### MANAGEMENT OF INFECTION GUIDANCE FOR PRIMARY CARE

This guidance is evidence based but its application must be modified by professional judgement.

#### PRINCIPLES OF TREATMENT

1. A dose and duration of treatment is suggested. In severe or recurrent cases consider a larger dose or longer course.
2. Prescribe an antibiotic only when there is likely to be a clear benefit.
3. Do not prescribe an antibiotic or delay prescribing for acute sore throat, common cold, acute cough and acute sinusitis.
4. Limit prescribing over the telephone to exceptional cases.
5. Use simple generic antibiotics if possible. Avoid broad spectrum antibiotics (e.g. co-amoxiclav, quinolones and cephalosporins), when narrow spectrum antibiotics remain effective, as they increase risk of *Clostridium difficile*, MRSA and resistant UTIs. Counsel all patients given antibiotics to seek advice if persistent diarrhoea occurs during or following antibiotic use. Always review the history of antibiotic use in patients with diarrhea. If there has been antibiotic use in recent weeks, *C Difficile* infection should be suspected and the following action considered: a stool sample, stopping of previously prescribed antibiotics, avoidance of the use of anti-motility drugs, and immediate treatment as if the patient had *C difficile* infection (see the relevant section of this guidance). Remember the onset of symptoms of *C difficile* infection may be delayed for several weeks after cessation of antibiotic therapy.
6. AVOID widespread use of topical antibiotics (especially those agents also available as systemic preparations)
7. In pregnancy AVOID tetracyclines, aminoglycosides, quinolones, *high dose* metronidazole, trimethoprim in first trimester (as folate antagonist) and nitrofurantoin at term (risk of neonatal haemolysis).
8. Children: AVOID tetracyclines in children under 12 (teeth motting). Quinolones are not recommended in children and growing adolescents (risk of arthropathy)
9. Clarithromycin is an acceptable alternative in those who are unable to tolerate erythromycin because of intolerable side effects.
10. Where a best guess therapy has failed or special circumstances exist, contact duty Medical Microbiologist at University Hospital Lewisham Tel 0208 333 3262, 3265, 3264. Out of hours contact via hospital switchboard 0208 333 3000

#### SOURCE DOCUMENTS

This guidance is based on “Management of Infections Guidance for Primary Care”, HPA (latest review March 2010) (www.hpa.org.uk); BNF 59 (March 2010); BNF for Children (2009); CKS (www.cks.nhs.uk), NICE Clinical Guidance 69 (www.nice.org.uk); SIGN guidance (www.sign.ac.uk); British Association for Sexual Health and HIV guidance (www.bashh.org) and advice from Antimicrobial Management Team, The Lewisham Hospital NHS Trust.

The majority of doses listed are for adults. Please refer to current BNFC (www.bnfc.org) or CKS (www.cks.nhs.uk) for children’s doses.

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>DRUG OPTION</th>
<th>DOSE</th>
<th>DURATION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INFECTIONS</strong></td>
<td><strong>DRUGS</strong></td>
<td><strong>DOSE</strong></td>
<td><strong>DURATION</strong></td>
<td><strong>COMMENTS</strong></td>
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<tr>
<td><strong>UPPER RESPIRATORY TRACT INFECTIONS</strong></td>
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<tr>
<td><strong>Influenza</strong></td>
<td><strong>NICE HPA</strong></td>
<td><strong>Annual vaccination is essential for all those at risk of influenz</strong>. For otherwise healthy adults, antivirals are not recommended. Treat ‘at risk’ patients, only when influenza is circulating in community or in a care home where influenza is likely, within 48 hours of onset. At risk: &gt;65 years, chronic respiratory disease (including COPD and asthma) significant cardiovascular disease (not hypertension), immunocompromised, diabetes mellitus, chronic neurological, renal or liver disease. Use oseltamivir 75 mg oral capsule BD (48hr post-exposure OD prophylaxis only for ‘at risk’ group who are not vaccinated AND HPA indicated that flu virus is circulating). Zanamivir 10mg (2 inhalations by dishkaler) BD for 5 days is recommended for children between 5-12 yrs.</td>
<td><strong>1. No antibiotics</strong></td>
<td><strong>Advice patients of usual illness length (1 week)</strong></td>
</tr>
<tr>
<td><strong>Pharyngitis/ Sore throat/ Tonsillitis</strong></td>
<td><strong>CKS NICE</strong></td>
<td><strong>Mainly viral</strong></td>
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<tr>
<td><strong>Otitis media</strong></td>
<td><strong>CKS NICE</strong></td>
<td><strong>Mainly viral</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
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<tr>
<td><strong>Acute sinusitis</strong></td>
<td><strong>CKS NICE</strong></td>
<td><strong>Mainly viral</strong></td>
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<sup>4</sup> Don’t prescribe antibiotics for viral sore throat, simple coughs & colds.

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ILLNESS | DRUG OPTION | DOSE | DURATION | COMMENTS
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**LOWER RESPIRATORY TRACT INFECTIONS**

Note: Low doses of penicillins are more likely to select out resistance. Do not use quinolones (ciprofloxacin, ofloxacin), 1st line due to poor activity against pneumococci. Reserve for PROVEN pseudomonal infections. Acute asthma exacerbation is less likely infectious and doesn’t require antibiotics.

### Acute bronchitis / acute cough (<3 weeks)

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| 1. No antibiotics | Advise patients of usual illness length (3 weeks) | All 5 days | • Antibiotics have marginal benefits in otherwise healthy adults. 
• Consider delayed antibiotic with symptomatic advice / leaflet. 
• For children, antibiotics are generally not effective for acute cough caused by simple ‘head colds’, including acute bronchitis and green coloured sputum in absence of signs of pneumonia. 
• Macrolide antibiotics should be given early (1-2 weeks of disease) to children with pertussis. |
| 2. Amoxicillin | 500mg TDS | |
| Clarithromycin (if penicillin allergic) | 250-500mg BD | |
| 3. Doxycline | 200mg STAT then 100mg OD | |

### Infective Exacerbation of COPD

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<tbody>
<tr>
<td>1. No antibiotics (if viral infection suspected)</td>
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<td>• Antibiotics not indicated in absence of purulent/mucopurulent sputum.</td>
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</tbody>
</table>
| 2. Amoxicillin OR Doxycline (if penicillin allergic) | | | • Use antibiotics promptly if purulent sputum AND shortness of breath AND/OR increased sputum volume. 
• If treatment failure or resistance suspected, send sputum sample first, contact microbiology for advice and consider Co-amoxiclav 625mg TDS |
| 3. Clarithromycin | | | |

### Community acquired pneumonia

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</table>
| 1. Amoxicillin OR Clarithromycin OR (if penicillin allergic) | | | • Start antibiotics immediately. 
• Manage using clinical judgement & CRB-65 score with review. Each scores 1: Confusion (AMT<8); Respiratory rate >30/min; BP systolic <90 or diastolic ≤60. Score 0 – suitable for home treatment. Score 1-2 consider hospital referral. Score 3-4 urgent hospital admission. IF CRB65 =1 add clarithromycin or doxycycline alone to cover Mycoplasma infection (rare in > 65s). 
• If delayed admission or severely ill give parenteral benzylpenicillin before admission or amoxicillin 1G po |
| 2. Doxycline | | | |

### GASTRO-INTESTINAL TRACT INFECTIONS

#### Eradication of Helicobacter pylori

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| 1. Licensed PPI (e.g. lansoprazole capsules) PLUS Clarithromycin and Amoxicillin OR Clarithromycin and Metronidazole (if penicillin allergic) | | | • See BNF or HPA quick reference guide for alternative combinations. 
• Triple treatment attains >85% eradication. 
• Avoid clarithromycin or metronidazole if used in the past year for any infection. 
• Treatment failure – consider endoscopy for culture & susceptibility. Use 14days BD PPI PLUS 2 antibiotics, PLUS triportassium dicitrato bismuthate. 
• Eradication is beneficial in DU, GU and low grade malacia, but not in GORD. In NUD, 8% of patients benefit. |
| 2. Amoxicillin 1G po | | | |

#### Gastroenteritis (food poisoning)

**Antibiotics should not be used.** Use of antibiotics in the treatment of E.coli 0157 increases the risk of haemolytic uraemic syndrome. Fluid replacement is essential. Check travel, food and antibiotic history (C. difficile is increasing). Only initiate treatment on advice from Microbiologist, if the patient is systemically unwell or if Typhoid/ Paratyphoid suspected. Send stool samples from suspected cases of food poisoning and post antibiotic use. Food poisoning is notifiable. Notify and seek advice on exclusion from Consultant in Communicable Disease Control on 020 3049 4338

#### Traveller’s diarrhoea

**Limit prophylactic antibiotic prescribing for use abroad:** For people travelling to remote areas or cases where an episode of infective diarrhoea could be dangerous, use ciprofloxacin 750mg single dose. In areas of high ciprofloxacin resistance (Asia), advise prophylactic subsalicyclate (Pepto Bismol) 2 tablets QDS Seek specialist advice from Consultant Microbiologist on 0208 333 3262

#### Clostridium difficile

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| 1st/2nd episodes: Metronidazole | 400mg oral TDS | All 10-14 days | • Stop all unnecessary antibiotics and/or PPIs if possible to re-establish normal flora. 
• 70% respond to metronidazole in 5 days; 94% in 14 days. 
• Severe if T>38.5; low BP; WCC>15, renal impairment/ rising creatinine or signs/symptoms of severe colitis. |
| 3rd episode/severe: Vancomycin | 125mg oral QDS | |

#### Threadworms

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| 1. Mebendazole (patients >6 months) | 100mg | STAT | • Treat household contacts. 
• Advise morning shower/baths & hand hygiene. 
• Use piperazine in children under 6 months |
| 2. Piperazine (4g sachet mixed with water/ milk as instructed) (children <6m) | 3-12 months: 1 level 2.5ml spoonful 1-6 yr: 1 level 5ml spoonful | STAT, repeat after 2 weeks | |

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1. No antibiotics
2. Amoxicillin
3. Doxycline
4. Clarithromycin
5. Amoxicillin OR Doxycline
6. Clarithromycin OR
7. Doxycline
8. Metronidazole
9. Clari-thromycin
10. Clarithromycin OR
11. Amoxicillin OR
12. Clarithromycin OR
13. Amoxicillin OR
14. Clarithromycin OR
15. Doxycline
16. Amoxicillin 1G po
17. Metronidazole
18. Vancomycin
19. Mebendazole
20. Piperazine
21. Food poisoning
22. Traveller’s diarrhoea
23. Clostridium difficile
24. Threadworms
<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>DRUG OPTION</th>
<th>DOSE</th>
<th>DURATION</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Suspected meningococcal disease (HPA)</td>
<td>1. Benzylpenicillin IV (IM if vein cannot be found) (NOT if history of penicillin anaphylaxis)</td>
<td>Child &lt;1yr: 300mg/1-9yrs: 600mg Adults/child ≥10yrs: 1200mg</td>
<td>STAT dose prior to admission</td>
<td>• Transfer patient to hospital immediately. • Administer benzylpenicillin, unless history of anaphylaxis, NOT allergy. • Cefotaxime IV (adults/ children &gt;12 years:1g, children &lt;12 years: 50mg/kg) may be an alternative if available in patients with penicillin allergy (not anaphylaxis). • Meningitis is a notifiable disease.</td>
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<td>2. 2nd line depends on sensitivity of MSU. ESBL remain sensitive to nitrofurantoin or fosfomycin (available on named patient basis)</td>
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<tr>
<td>Uncomplicated UTI (i.e. no fever or flank pain) in men &amp; women HPA SIGN CKS</td>
<td>1. Nitrofurantoin OR Trimethoprim</td>
<td>100mg m/r BD</td>
<td>Stat post coital OR OD at night</td>
<td>• Post coital or nightly prophylaxis is equally effective but adverse effects.</td>
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<tr>
<td></td>
<td>Send MSU then start 1. Cefalexin OR 2. Nitrofurantoin OR Trimethoprim</td>
<td>500mg TDS 100mg m/r BD 200mg BD</td>
<td>All 7 days</td>
<td>• Review treatment on results of MSU. • Short-term use of trimethoprim or nitrofurantoin in pregnancy is unlikely to cause problems to the foetus. Avoid trimethoprim in 1st trimester &amp; nitrofurantoin at term. • Avoid trimethoprim if low folate status or taking folate antagonists (eg antiepileptics, proguanil)</td>
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<tr>
<td></td>
<td>Send for MSU then start 1. Ciprofloxacin OR 2. Co-amoxiclav</td>
<td>500mg BD 625mg TDS</td>
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<td>• Antibiotics will not eradicate bacteriuria. • Treat based on sensitivities. May require hospital admission.</td>
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<td>If asymptomatic - No antibiotic/action required. If symptomatic - Send CSU then change catheter. Only treat if systemically unwell or pyelonephritis likely (follow pyelonephritis above pending culture results).</td>
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<tr>
<td></td>
<td>Send MSU then start: 1. Trimethoprim OR Nitrofurantoin OR Cefalexin</td>
<td>1m - 12 yr: 4mg/kg (max.200mg) BD 3m - 12yrs:750mcg/kg QDS 12 - 18yrs: 50mg QDS 1m - 12yrs: 12.5mg/kg BD</td>
<td>All 3 days</td>
<td>• Refer children &lt;3 months to specialist. • If ≥3 months, use positive nitrite to start antibiotics. If only refer children &lt;6 months, or with atypical UTI for imaging • Double nitrofurantoin dose in 12-18 yr olds if severe chronic recurrent infection. • Double cefalexin dose if severe (max. 25mg/kg QDS or 1g QDS). • Double amoxicillin dose in severe infection.</td>
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<tr>
<td></td>
<td>2. If susceptible: Amoxicillin</td>
<td>1-12 m: 62.5mg TDS 1-5 yr: 125mg TDS 5-18 yr: 250mg TDS</td>
<td>3 days</td>
<td></td>
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<tr>
<td></td>
<td>1. Co-amoxiclav</td>
<td>1-12 m: 0.25mg/kg TDS 1-6 yr: 125/31mg TDS 6-12 yr: 250/62mg TDS 12-18 yr: 250/125mg TDS</td>
<td>7-10 days</td>
<td>• Dose for 1-12m: use 125/31 in 5ml suspension • Double dose in severe infection.</td>
</tr>
<tr>
<td>Genital tract infections</td>
<td>1. Metronidazole IV</td>
<td>400mg BD orally</td>
<td>5 days</td>
<td>• A 5 day course of oral metronidazole is slightly more effective than 2 g stat. • Avoid metronidazole 2g stat dose in pregnancy and breast feeding. • Topical treatment gives similar cure rates but is more expensive. • Clindamycin cream damages latex condoms • Avoid alcohol during treatment with</td>
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<td>2. Metronidazole 0.75% vag gel</td>
<td>5g applicatorful at night</td>
<td>5 nights</td>
<td></td>
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<tr>
<td></td>
<td>3. Clindamycin 2% cream</td>
<td>5g applicatorful at night</td>
<td>7 nights</td>
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</tbody>
</table>
**SKIN / SOFT TISSUE INFECTIONS**

<table>
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<tr>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaginal candidiasis</strong></td>
<td>1. Clotrimazole 10% 5g vaginal cream</td>
<td>All STAT doses</td>
<td>• All topical and oral azoles give 80-95% cure.</td>
</tr>
<tr>
<td></td>
<td>2. Clotrimazole pessary 500mg pessary 150mg orally</td>
<td></td>
<td>• In pregnancy avoid oral azole.</td>
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<tr>
<td></td>
<td>3. Fluconazole</td>
<td></td>
<td>• Clotrimazole may damage latex condoms.</td>
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<tr>
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<td></td>
<td>• If refractory/recurrence, send HSV for culture</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong></td>
<td>1. Cefixime A (Unlicensed) 400mg</td>
<td>All STAT doses</td>
<td>• Partner notification; Test contacts and treat at initial visit or refer to sexual health clinic.</td>
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<tr>
<td></td>
<td>2. Ciprofloxacin B (NOT in pregnancy/ breastfeeding) 500mg</td>
<td></td>
<td>• Patients with +ve GC NAAT test should have charcoal swabs for antibiotic sensitivities. Treat empirically before results return and change according to sensitivities.</td>
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<td></td>
<td>• If the index case’s chlamydia status is +ve or unknown, treat contacts for Chlamydia as well.</td>
</tr>
<tr>
<td><strong>Chlamydia trachomatis</strong></td>
<td>1. Azithromycin ** (Unlicensed) 1g 1hr before or 2hrs after food STAT</td>
<td>7 days</td>
<td>• Partner notification; Test contacts and treat at initial visit or refer to sexual health clinic.</td>
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<td>2. Doxycycline ** (NOT in pregnancy/ breastfeeding) 100mg BD 7 days</td>
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<td>• In pregnancy/breastfeeding: azithromycin can be used but is ‘off label’.</td>
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<td>3. Erythromycin A+ (if patient unwilling to use off-licence treatment) 500mg BD or 500mg QDS 7 days</td>
<td></td>
<td>• If erythromycin used, retest after 5 weeks, as less effective.</td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong></td>
<td>1. Metronidazole A+ 400mg BD (or 2g STAT) 5 days</td>
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<td>• Test for chlamydia and gonorrhoea (dual NAATs test)</td>
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<td></td>
<td>2. Clotrimazole 100mg pessary 6 days</td>
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<td>• Treat partners simultaneously.</td>
</tr>
<tr>
<td><strong>Acute Pelvic Inflammatory Disease (PID)</strong></td>
<td>1. Cefixime PLUS Metronidazole PLUS Doxycycline 400mg stat 400mg BD 100mg BD stat 5 days 14 days</td>
<td></td>
<td>• Avoid metronidazole 2g stat in pregnancy/ breastfeeding.</td>
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<tr>
<td></td>
<td>2. Cefixime PLUS Metronidazole PLUS Erythromycin 400mg stat 400mg BD 500mg BD stat 5 days 14 days</td>
<td></td>
<td>• Topical clotrimazole gives symptomatic relief (not cure).</td>
</tr>
<tr>
<td><strong>Acute prostatitis</strong></td>
<td>1. Ciprofloxacin OR Ofloxacin 500mg BD 28 days</td>
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<td>• Avoid alcohol during treatment with metronidazole and for 2 days after.</td>
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<tr>
<td></td>
<td>2. Trimethoprim 200mg BD 28 days</td>
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<td>• Test and treat for N. gonorrhoea and chlamydia.</td>
</tr>
<tr>
<td><strong>SKIN / SOFT TISSUE INFECTIONS</strong></td>
<td>Notes: 1.Send swabs for culture if persistent recurrent pustules and carbuncles or cellulitis to exclude Panton-Valentine Leukocidin (PVL; toxin produced by Staph. aureas). Risk factors include: nursing homes, contact sports, sharing equipment, poor hygiene and eczema. See HPA guidelines for advice on management and treatment at <a href="http://www.hpa.org.uk">www.hpa.org.uk</a> and seek advice from local microbiologist. 2. When treating infections, consideration should be given to if the patient has had a positive MRSA culture in the past, and if so, advice on agent choice should be sought from microbiology.</td>
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**Impetigo**

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<tr>
<th>Treatment</th>
<th>Duration</th>
<th>Notes</th>
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<tbody>
<tr>
<td>1. Fluocloxacillin 500mg QDS 250-500mg BD</td>
<td>All 7 days</td>
<td>• Resistance to topical antibiotics is increasing. Reserve for very localised lesions C or D</td>
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<tr>
<td>2. Clarithromycin (if penicillin allergic)</td>
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<td>• Reserve mupirocin for MRSA only.</td>
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**Eczema**

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<th>Treatment</th>
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<th>Notes</th>
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<tbody>
<tr>
<td>No antibiotics</td>
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<td>- do not improve healing unless visible signs of infection. If infected use treatment as in impetigo.</td>
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**Cellulitis**

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<th>Duration</th>
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<tbody>
<tr>
<td>1. Fluocloxacillin 500mg QDS</td>
<td>All 7-14 days</td>
<td>• If patient febrile and healthy other than cellulitis, use fluocloxacillin alone. If water exposure, discuss with microbiologist.</td>
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<tr>
<td>2. Clarithromycin (if penicillin allergic)</td>
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<td>• If febrile and ill, admit for IV treatment.</td>
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**Facial cellulitis**

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<th>Treatment</th>
<th>Duration</th>
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<tbody>
<tr>
<td>1. Co-amoxiclav A+ 625mg TDS</td>
<td>7-14 days</td>
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**Leg ulcers**

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<tr>
<th>Treatment</th>
<th>Duration</th>
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<tr>
<td>No antibiotics. Bacteria will always be present. Antibiotics do not improve healing. Culture swabs and antibiotics are only indicated if there is evidence of clinical cellulitis; increased pain; purulent exudate; enlarging ulcer or pyrexia. If antibiotic indicated, treat as for cellulitis. Seek specialist opinion if severe.</td>
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**Diabetic leg ulcers**

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<th>Duration</th>
<th>Notes</th>
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<tbody>
<tr>
<td>1. Fluocloxicillin plus Metronidazole 1 gram QDS 400mg TDS</td>
<td>7 days, then review</td>
<td>• Always send swab to microbiology before starting antibiotics.</td>
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<tr>
<td>2. Cefalexin plus Metronidazole (if penicillin allergic)</td>
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<td>• Antibiotics to be prescribed if clinical signs of infection are present at initial presentation.</td>
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<td>• Review antibiotics after culture results.</td>
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<td>• Refer for specialist opinion if moderate or severe infection, or wound probing to bone.</td>
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<td>• If febrile and ill, admit for IV treatment.</td>
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<tr>
<td>ILLNESS</td>
<td>DRUG OPTION</td>
<td>DOSE</td>
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<td>---------</td>
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</tr>
<tr>
<td>Animal and human bite prophylaxis &amp; treatment</td>
<td>1. Co-amoxiclav B-</td>
<td>625mg TDS</td>
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<tr>
<td></td>
<td>2. If penicillin allergic: Metronidazole PLUS Doxycycline (animal/man) OR Clarithromycin (human)</td>
<td>200-400mg TDS 100mg BD 250-500mg QDS 250-500mg BD</td>
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<tr>
<td>Acne</td>
<td>1. Oxytetracycline</td>
<td>500mg BD</td>
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<td></td>
<td>2. Erythromycin</td>
<td>500mg BD</td>
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<tr>
<td>Dermatophyte infection of the proximal fingernail or toenail</td>
<td>1. Take nail clippings and await results (treat if confirmed infection)</td>
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<td>2. Amorolfine 5% nail lacquer (for superficial) B OR Terbinafine A</td>
<td>1-2 times weekly Fingers: 6 months 250mg OD Fingers: 12 months 12 months Toes: 6-12 weeks 3-6 months</td>
</tr>
</tbody>
</table>
| | 3. Itraconazole | 200mg BD 7 days monthly Fingers: 2 courses Toes: 3 courses | | • Use itraconazole for infections with yeasts and non-dermatophyte moulds.

For children seek advice

**Note:** Level of Evidence:
- A+ Approved: June 2010, and January 2012. Review date: Mar 2013
- A One or more retrospective studies
- B One or more prospective studies
- C Formal combination of expert opinion
- D Informal opinion, other info

**Produced by Kenneth Chan & Kath Howes, June 2010**
Prescribing & Medicines Management Team with input from Local Microbiologist, Antibiotic pharmacist and Sexual Health Lead Approved: June 2010, and January 2012. Review date: Mar 2013