NHS Lincolnshire

Prescribing and Clinical Effectiveness Bulletin

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HAPPY NEW YEAR READERS!

GUIDELINES FOR THE TREATMENT OF COMMONLY OCCURRING INFECTIONS IN LINCOLNSHIRE PRIMARY CARE: WINTER 2012/13 UPDATE

Infection	Recommended Agents	Notes
Pharyngitis / sore throat / tonsillitis Average length of illness is 1 week	**Most sore throats are viral** **Antibiotics unnecessary in many cases** as 90% resolve in 7 days **Phenoxymethylpenicillin** 500mg four times a day for 10 days If allergic to penicillin: **Clarithromycin** 250 – 500mg twice daily for 10 days (as recommended in BNF)	Consider a **'no antibiotic'** or **'delayed antibiotic strategy'** and ensure that the patient knows that the average length of the illness is 1 week. Patients with 3 of 4 Centor criteria (presence of tonsillar exudate, tender anterior cervical lympadenopathy or lymphadenitis, presence of fever and an absence of cough) may benefit from antibiotics. Numbers Needed to Treat Antibiotics to prevent 1 case of quinsy >4000 Antibiotics to prevent 1 case of AOM 200
Acute Otitis Media (AOM) Antibiotics should not be routinely prescribed for AOM Average length of illness 4 days	**Antibiotics are unnecessary in many cases; AOM resolves in 60% of patients within 24 hours**. Antibiotics do not prevent deafness. First Line **Amoxicillin** 40mg/kg/day in 3 divided doses for 5 days Maximum 1.5g daily If allergic to penicillin: **Erythromycin or Clarithromycin (5 days)**	Depending on severity, consider prescribing antibiotics for children < 2 years with bilateral AOM and for children with otorrhoea, or children with CF or immune suppression. Children who do not meet these criteria should not be given antibiotics. Use a **'no antibiotic'** or **'delayed antibiotic'** strategy. Reassure patients/carers that antibiotics are not needed immediately because they will make little difference to symptoms and may have side effects (e.g. diarrhoea, vomiting and rash). Use analgesia for symptom relief

Infection	Recommended Agents	Notes
Acute Rhinosinusitis Antibiotics should not be routinely prescribed for sinusitis The average duration of symptoms is 2½ weeks	**Antibiotics are unnecessary in many cases as 80% resolve in 14 days.** First Line (7 days) **Amoxicillin** 500mg three times daily (1g if severe) or **Doxycycline** 200mg stat followed by 100mg daily or **Phenoxymethylpenicillin** 500mg four times daily **For persistent symptoms** **If there is no improvement following treatment with a first line antibiotic, an alternative first line agent should be tried before commencing with a third line option.** **Co-amoxiclav** 625mg three times a day for 7 days	**Many cases of sinusitis are of viral origin.** NICE CG 69 Respiratory Tract Infections recommends using a '**no antibiotic prescribing strategy'** or '**delayed antibiotic prescribing strategy'.** Patients with acute sinusitis who are likely to be at risk of developing complications should be offered an immediate antibiotic prescription in the following situations: (1) if the patient is systemically very unwell; (2) if the patient has symptoms and signs suggestive of serious illness and/or complications (3) if the patient is at high-risk of serious complications due to pre-existing co-morbidity (e.g. significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis and young children born prematurely). Use adequate analgesia. Consider a 7 day delayed or immediate antibiotic when there is a purulent nasal discharge.
Acute cough / bronchitis Average duration of cough is 3 weeks. If > 3 weeks, consider pertussis	**In primary care antibiotics have marginal benefits in otherwise healthy adults.** First Line **Amoxicillin** 500mg three times a day for 5 days or **Doxycycline** 200mg stat followed by 100mg daily for 5 days.	**Routine antibiotic treatment of uncomplicated acute bronchitis is not recommended regardless of duration of cough.** Antibiotics should be prescribed for patients > 65 years with acute cough and 2 or more of the following, or older than 80 years with one or more of the following: - hospitalisation in previous year - type 1 or type 2 diabetes mellitus - history of congestive heart failure - current use of oral steroids Antibiotics should be prescribed for patients who are - systemically very unwell, - have symptoms or signs suggestive of serious illness and/or complications (particularly pneumonia), - are at high risk of serious complications because of pre-existing co-morbidity. This includes patients with significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis and young children born prematurely.
Community acquired pneumonia	If CRB65 =0 **Amoxicillin** 500mg three times daily for 7 days or **Doxycycline** 200mg stat/100mg daily for 7 days or **Clarithromycin** 500mg twice daily for 7 days If CRB65 = 1 and at home **Amoxicillin** 500mg three times daily for 7 - 10 days **and** **Clarithromycin** 500mg twice daily for 7 - 10 days **or** **Doxycycline** alone 200mg stat, 100mg daily for 7 – 10 days	**Start antibiotics immediately** Use CRB-65 to assess risk. Each scores 1: **C**onfusion(AMT<8); **R**espiratory rate >30/min; age>**65**; **B**P systolic < 90 or diastolic ≤ 60. Score 0: suitable for home treatment. Score 1-2: hospital assessment or admission. Score 3-4: urgent hospital admission. If no response in 48 hrs add clarithromycin first line, or tetracycline to cover Mycoplasma infection (rare in >65y)

Infection	Recommended Agents	Notes
Acute exacerbation of COPD	Prescribe antibiotics if increased dyspnoea and sputum is more purulent than usual. First Line **Doxycycline 200mg stat followed by 100mg daily for 5 days** **or Amoxicillin 500mg three times a day for 5 days** If the patient is allergic to penicillin and a tetracycline is contraindicated, use **Clarithromycin 500mg twice daily for 5 days** Second Line If there is a clinical failure or suspected resistance to first line antibiotics use: **Co-amoxiclav 625mg three times daily for 5 days.** Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations, antibiotics in last 3 mths.	
Uncomplicated UTI in men or women (i.e. no fever or flank pain)	**In women with > 3 symptoms of UTI (dysuria, urgency, frequency, polyuria, suprapubic tenderness, haematuria): treat** **In women with < 2 symptoms: use dipstick test to guide treatment and exclude UTI.** In men: send pre-treatment MSU or, if symptoms are mild or non-specific, use a negative dipstick test to exclude UTI. NB a negative dipstick result can help to rule out UTI, but false positive dipsticks are very common and should not automatically lead to antibiotic treatment. **First Line** **Trimethoprim** 200mg twice daily or **Nitrofurantoin** MR capsules 100mg twice daily. Treatment length **3 days in women** and **7 days in men**. Second Line Dependent upon sensitivities. Amoxicillin resistance is common; only use if susceptible. Community multi-resistant Extended-spectrum Beta-lactamase *E.coli* are increasing: consider nitrofurantoin (or pivmecillinam subject to sensitivities). Microbiologist advice must be sought.	
UTI in pregnancy	Send MSU for culture and sensitivities and start empirical antibiotics. First Line **Co-amoxiclav 625mg three times per day for 7 days** **or Amoxicillin 500mg three times daily for 7 days (if known to be susceptible)** Second Line Cefalexin 500mg twice daily for 7 days Third line Nitrofurantoin MR capsules 100mg twice daily for 7 days (avoid nitrofurantoin in late pregnancy) Trimethoprim is not recommended in early pregnancy even with folic acid cover.	

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Stephen Gibson
Head of Prescribing and Medicines Optimisation
NHS Lincolnshire

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