treatment of patients under 13 years. ^{4D} In severe immunosuppression, or oseltamivir resistance, use zanamivir 10mg BD ^{5A+,6A+} (2 inhalations twice daily by diskhaler for up to 10 days) and seek advice. ^{4D} <i>Access supporting evidence and rationales on the PHE website.</i>					

Upper Respiratory Tract Infections Mar 2022 v1

Infection	Key points	Medicine	Doses		Length	Visual summary
			Adult	Child		
Acute otitis media NICE Public Health England Last updated: March 2022	Regular paracetamol or ibuprofen for pain (right dose for age or weight at the right time and maximum doses for severe pain). Consider ear drops containing an anaesthetic and an analgesic for pain if an immediate antibiotic is not given and there is no ear drum perforation or otorrhoea. 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. For detailed information click on the visual summary.	First choice: amoxicillin	-		5 to 7 days	
		Penicillin allergy: clarithromycin OR erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	-		5 to 7 days	
		Second choice: co-amoxiclav	-		5 to 7 days	
Acute otitis externa Public Health England Last updated: Nov 2017	First line: analgesia for pain relief, ^{1D,2D} and apply localised heat (such as a warm flannel). ^{2D} Second line: topical acetic acid or topical antibiotic +/- steroid: similar cure at 7 days. ^{2D,3A+,4B-} If cellulitis or disease extends outside ear canal, or systemic signs of infection, start oral flucloxacillin and refer to exclude malignant otitis externa. ^{1D}	Second line: topical acetic acid 2% ^{2D,4B-} OR	1 spray TDS ^{5A-}		7 days ^{5A}	Not available. Access supporting evidence and rationales on the PHE website
		topical neomycin sulphate with corticosteroid ^{2D,5A-} (consider safety issues if perforated tympanic membrane) ^{6B-}	3 drops TDS ^{5A-}		7 days (min) to 14 days (max) ^{3A+}	
		If cellulitis: flucloxacillin ^{7B+}	250mg QDS ^{2D}		7 days ^{2D}	
			If severe: 500mg QDS ^{2D}			
Scarlet fever (GAS) Public Health England Last updated: Oct 2018	Prompt treatment with appropriate antibiotics significantly reduces the risk of complications. ^{1D} Vulnerable individuals (immunocompromised, the comorbid, or those with skin disease) are at increased risk of developing complications. ^{1D}	Phenoxyethylpenicillin ^{2D}	500mg QDS ^{2D}		10 days ^{3A+,4A+,5A+}	Not available. Access supporting evidence and rationales on the PHE website
		Penicillin allergy: clarithromycin ^{2D}	250mg to 500mg BD ^{2D}		5 days ^{2D,5A+}	
		Optimise analgesia ^{2D} and give safety netting advice				

Upper Respiratory Tract Infections Mar 2022 v1

Infection	Key points	Medicine	Doses		Length	Visual summary	
			Adult	Child			
Sinusitis NICE Public Health England Last updated: Oct 2017	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. <i>For detailed information click on the visual summary.</i>	First choice: phenoxymethylpenicillin	500mg QDS		5 days		
		Penicillin allergy: doxycycline (not in under 12s) OR clarithromycin OR	200mg on day 1, then 100mg OD				5 days
		erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg BD or 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				