Lambeth Antibiotic Guideline for Primary Care 2024 Update

This guideline is the official Antibiotic Guideline for Primary Care in Lambeth, which is stand-alone to other antibiotic guidelines in development across South East London.

This guideline has been developed by the Lambeth Medicines & Long Term Conditions team, Department of Microbiology and the Pharmacy Department at Guy's and St Thomas' NHS Foundation Trust (GSTFT), and Lambeth Public Health.

Please direct any comments or queries to the Lambeth Medicines & Long Term Conditions team: Lambethmedicines@selondonics.nhs.uk

Aims

- To provide a simple, empirical approach to the treatment of common infections based on our local community and sensitivity patterns.
- To promote the safe, cost-effective and appropriate use of antimicrobials by targeting those who may benefit most.
- To minimise the emergence of antimicrobial resistance in the community.

Principles of Treatment

1. This guidance is based on the best available evidence at the time of development. Its application must be modified by professional judgement, based on knowledge about individual patient co-morbidities, potential for drug interactions and involve patients in management decisions.
2. It is important to initiate antibiotic as soon as possible in severe infection or in those immunocompromised, particularly if sepsis is suspected. Refer to the NICE guideline [NG51] Sepsis: recognition, diagnosis and early management for further information.
3. This guidance should not be used in isolation; it should be supported with patient information about safety netting, back-up/delayed antibiotics, self –care, infection severity and usual duration, clinical staff education, and audits. The RCGP TARGET antibiotics toolkit is available via the RCGP website.
4. The majority of this guidance provides dose and duration of treatment for **ADULTS**. Doses may need modification for age, weight and renal function. Refer to the BNF for Children for information on paediatric doses.
5. Refer to BNF for further dosing and interaction information (e.g. interaction between macrolides and statins), ALWAYS check for hypersensitivity/allergy.
6. Have a lower threshold for antibiotics in immunocompromised or in those with multiple co- morbidities; send samples for culture and seek advice.
7. **Drugs in RED are contra-indicated in true penicillin allergy. Drugs in GREEN are considered safe in penicillin allergy**.
8. Prescribe an antimicrobial only when there is likely to be a clear clinical benefit, giving alternative, non-antibiotic self –care advice where appropriate.
9. Consider a no, or delayed, antibiotic strategy for acute self-limiting upper respiratory tract infections (e.g. acute sore throat, acute cough and acute sinusitis) and mild UTI symptoms
10. Where possible, prescribe the shortest effective duration of antibiotics for common infections. Five-day courses are recommended by NICE when antibiotics are indicated for sinusitis, sore throat, COPD infective exacerbation, cough (acute), pneumonia (community-acquired) and otitis media – please note, this is not an exhaustive list.
11. 'Blind' antibiotic prescribing for unexplained pyrexia usually leads to further difficulty in establishing the diagnosis.
12. Limit prescribing over the telephone/eConsult to exceptional cases.
13. As per the MHRA safety update (January 2024), systemic fluoroquinolones must only be administered when no other antibiotics are appropriate for use. This means that fluoroquinolones should only be prescribed when other recommended antibiotics have failed, will not work due to resistance, or are unsafe to use in an individual patient.
14. Avoid broad spectrum antibiotics (e.g. co-amoxiclav, quinolones and cephalosporins) when narrow spectrum antibiotics remain effective, as they increase the risk of all infections, including *Clostridium difficile*, MRSA and resistant Urinary Tract Infections (UTIs).
15. Avoid widespread use of topical antibiotics (especially those agents also available as systemic preparations, in most cases, topical use should be limited).
16. If diarrhoea or vomiting occurs due to an antibiotic or the illness being treated, the efficacy of hormonal contraception may be impaired and additional precautions should be recommended.

17. Clarithromycin is now recommended over erythromycin, except in pregnancy and breastfeeding. It has fewer side-effects and twice daily rather than four times daily dosing promotes compliance. **Statins should be withheld when macrolide antibiotics are prescribed.**
18. In pregnancy, take specimens to inform treatment. Penicillins, cephalosporins and erythromycin are not associated with increased risk of spontaneous abortion. If possible, avoid tetracyclines, quinolones, aminoglycosides, azithromycin (except in chlamydial infection), clarithromycin and high dose metronidazole (2g stat) unless the benefits outweigh the risks. Short-term use of nitrofurantoin is not expected to cause foetal problems (theoretical risk of neonatal haemolysis). Trimethoprim is also unlikely to cause problems unless poor dietary folate intake or taking another folate antagonist. **If you are unsure about a particular drug's use in pregnancy contact the relevant Medicines Optimisation team for further advice.**
19. Annual vaccination is essential for all those at clinical risk of severe influenza. Visit Annual Flu Programme for further information. For information on Immunisation against infectious disease refer to The Green Book.
20. For information on causative pathogens, refer to UKHSA guidance: Management of infection guidance for primary care for consultation and local adaptation

Self Care

Promote self-care where appropriate. Refer to the Self Care sections highlighted throughout the guideline. Treatments that are often available to purchase over the counter include:

- Analgesics (painkillers) for short-term use
- Topical antifungal treatment for short-term minor ailments
- Cold sore treatment
- Colic treatment
- Cough and cold remedies
- Eye treatments/lubricating products
- Head lice treatment and scabies treatment
- Threadworm tablets
- Topical acne treatment
- Warts and verruca treatment

For further information see:

- NHS South East London ICB: 'Prescribing of over the counter medicines is changing' leaflet
- Self-care Forum website
- NHS.UK website

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Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
UPPER RESPIRATORY TRACT INFECTIONS					
Acute sore throat CKS NICE FeverPAIN Treating your infection patient leaflet	**AVOID ANTIBIOTICS or consider back-up/ delayed antibiotic prescription.** 82% of cases resolve in 7 days without antibiotics and pain is only reduced by 16 hours. Use **FeverPAIN*** Score to assess. Criteria include: **F**ever in last 24h, **P**urulence, **A**ttend rapidly under 3 days, severely **I**nflamed tonsils, **N**o cough or coryza). **Score 0-1 (≡ Centor ≤2)**: 13-18% streptococci isolation - use NO antibiotic strategy **Score 2-3:** 34-40% streptococci isolation - consider no antibiotic or a back-up antibiotic prescription **Score 4-5 (≡ Centor 3-4)**: 62-65% streptococci isolation. Use clinical judgement to assess severity on baseline symptoms (difficulty swallowing, runny nose, cough, headache, muscle ache, interference with normal activities) and use immediate antibiotic or 48 hour short delayed antibiotic prescription. Always share self-care advice & safety net. Complications are rare. If systemically unwell, refer to emergency department.	First Line: Fever Pain 0-1: self-care see NHS.UK Second Line: Fever pain 2-3: delayed prescription of phenoxymethylpenicillin Phenoxymethylpenicillin (oral) 500mg QDS OR 1g BD (if mild) for 5-10 days If severe (refer to comments): 500mg QDS for 10 days	Second Line: Fever pain 2-3: delayed prescription of clarithromycin Clarithromycin (oral) 250mg BD for 5 days If severe (refer to comments): 500mg BD for 5 days	Second Line: Fever pain 2-3: delayed prescription of Phenoxymethylpenicillin Phenoxymethylpenicillin (oral) 500mg QDS OR 1g BD (if mild) for 5-10 days If severe (refer to comments): 500mg QDS for 10 days	Second Line: Fever pain 2-3: delayed prescription of erythromycin Erythromycin (oral) 250mg – 500mg QDS OR 500mg – 1g BD for 5 days

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
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	*Centor criteria can also be used. Tonsillar exudate, tender anterior, cervical lymphadenopathy or lymphadenitis, history of fever (>38°C), no cough 1 point for each				
Scarlet Fever UKHSA Scarlet Fever	**Prompt treatment** with appropriate antibiotics significantly reduces the risk of complications. Vulnerable individuals (immunocompromised, the co-morbid, or those with skin disease) are at increased risk of developing complications **This is a notifiable disease**	First line: Phenoxymethylpenicillin (oral) 500mg QDS for 10 days	First line: Clarithromycin (oral) 250mg - 500mg BD for 5 days	First Line: Phenoxymethylpenicillin (oral) 500mg QDS for 10 days	First Line: Erythromycin (oral) 250mg – 500mg QDS or 500mg – 1g BD for 5 days.
Influenza UKHSA	See the UKHSA Influenza guidance for further information.				
Acute Rhino-sinusitis NICE CKS Treating your infection patient leaflet	**Symptoms <10 days**: do not offer antibiotics as most resolve in 14 days without. Antibiotics only offer marginal benefit after 7 days. **Symptoms >10 days:** no antibiotic, or **back-up/delayed antibiotic** if several episodes of: purulent nasal discharge; severe localised unilateral pain; fever; marked deterioration after initial milder phase. **Systemically very unwell or more serious signs and symptoms: immediate antibiotic.** **Suspected complications:** e.g. sepsis, intraorbital or intracranial infection, refers to secondary care.	First Line: Fever Pain 0-1: self-care see NHS.UK Second Line: (delayed antibiotic) phenoxymethylpenicillin (oral) 500mg QDS for 5 days Offer as first choice if systemically very unwell or high risk of complications; Co-amoxiclav 625mg TDS for 5 days Mometasone nasal spray 200mcg BD for 14 days (with or without an oral antibiotic)	Second Line: (delayed antibiotic) Doxycycline (oral) 200mg STAT then 100mg OD for a total of 5 days *OR* Clarithromycin (oral) 500mg BD for 5 days Mometasone nasal spray 200mcg BD for 14 days For 2nd line choice of antibiotic or worsening	Second Line: (delayed antibiotic) Phenoxymethylpenicillin (oral) 500mg QDS for 5 days Mometasone nasal spray 200mcg BD for 14 days if benefit outweighs risk. For 2nd line choice of antibiotic or if worsening contact local medical infection team (refer to	Second Line: (delayed antibiotic) Erythromycin (oral) 250 mg – 500 mg QDS for 5 days Mometasone nasal spray 200mcg BD for 14 days if benefit outweighs risk. For 2nd line choice of antibiotic or if worsening contact local medical

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	Self-care: paracetamol/ibuprofen for pain/fever. Consider high-dose nasal steroid if >12 years. Little evidence that nasal saline or nasal decongestants help, but people may want to try them (suitable for self-care). Consider a high-dose nasal corticosteroid for 14 days for adults and children aged 12 years (off-label) and over with symptoms for 10 days or more, but being aware that nasal corticosteroids: • may improve symptoms but are not likely to affect how long they last • could cause systemic effects, particularly in people already taking another corticosteroid • may be difficult for people to use correctly -consider providing patient information leaflet on usage For detailed information click on the visual summary contained within the NICE hyperlink		contact local medical infection team (refer to page 24 for contact details).	page 24 for contact details).	infection team (refer to page 24 for contact details).

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
Acute otitis media (AOM) CKS NICE NICE: Fever in Under 5s Treating your infection patient leaflet NHS.UK	**Consider no or back up/delayed antibiotics.** **Regular paracetamol or ibuprofen for pain (ensure correct dose for age or weight at the right time and maximum doses for severe pain).** AOM resolves in 60% of cases in 24hrs without antibiotics, which only reduce pain at 2 days and does not prevent deafness. **Otorrhoea (discharge after eardrum perforation) or under 2 years with infection in both ears**: No – see here Yes – consider no/delayed or immediate **Systemically unwell or high risk of complications:** immediate antibiotic **If severe systemic infection, refer to emergency department.**	First Line: Fever Pain 0-1: self-care see NHS.UK Amoxicillin (oral) for 5 days 500mg TDS Second Line: (If symptoms worsen on first choice antibiotic taken for at least 2-3 days): Co-amoxiclav 625mg TDS for 5 days	Clarithromycin (oral) for 5 days 250mg BD, increased if necessary in severe infections to 500mg BD	Amoxicillin (oral) 500mg TDS for 5 days	Erythromycin (oral) 250mg – 500mg QDS for 5 days
Acute Otitis Externa (OE) CKS	If cellulitis/disease extending outside ear canal, take a swab for culture, start oral flucloxacillin & refer to exclude malignant OE. Malignant OE can be caused by *Pseudomonas aeruginosa* and therefore may not respond to flucloxacillin. If patient presents with symptoms of longer than 2 weeks, in particular patients with diabetes, refer to exclude malignant OE.	First Line: Fever Pain 0-1: self-care see NHS.UK Second Line: Topical acetic acid 2% spray: 1 spray TDS for 7 days (available OTC as EarCalm®) **OR** Neomycin sulphate with corticosteroid ear drops: 3 drops TDS for 7 days minimum to 14 days maximum. Cure rates similar at 7 days for topical acetic acid or antibiotic +/- steroid. If cellulitis: flucloxacillin (oral) 250mg QDS for 7 days If severe: 500mg QDS for 7 days **In case of treatment failure, refer to NICE CKS.**			

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LOWER RESPIRATORY TRACT INFECTIONS					
Community Acquired Pneumonia (treatment in the community) BTS NICE: Pneumonia in Adults	Use **CRB65** score in conjunction with clinical judgement to help guide and review: Each parameter scores 1: **C**onfusion (AMT≤8); **R**espiratory rate ≥30/min; **BP** systolic <90mmHg or diastolic ≤ 60mmHg, Age ≥**65**. **Score 3-4:** urgent hospital admission **Score 1-2:** intermediate risk consider hospital assessment **Score 0**: low risk consider home based care **Provide safety net advice and likely duration of symptoms: fever for 1 week, sputum production for up to 4 weeks, cough up to 6 weeks, most symptoms resolve with 3 months and may take up to 6 months to get back to normal.** Atypical mycoplasma infection is rare in > 65 years. Failure to improve or worsening within 48 hours, consider hospital treatment or chest X-ray. 'When **life threatening infection**, GP should administer antibiotics. Benzylpenicillin 1.2 gram IV or amoxicillin 1 gram orally are preferred agents[5].	**Refer to hospital if CRB65≥3**		**Refer to hospital if CRB65 ≥ 1**	
		If **CRB65=1, 2 and at home:** clinically assess need for antibiotic cover for atypicals: Amoxicillin (oral) 500mg TDS **AND** Clarithromycin (oral) 500mg BD for a total of 5 days depending on severity **OR** Doxycycline **alone** (oral) 200mg STAT on day 1 then 100mg OD for a total of 5 days depending on severity If **CRB65=0:** Amoxicillin (oral) 500 mg TDS for a total of 5 days with safety netting advice; to review antibiotics at 3 days	If **CRB65=1, 2 and at home:** Clarithromycin(oral) 500mg BD for a total of 5 days depending on severity **OR** Doxycycline(oral) 200mg STAT on day 1 then 100mg OD for a total of 5 days depending on severity If **CRB65=0:** Clarithromycin (oral) 500mg BD for a total of 5 days with safety netting advice; to review antibiotics at 3 days **OR** Doxycycline (oral) 200mg STAT on day 1, then 100mg OD for a total of 5 days; to review antibiotics review at 3 days.	If **CRB65=0:** Amoxicillin(oral) 500mg TDS for a total of 5 days To return for review at 3 days; if not improving or worsening refer to hospital	If **CRB65=0:** Erythromycin (oral) 250mg – 500mg QDS for a total of 5 days To return for review at 3 days; if not improving or worsening refer to hospital
Acute cough, bronchitis CKS-cough CKS-Bronchitis	**Consider no or 7 day back up/delayed antibiotic with self-care and safety netting and advise that symptoms can last 3 weeks.**	**First line: Self Care and safety netting advice, see NHS.UK**			
		Second line: Doxycycline (adults and children over 12 years) (oral) 200mg STAT, then 100mg OD (total 5 days treatment)	Second line: Doxycycline (adults and children over 12 years) (oral) 200mg STAT, then	Second line: Amoxicillin(oral) 500mg TDS for 5 days	Second line: Erythromycin(oral) 250mg – 500mg QDS or 500mg – 1g BD for 5 days

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
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Treating your infection patient leaflet	Antibiotics are of little benefit if no co-morbidity. Symptom resolution can take up to 3 weeks. Consider immediate antibiotics if >80years of age and **ONE** of: hospitalisation in past year; taking oral steroids; insulin dependent diabetic; congestive heart failure, serious neurological disorder/stroke **OR** >65 years with **TWO** of the above. Consider CRP testing if antibiotic treatment is being considered. No antibiotics if CRP<20mg/L and symptoms for >24 hours; delayed antibiotics if CRP 20-100mg mg/L; immediate antibiotics if >100mg/L.	Third line: Amoxicillin(oral) 500mg TDS for 5 days	100mg OD (total 5 days treatment) **OR** Clarithromycin (in children < 12 years old) 250mg-500mg BD for 5 days		
Acute exacerbation of COPD NICE: COPD in over 16s GOLD COPD	Treat exacerbations promptly with antibiotics if purulent sputum **and** increased shortness of breath **and/or** increased sputum volume. Consider risk factors for antibiotic resistance: severe COPD (MRC>3), co-morbidity, frequent exacerbations, antibiotics in the last 3 months Previous microbiology should be reviewed if at risk of resistance.[14] Antibiotics should be used to treat exacerbations of COPD associated with a history of more purulent sputum. Patients with exacerbations without more purulent sputum do not need antibiotic therapy unless there	**Rescue Pack (for initial management of exacerbation)** Prescribe prednisolone 5mg tablets - Take SIX tablets in the morning for 5 days and Doxycycline 100mg capsules **(unless allergic/pregnant/breastfeeding – see below for antibiotic choice)** - Take TWO capsules on the first day, then 100mg daily for a further 4 days, if no improvement in symptoms or doxycycline allergy refer to Visual Summary for choice of antibiotics and prescribing considerations **If a patient is using two or more packs in a year they need a specialist review. Consider referral to the Integrated Respiratory Team who can be contacted 7 days a week 9am-5pm on 07796 178719 (St Thomas') or 0203 299 6531 (Kings). Single Point of Referral can be accessed via e-RS** The South East London integrated guideline for the management of COPD is in the process of being updated at the time of updating, therefore please refer to the relevant NICE guidance.			
		Doxycycline(oral) 200mg OD for 1 day then 100mg for a further 4 days	Doxycycline (oral) 200mg OD for 1 day then 100mg for a further 4 days **OR** Clarithromycin (oral) 500mg BD for 5 days **If risk factors present, contact microbiology for advice on antibiotic**	Amoxicillin (oral) 500mg TDS for 5 days **If risk factors present, contact microbiology**	Erythromycin(oral) 250mg – 500mg QDS for 5 days **If risk factors present, contact microbiology**

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	is consolidation on a chest radiograph or clinical signs of pneumonia[7] - in which case follow treatment guidance for pneumonia. Oral corticosteroids should be considered in patients with a significant increase in breathlessness which interferes with daily activities[7].	**If at risk of resistance:** Co-amoxiclav (oral) 625mg TDS for 5 days	**choice in recurrent/resistant cases**		
URINARY TRACT INFECTIONS					
Lower UTI in adults (no fever or flank pain) PHE UTI quick reference guide CKS women CKS men TARGET Antibiotic Toolkit	**Women** treat **empirically** if ≥ 2 symptoms a) Send urine culture if risk of antibiotic resistance. If not pregnant and mild symptoms, watch & wait with back-up antibiotic OR consider immediate antibiotic b) Advise paracetamol or ibuprofen for pain **Men**: Consider prostatitis and send pre-treatment Mid-stream urine (MSU OR if symptoms mild/non-specific, use negative dipstick to exclude UTI. **Always provide safety net advice.** **In treatment failure:** always perform culture **Low risk of resistance: younger women with acute UTI and no risk.** **Risk factors for increased resistance include:** care home resident, recurrent UTI,	**First line for women and men**: Nitrofurantoin (oral) 100mg MR twice daily (or 50mg QDS if unavailable) if eGFR over 45ml/min. Use nitrofurantoin 1st line as resistance and community multi-resistant Extended-spectrum Beta-lactamase *E. coli* are increasing. Nitrofurantoin is contraindicated if eGFR < 45 mL/min or if known G6PD deficiency or in acute porphyria. **Alternative 1st line agents for women and men:** Trimethoprim (oral) 200mg BD (local resistance is high, therefore only recommend if patient has low risk factors for resistance or if sensitivity of this is known). **OR** **For non-pregnant women >16y** Pivmecillinam (oral) 400mg STAT then 200mg TDS If eGFR<45ml/min or elderly consider pivmecillinam or fosfomycin (3g stat in women). **NOTE:** Fosfomycin should **only** be prescribed on the advice of a microbiologist following culture sensitivity results for the treatment of complicated ESBL producing UTI **For men >16y: Second-choice**: *If no improvement in UTI symptoms on first-choice taken for at least 48 hours or when first-choice not suitable, consider alternative diagnoses and follow recommendations in the NICE guidelines on pyelonephritis (acute): antimicrobial prescribing or prostatitis (acute): antimicrobial prescribing*,		Prompt treatment for **seven** days to prevent progression to pyelonephritis. Send MCS prior to starting antibiotics if possible and review antibiotics already prescribed based on results. Short-term use of nitrofurantoin in pregnancy is unlikely to cause problems to the foetus. **Do not prescribe trimethoprim for pregnant women with established folate deficiency, or low dietary folate intake, or those taking folate antagonists (e.g. antiepileptics or proguanil)**	
				Treat for 7 days: 1st line: Nitrofurantoin (oral) 100mg m/r BD, unless at term 2nd line: Cefalexin (oral) 500 mg BD Risk of C.*difficile*	**Treat for 7 days:** Nitrofurantoin (oral) 100mg m/r BD **OR** 2nd line: Contact local medical infection team (refer to contact details on page 22)

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	hospitalisation anywhere >7days within the last 12 months unresolving urinary symptoms, recent travel to a country with increased antimicrobial resistance (outside Northern Europe and Australasia), previous known UTI resistant to trimethoprim, cephalosporins or quinolones (consider safety issues) If increased resistance risk send culture for susceptibility testing & give safety net advice. **>65 years:** treat if fever ≥38°C, or 1.5°C above base twice in 12 hours, and >1 other symptom	*basing antibiotic choice on recent culture and susceptibility results.* **Treatment duration: Women: 3 days** **Men: 7 days**. Referral to hospital may be indicated in non-responding, severe or recurrent infection or suspicion of underlying UT abnormality **People > 65 years: do not treat asymptomatic bacteriuria;** it is common but is not associated with increased morbidity Do not perform urine dipsticks (which may detect a bacteriuria which is not harmful)			
Recurrent UTI in women (2 in 6 months or ≥ 3 proven UTIs/year) UKHSA UTI diagnosis guide for primary care TARGET UTI	Consider STI screen and Urology referral where necessary.	First line: Advise simple measures, including hydration & ibuprofen for symptom relief. Cranberry products, which can be purchased from pharmacies and health food stores, work for some women, but good evidence is lacking. For postmenopausal women, if no improvement, consider vaginal oestrogen (review within 12 months).		Contact local medical infection team (refer to contact details on page 24) for advice on treating recurrent UTIs in pregnant, breastfeeding women and women trying to conceive.	
		Second line: **Standby:** for those with recurrent UTIs consider a course at home to start as soon as symptoms occur. Base choice on past sensitivity. OR **Post-coital** (off label) take STAT Third line: Prophylaxis once daily at night and review at 3 months.			
		First line drug choice (if eGFR≥45ml/min): Nitrofurantoin 100mg single dose or if recent culture sensitive Trimethoprim 200mg single dose			
		Second line choice drug: Amoxicillin 500mg single dose or Cefalexin 500mg single dose	See advice on right		

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
Recurrent UTI in men	**Refer to hospital.**				
Lower UTI in children PHE UTI CKS NICE: UTI in under 16s	**Urgently refer children < 3 months old for assessment** If ≥ 3 months old: • If nitrate positive and fresh sample, start antibiotics and send for microscopy, culture and sensitivity (MC+S). • If leucocyte only positive, may be indicative of infection outside urinary tract, send MSU for MC+S, initiate antibiotics if there is good clinical evidence of UTI. • If nitrate and leucocyte negative, consider another cause for illness. **Imaging:** only refer if child <6 months, or recurrent or atypical UTI	**See BNF-C for doses** First Line: Trimethoprim (oral) **OR** if eGFR≥45ml/min Nitrofurantoin (oral) Second line: If susceptible, amoxicillin (oral) **OR** Cefalexin (oral) **3 days treatment**		Contact local trust medical infection team (see contact details on page 24).	
Upper UTI in children PHE UTI CKS NICE: UTI in under 16s	**Refer to paediatrics to obtain a urine sample for culture; assess signs of systemic infection, consider systemic antimicrobials**				
Catheter associated UTI	**Antibiotic treatment is not routinely needed for asymptomatic bacteriuria in people with a urinary catheter. do not delay antibiotic" if symptomatic infection.** 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. When prescribing antibiotics, take account	**If no upper UTI symptoms** First line: Nitrofurantoin (if eGFR≥45ml/min) 100mg M/R BD (or 50mg QDS if unavailable) **OR** Trimethoprim (if low risk of resistance) 200mg BD **OR** Amoxicillin (only if culture results available and susceptible) 500mg TDS Second line	**If no upper UTI symptoms** First line: Nitrofurantoin (if eGFR≥45ml/min) 100mg M/R 100mg BD (or 50mg QDS if unavailable) **OR** Trimethoprim (if low risk of resistance) 200mg BD **7 days treatment**	First line: Cefalexin 500mg BD or TDS (up to 1g-1.5g TDS or QDS for severe infections) **7-10 days treatment** Second line: Seek advice from the local Microbiologist	Contact local medical infection team (refer to contact details on page 24)

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	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. Do not routinely offer antibiotic prophylaxis to people with a short-term or long-term catheter.	Pivmecillinam 400mg STAT then 200mg TDS **7 days treatment** **If upper UTI symptoms present** Cefalexin 500mg BD or TDS (up to 1g-1.5g TDS or QDS for severe infections) **OR** Co-amoxiclav (only if culture results available and susceptible) 625mg TDS **7-10 days treatment** **OR** Trimethoprim (only if culture results available and susceptible) 200mg BD **14 days treatment** **Third line: Consider only when other recommended antibiotics have failed, will not work due to resistance, or are unsafe to use:** Ciprofloxacin (oral) 500mg BD (consider safety issues) **7 days treatment** **OR: Seek advice from the local Microbiologist if there are safety concerns around the use of Ciprofloxacin**	**If upper UTI symptoms present** Trimethoprim (only if culture results available and susceptible) 200mg BD **14 days treatment** **Third line: Consider only when other recommended antibiotics have failed, will not work due to resistance, or are unsafe to use:** Ciprofloxacin (oral) 500mg BD (consider safety issues) **7 days treatment** **OR: Seek advice from the local Microbiologist if there are safety concerns around the use of ciprofloxacin**		
Acute prostatitis BASHH CKS	Advise paracetamol (+/- low-dose weak opioid) for pain, or ibuprofen if preferred and suitable. Review antibiotic treatment after 14 days and either stop antibiotics or	**Send MSU for culture and start antibiotics. Consider STI screen and urology referral where necessary.** **Treatment duration: 14 days then review**		**Not applicable**	

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	continue for a further 14 days if needed (based on assessment of history, symptoms, clinical examination, urine and blood tests). **A 4-week course may prevent chronic prostatitis**. **At the time of updating this guideline, the British Association for Sexual Health and HIV (BASHH) Clinical Effectiveness Group, NHS England and NICE have stated that they will be reviewing their guidelines where quinolone antibiotics are presently recommended; however, a timeline for review has not yet been provided.**	**At the time of updating this guideline, quinolones are still considered to be first line for empirical treatment of acute bacterial prostatitis due to achieving higher prostate levels and their antimicrobial activity against Gram-negative pathogens.** **If a patient is unable to take quinolones due to safety concerns and/or previous adverse effects resulting from quinolone treatment, please consider the alternative options, as below.** First line, **guided by susceptibilities when available**: Ciprofloxacin (oral) 500mg BD (consider safety issues) **OR** ofloxacin 200mg BD (consider safety issues) **If quinolones are inappropriate or there are safety concerns, then consider:** Trimethoprim (oral) 200mg BD **OR seek advice from the local Microbiologist** Second line: Discuss with a specialist/local medical infection team or microbiologist before considering Levofloxacin 500mg OD (consider safety issues) **OR** co-trimoxazole 960mg BD			
Acute pyelonephritis CKS	Advise paracetamol (+/- low-dose weak opioid) for pain, or ibuprofen if preferred and suitable. If admission not needed, send MSU for culture & susceptibility for people aged ≥16 years and start empirical antibiotics. **Review MSU result once available and adjust treatment appropriately if necessary. Arrange if there is any clinical deterioration or the person does**	Cefalexin (oral) for 7 days ≥16 years: 500mg BD or TDS For severe infections: Up to 1-1.5g TDS - QDS **OR** Co-amoxiclav (oral) for 7 days ≥16 years: 625mg TDS **OR: If MSU results show susceptibility consider switch to:** Trimethoprim (oral) 200mg BD for 14 days	**If susceptible:** Trimethoprim (oral) 200mg BD for 14 days **Consider only when other recommended antibiotics will not work due to resistance, or are unsafe to use:** Ciprofloxacin (consider safety issues) 500mg BD for 7 days **OR: Refer to hospital if 2nd line agent required.**	Cefalexin (oral) 500mg BD-TDS (up to 1-1.5g TDS-QDS for severe infections **7-10 days treatment**	Contact local medical infection team for advice (see contact details on page 24)

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	not respond to treatment within 24 hours. **If extended-spectrum beta-lactamases (ESBL) risk** and with microbiology advice consider intravenous (IV) antibiotic via the Outpatient Parenteral Antimicrobial Therapy (OPAT) service. This service is managed by the acute trust and GPs would not be expected to prescribe intravenous antibiotics. For children: Ensure sample is taken and referral is made to paediatrics	**Consider only when other recommended antibiotics have failed, will not work due to resistance, or are unsafe to use:** Ciprofloxacin (consider safety issues) 500mg BD for 7 days **OR: Refer to hospital if 2nd line agent required**			
SKIN INFECTIONS **Refer to local infection department for all patients with known or suspected MRSA where oral antibiotics are required**					
Impetigo CKS	A systematic review indicates topical and oral treatment produces similar results. Reserve topical antibiotics for very localised lesions to reduce the risk of resistance. Treatment for 7 days is usually adequate. Max. duration of topical treatment 10 days. **For extensive, severe, or bullous impetigo, use oral antibiotics for 7 days.**	Topical Fusidic acid 2% TDS (thinly) for 5 days Mupirocin 2% TDS for 5 days (if fusidic acid resistance suspected or confirmed) Flucloxacillin (oral) 500mg QDS for 5 days	Clarithromycin (oral) 250mg BD for 5 days	Flucloxacillin (oral) 250-500mg QDS for 5 days	Erythromycin (oral) 250mg – 500mg QDS for 5 days

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	Do not offer combination treatment with a topical and oral antibiotic to treat impetigo. **If MRSA suspected or confirmed – consult local microbiologist.**				
Cellulitis and Erysipelas CKS British Lymphology Society	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.	**Non facial cellulitis/erysipelas** Flucloxacillin (oral) 500mg to 1g QDS for 7 days **Facial cellulitis/erysipelas (non dental):** Co-amoxiclav (oral) 625mg TDS for 7days **For severe infections:** Co-amoxiclav (oral) 625mg TDS for 7days **OR** Clindamycin 150mg -300mg QDS (can be increased to 450mg) for 7 days	Clarithromycin (oral) 500mg BD for 7days If on statins: Doxycycline (oral) 200mg stat on day 1, then 100mg daily for 6 days **Facial cellulitis/erysipelas (non dental):** Clarithromycin (oral) 500mg BD **AND** Metronidazole (oral) 400mg TDS for 7days **For severe infections:** Clindamycin 150mg-300mg QDS (can be increased to 450mg) for 7days	Flucloxacillin (oral) 500mg QDS for 7days	Erythromycin (oral) 500mg QDS for 7 days – be particularly alert to deteriorating disease, carry out an early review
		If slow response, continue treatment for a further 7 days. Skin changes (such as discolouration) may persist for months or longer following severe cellulitis and do not necessarily require ongoing antibiotics.			

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
Mastitis CKS	*S. aureus* is the most common infecting pathogen. Suspect if woman has: a painful breast; fever and/or general malaise; a tender, red breast. Treat all non-lactating women with oral antibiotics; consider 24-48 hours of effective breast milk removal by expressing milk/breastfeeding from affected breast before starting antibiotics for lactating women. **If a breast abscess is suspected, the woman should be referred urgently to a general surgeon for confirmation of the diagnosis and management.**	Flucloxacillin 500mg QDS for 10-14 days	Erythromycin 250 - 500mg QDS for 10-14 days **OR** Clarithromycin 500mg BD for 10-14 days	Flucloxacillin 500mg QDS for 10-14 days **Breastfeeding: oral antibiotics are appropriate, where indicated. Women should continue feeding, including from the affected breast**	Erythromycin 250 - 500mg QDS for 10-14 days
Diabetic foot infections	Refer for specialist (e.g. microbiologist, diabetes foot specialist) opinion unless mild, superficial wound margins. If diagnosis of mild cellulitis is suspected, treat as above. Check microbiology results in those who may have been previously treated. Refer MRSA and treatment failure cases				
Acne CKS	**Mild (open and closed comedones) or moderate (inflammatory lesions):** **First-line:** self-care (wash with mild soap; do not scrub; avoid make-up). **Second-line:** topical retinoid or benzoyl peroxide. **Third-line:** add topical antibiotic, or consider addition of oral antibiotic. **Severe (nodules and cysts):** add oral antibiotic (for 3 months max) and refer to a dermatologist.	First-line: Self-care NHS.UK Second-line: 0.1% adapalene/ 2.5% benzoyl peroxide (OTC) OR 0.3% adapalene/2.5% benzoyl peroxide (OTC) OD (thinly in the evening) Third-line: 0.025% tretinoin/ 1% clindamycin OD (thinly in the evening) Forth-line: 3% benzoyl peroxide (OTC)/1% clindamycin OR 5% benzoyl peroxide/1% clindamycin OD (in the evening) Fifth-line (treatment failure/severe): 0.1% adapalene/ 2.5% benzoyl peroxide AND doxycycline 100mg OD OR Lymecycline 408mg OD should ONLY be considered in patients experiencing photosensitivity / ADRs / contraindication / intolerance / inefficacy with doxycycline.		Erythromycin (oral) 500mg BD for 6-12 weeks	

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
Eczema CKS	If no visible signs of infection use of antibiotics (alone or with steroids) encourages resistance and does not improve healing. In eczema with visible signs of infection, use treatment as in impetigo (see page 16).				
Human or animal bites CKS	Ensure thorough cleaning of wound and check tetanus status. For further information and advice on tetanus schedule refer to Immunisation against Infectious Disease (The Green Book): Assess rabies risk. For advice on rabies prophylaxis, contact South East London Health Protection Team (HPT). Surgical toilet most important. Contact the South London HPT on: Telephone 0300 303 0450 (in and out of hours) OR e-mail phe.slhpt@nhs.net (for sending Patient Identifiable Information (PII) securely from another NHS.net email address); slhpt.oncall@ukhsa.gov.uk (for sending non-PII, or password-protected / Egress encrypted emails) **Do not offer antibiotics for prophylaxis for an uninfected bite if the bite has not broken the skin.** Human bites: Assess HIV/hepatitis B/hepatitis C risk. Thorough irrigation. Bite has broken the skin and drawn blood: Offer antibiotics Bite has broken the skin but not drawn blood: Consider antibiotics if in high-risk area or person. Animal bites:	**First line:** Co-amoxiclav 375-625mg TDS **Prophylaxis: 3 days** **Treatment: 5 days** Children with bites should also be treated with: Co-amoxiclav. See BNF-C for doses. Seek advice from the local Microbiologist if necessary (see contact details on page 24).	**First line:** Metronidazole 400mg TDS **PLUS** doxycycline 200mg on first day then 100mg or 200mg daily **Prophylaxis: 3 days** **Treatment: 5 days** **Children under 12 years:** Co-trimoxazole. See BNF-C for doses. **Prophylaxis: 3 days** **Treatment: 5 days**	Co-amoxiclav 375-625mg TDS **Prophylaxis: 3 days** **Treatment: 5 days** The use of a combination of co-amoxiclav is **NOT** recommended for women with Preterm Prelabour Rupture of Membranes or 4 weeks before term.	If pregnancy and rash after penicillin, refer to ambulatory.

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	<u>Cat bite:</u> Bite has broken the skin and drawn blood: Offer antibiotics Bite has broken the skin but not drawn blood: Consider antibiotics if the wound could be deep <u>Dog or other traditional animal bite:</u> Bite has broken the skin and drawn blood: Offer antibiotics if it has caused considerable, deep issue damage or is visibly contaminated (for example, with dirt or a tooth) Bite has broken the skin but not drawn blood: Do not offer antibiotics High-risk areas include the hands, feet, face, genitals, skin overlying cartilaginous structures or an area of poor circulation. People at high risk include those at risk of a serious wound infection because of a co-morbidity (such as diabetes, immunosuppression, asplenia or decompensated liver disease) **Review at 24 and 48 hours.** People with severely infected wounds or who are systemically unwell may require referral to A&E for IV antibiotics.				

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
Varicella zoster/ chickenpox CKS **Herpes zoster/ shingles** CKS	Pregnant/immunocompromised/ neonate: seek urgent specialist advice. Chickenpox: consider aciclovir if: onset of rash > 24 hours and 1 of the following: 14 years of age; severe pain; dense/oral rash; taking steroids; smoker. Give paracetamol for pain relief. Shingles: treat if >50 years (Postherpetic neuralgia rare if, <50 years) and within 72 hours of rash, or if 1 of the following: active ophthalmic; Ramsey Hunt, eczema, non-truncal involvement, moderate/severe pain or rash Shingles treatment if not within 72 hours; consider starting antiviral drug up to 1 week after rash onset, if high risk of severe shingles or continued vesicle formation, older age, immunocompromised or severe pain	First Line: Aciclovir 800mg, 5 TDS for 7 days Second line for shingles if poor compliance: Valaciclovir 1g TDS for 7 days		Seek urgent specialist advice	
Tick bites (Lyme disease) CKS	**Prophylaxis: Not routinely recommended**. If immunocompromised, consider prophylactic doxycycline. High-risk areas include grassy and wooded areas in southern England and the Scottish Highlands. Only give prophylaxis within 72 hours of tick removal. Give safety net advice about erythema migrans and other	Prophylaxis: Doxycycline 200mg STAT Treatment Doxycycline 100mg BD for 21 days First alternative: Amoxicillin 1g TDS for 21 days	Prophylaxis: Doxycycline 200mg STAT Treatment Doxycycline 100mg BD for 21 days	Amoxicillin 1g TDS for 21 days	Contact local medical infection team for advice (see contact details on page 24)

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	possible symptoms that may occur within 1 month of tick removal.				
SEXUALLY TRANSMITTED INFECTIONS (STIs): For guidance, refer to Lambeth STI Management in Primary Care					
GASTROINTESTINAL INFECTIONS					
Infectious diarrhoea CKS	**Refer** previously healthy children with acute painful or bloody diarrhoea to exclude E. coli 0157 infection. Normal feeding should be restarted as soon as possible; there is no evidence that fasting will have any benefit. Fluid replacement is essential. Travel history should be reported if stool sample sent.	**Antibiotic therapy usually not indicated unless systemically unwell** as it only reduces diarrhoea by 1-2 days and can cause resistance. Initiate treatment, on advice of Microbiologist (see contact details on page 24). If systemically unwell and campylobacter suspected (e.g. undercooked meat and abdominal pain), consider clarithromycin 250 – 500mg BD for 5–7 days if treated early (within 3 days). If giardia is confirmed or suspected – tinidazole 2g single dose is the treatment of choice Notify suspected cases of food poisoning to, and seek advice on exclusion of patients from, South London HPT on 0300 303 0450 (in and out of hours), or email phe.slhpt@nhs.net (for sending Patient Identifiable Information (PII) securely from another NHS.net email address); slhpt.oncall@ukhsa.gov.uk (for sending non-PII, or password-protected / Egress encrypted emails). Send stool samples in these cases.	Notify suspected cases of food poisoning to, and seek advice on exclusion of patients from, South London HPT on 0300 303 0450 (in and out of hours), or email phe.slhpt@nhs.net (for sending Patient Identifiable Information (PII) securely from another NHS.net email address); slhpt.oncall@ukhsa.gov.uk (for sending non-PII, or password-protected / Egress encrypted emails). Send stool samples in these cases.	
Clostridioides difficile (CD)	For adults, offer an oral antibiotic to treat suspected or confirmed CD infection. In the community**, consider seeking prompt specialist advice from a microbiologist or infectious diseases specialist before starting treatment.** **Refer people in the community with suspected or confirmed CD infection to hospital if they are severely unwell, or their symptoms or signs worsen rapidly or significantly at any**	If severe symptoms or signs (see below) should treat with oral vancomycin, review progress closely and/or consider hospital referral. Severe if temperature > 38.5^0C; WCC > 15 x10^9/L, rising creatinine (> 50% increase above baseline) or signs/symptoms of severe colitis (abdominal or radiological). Some patients with recurrent *C. difficile* infections (CDI) may continue their treatment in a primary care setting, due to long-duration and/or tapering courses of vancomycin and attempts to avoid long hospital stays. *1st episode of mild-severe CDI, 1st line: Oral* vancomycin 125 mg QDS for 10 days 1st episode *of mild-severe CDI* 2nd line (if vancomycin ineffective): Oral fidaxomicin 200mg BD for 10 days	Contact local medical infection team for advice (see contact details on page 24).	

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	time. Refer urgently if the person has a life-threatening infection. **Consider referring people in the community to hospital if they could be at high risk of complications or recurrence because of individual factors such as age, frailty or comorbidities.** Stop unnecessary antibiotics and/or PPIs to re-establish normal flora. Stop any antidiarrheal agents in patients who are proven CD toxin positive. CD has been identified as a causative organism in pseudomembranous colitis/antibiotic-associated diarrhoea. Fluids and electrolytes should be replaced.	Treatment can be initiated in primary care after a recommendation from a Consultant Microbiologist. **Restricted to treatment of laboratory-confirmed CDI in the following groups:** • Recurrence following vancomycin treatment • Patients who require ongoing concomitant antibiotic treatment • Patients who are immunocompromised and at risk of further recurrence Subsequent recurrences and all cases of severe CDI will require admission. If the patient is well enough to avoid admission to hospital but has diarrhoea and there is a suspicion of CDI, for the first and second episodes, send a stool sample, rehydrate and consider treatment as above. Seek specialist advice if both 1st episode options are ineffective. *2nd episode within 12 weeks of symptom resolution : Oral* fidaxomicin 200mg BD for 10 days *2nd episode more than 12 weeks of symptom resolution : Oral* fidaxomicin 200mg BD or *Oral* vancomycin 125 mg QDS for 10 days **Vancomycin monitoring** The manufacturers advise that serial tests of auditory function may be helpful to reduce the risk of ototoxicity in patients with an underlying hearing loss, or who are receiving concomitant therapy with other ototoxic drugs. Serum-vancomycin concentration should be monitored in patients with inflammatory intestinal disorders.		

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
MENINGITIS					
Suspected meningococcal disease UKHSA	Transfer all patients to hospital immediately. Keep supply of benzylpenicillin and check expiry dates. **ARRANGE URGENT TRANSFER TO HOSPITAL**	**If time before hospital admission, and non-blanching rash, administer benzylpenicillin prior to admission, unless history of true anaphylaxis reaction to previous penicillin.** **Ideally administer IV bolus** but IM if a vein cannot be found. **Adults and children:** 10 years and over: 1200mg (1.2grams) Children 1 - 9 years: 600mg Children <1 years: 300mg **Past history of allergic responses other than anaphylaxis, such as a rash is not a contraindication to an urgent penicillin injection in this situation**. No alternative antibiotic is indicated in patients with anaphylactic reactions to penicillin. Prevention of secondary case of meningitis (prophylaxis): prescribe only on advice of South London HPT: 0300 303 0450 (in and out of hours), or email phe.slhpt@nhs.net (for sending Patient Identifiable Information (PII) securely from another NHS.net email address); slhpt.oncall@ukhsa.gov.uk (for sending non-PII, or password-protected / Egress encrypted emails)			
METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)					
MRSA infections CKS	For support in prophylaxis and treatment of MRSA infections contact the local Medical Infection team (refer to page 24 for contact details). For advice on infection control, contact the local Infection Prevention and Control Team (IPCT) (refer to page 24 for contact details). Severe MRSA infections would be better treated in secondary care, on an individual case basis, working closely with the IPCT.				
EYE CONDITIONS					
Conjunctivitis NHS.UK CKS (Infective) CKS (Allergic)	**Treat only if severe**, as most cases are viral or self-limiting especially in children. **Bacterial conjunctivitis:** usually unilateral and also self-limiting. It is characterised by red eye with mucopurulent, not watery discharge. 65% and 74% resolve on placebo by days 5 and 7.	First line: Self-care and OTC lubricant eye drops. Children rarely require treatment or exclusion. Bathe/clean eyelids with cotton wool dipped in sterile saline or boiled (cooled) water, to remove crusting Second line: Chloramphenicol 0.5% eye drops (available OTC to patients aged 2 years and above) 2 hourly for 2 days, then reduce frequency to 3-4 times a day OR 1% ointment (available OTC to patients aged 2 years and above) 3-4 times daily,or just at night if using eye drops Third line (as less gram-negative activity): Topical fusidic acid 1% gel BD **Treatment should continue for 48 hours after resolution**			
Blepharitis CKS (Blepharitis) NHS.UK	**First line:** -Lid hygiene for symptom control, including: warm compresses; lid massage and scrubs; gentle washing; avoiding cosmetics.	First line: Self-care Second line: Topical chloramphenicol 1% ointment (available OTC only patients aged 2 years and above) BD 6 week trial Third line (excluding pregnancy and breastfeeding):			

Infection	Comments	First Choice Antibiotics		Pregnancy & Breastfeeding	
		No allergy	Penicillin allergy	No allergy	Penicillin allergy
	Second line: topical antibiotics if hygiene measures are ineffective after 2 weeks. **Signs of Meibomian gland dysfunction, or acne rosacea:** consider oral antibiotics.	Oral oxytetracycline 500mg BD 4 weeks (initial) then 250mg BD 8 weeks (maintance) OR Oral doxycycline 100mg OD 4 weeks (initial) then 50mg OD 8 weeks (maintance)			
DENTAL INFECTIONS					
GPs should not be involved in prescribing antibiotics for dental treatment. Patients should be directed to their regular dentist or if this is not possible 111. Most dental conditions require dental input rather than antibiotics. Advise regular analgesia until a dentist can be seen. Also refer to NHS.UK topic on Dental Abscess.					

Contact Details	
Guy's and St Thomas' NHS Foundation Trust	**Medical Infection team:** During working hours: (Monday – Friday, 9am – 5pm) Tel: 0207 188 3100 or call 0207 188 7188 (switchboard) Out of hours: Call switchboard on 0207 188 7188 and ask to speak to the Microbiology Registrar on call. **Infection Prevention and Control Team (IPCT)** Tel: 020 7188 3153 Email: gst-tr.infectiousdiseases@nhs.net
Kings College Hospital	**Microbiology:** During working house: (Monday – Friday, 9am – 5pm) Call switchboard on 020 3299 9000 and ask to speak to the Microbiology Registrar on call (extension 34360 or 34356). **Virology:** During working house: (Monday – Friday, 9am – 5pm) Call switchboard on 020 3299 9000 and ask for extension 36978. **Infection Prevention and Control Team:** During working house: (Monday – Friday, 9am – 5pm) Call switchboard on 020 3299 9000 and ask for extension 32240 or 38176.

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All resources last accessed on 23 February 2024