Summary tables: infections in primary care

**Principles of Treatment**

1. This guidance is based on the best available evidence but use professional judgement and involve patients in management decisions.
2. It is important to initiate antibiotics as soon as possible in severe infection.
3. Where an empirical therapy has failed or special circumstances exist, microbiological advice can be obtained from ** or **.
4. Prescribe an antibiotic only when there is likely to be a clear clinical benefit.
6. Limit prescribing over the telephone to exceptional cases.
7. Use simple generic antibiotics if possible. Avoid broad spectrum antibiotics (eg. co-amoxiclav, quinolones and cephalosporins) when narrow spectrum antibiotics remain effective, as they increase risk of Clostridium difficile, MRSA and resistant UTIs.
8. A dose and duration of treatment for adults is usually suggested, but may need modification for age, weight and renal function.
9. In severe or recurrent cases consider a larger dose or longer course.
10. Please refer to BNF for further dosing and interaction information (e.g. interaction between macrolide and statins) if needed and please check for hypersensitivity.
11. Lower threshold for antibiotics in immunocompromised or those with multiple morbidities; consider culture and seek advice.
12. Avoid widespread use of topical antibiotics (especially those agents also available as systemic preparations, eg. fusidic acid).
13. In pregnancy take specimens to inform treatment; where possible avoid tetracyclines, aminoglycosides, quinolones, high dose metronidazole (2 g) unless benefit outweighs risks. Short-term use of nitrofurantoin (at term, theoretical risk of neonatal haemolysis) is not expected to cause fetal problems. Trimethoprim is also unlikely to cause problems unless poor dietary folate intake or taking another folate antagonist eg antiepileptic.
14. This guidance should not be used in isolation; it should be supported with patient information about back-up/delayed antibiotics, infection severity and usual duration of treatment, clinical staff education, and audits. Materials are available on the RCGP website.

**ILLNESS** | **GOOD PRACTICE POINTS** | **DRUG** | **ADULT DOSE** | **DURATION OF TREATMENT**
--- | --- | --- | --- | ---
**UPPER RESPIRATORY TRACT INFECTIONS**

### Influenza treatment
**PHE Influenza**

**For prophylaxis see: NICE Influenza**

**Acute sore throat**
**CKS**

**FeverPAIN**

Avoid antibiotics as 90% resolve in 7 days, with pain only reduced by 16 hours.

Use **FeverPAIN Score**: Fever in last 24h, Purulence, Attend rapidly under 3d, severely Inflamed tonsils, No cough or coryza.

- Score 0-1: 13-18% streptococci, use NO antibiotic strategy; 2-3: 34-40% streptococci, use 3 day back-up antibiotic; 4 or more: 62-65% streptococci, use immediate antibiotic if severe, or 48h short back-up prescription.

- Always share self-care advice & safety net.

Antibiotics to prevent Quinsy NNT >4000.

Antibiotics to prevent Mastoiditis NNT >4000.

**Penicillin Allergy:** clarithromycin

- 500mg QDS or 1G BD (500mg QDS when severe)**

- 250-500mg BD

- 5 days**

**Acute Otitis Media (child doses)**

**NICE OM**

Optimise analgesia and target antibiotics. AOM resolves in 60% in 24hrs without antibiotics, which only reduce pain at 2 days (NNT15) and does not prevent deafness.

Consider 2 or 3-day delayed or immediate antibiotics for pain relief if:

- <2 years AND bilateral AOM (NNT4) or bulging membrane and ≥ 4 marked symptoms.

- All ages with otorrhoea NNT1.3a.

- 10d penicillin lower relapse vs 7d in <1yrs.

- Amoxicillin 87a

- 87 days**

**Penicillin Allergy:** erythromycin

- ND

- 2-8 years 250mg QDS

- 8-18 years 250-500mg QDS

- 5 days**

**Acute Otitis Externa**

**CKS OE**

First use analgesia. Cure rates similar at 7 days for topical acetic acid or antibiotic +/- steroid. If cellulitis/disease extending outside ear canal, start oral antibiotics & refer to exclude malignant OE.

**First Line:** acetic acid 2%

**Second Line:** neomycin sulphate with corticosteroid 3a-4b.

- 1 spray TDS

- 3 drops TDS

- 7 days

**Acute Rhinosinusitis**

**CKS RS**

Avoid antibiotics as 80% resolve in 14 days without; they only offer marginal benefit after 7 days NNT15.3a.4b

**Use adequate analgesia.** Consider 7-day delayed or immediate antibiotic when purulent nasal discharge NNT1.3a.

In persistent infection use an agent with anti-anacrobic activity eg, co-amoxiclav.

**Amoxicillin 87a or doxycycline (if severe)**

- 500mg TDS

- 1g if severe 1d

- 200mg stat then100mg OD

- 500mg QDS

- 7 days**

- 7 days

- 7 days

- 7 days

**Summary tables: infections in primary care**

**Produced 2000; last full review 2012, last update 25.01.2017**

**Next full Review: Mar 2017**

**Endorsed by:**

**BIAM**

**RCPs**

**RCPG**

**TARGET website**
Acute cough bronchitis CKS 2
NICE 69
Antibiotic little benefit if no co-morbidity,1,1A
Consider 7d delayed antibiotic with advice.1,1A
Symptom resolution can take 3 weeks.
Consider immediate antibiotics if >80yr and ONE of:
Hospitalisation in past year, oral steroids, 
diabetic, congestive heart failure OR > 65yrs with 2 
of above.
Consider CRP test 1A,1A if antibiotic being considered.
If CRP>20mg/L no antibiotics, 20-100mg/L 
delayed, CRP>100mg immediate antibiotics.

Acute exacerbation of COPD NICE 12
GOLD
Treating exacerbations promptly with antibiotics if 
purulent sputum and increased shortness of breath 
and/or increased sputum volume.1,1B
Risk factors for antibiotic resistant organisms 
include co-morbid disease, severe COPD, frequent 
exacerbations, antibiotics in last 3 months.2

Community acquired pneumonia—treatment in 
the community2,3
BTS 2009
Use CRB65 score to guide mortality risk, place of 
care & antibiotics3 Each CRB65 parameter scores 1:
Confusion (AMT≤8) Respiratory rate >50/min; 
BP systolic <90 or diastolic ≤60; Age ≥65;
Score 0-4 urgent hospital admission; Score 1-2 
intermediate risk consider hospital assessment;
Score 0 low risk: consider home based care.
Always give safety-net advice and likely duration 
of symptoms. Mycoplasma infection is rare in >65s.1

Acute UTI in adults (lower)
PHE URINE
SIGN
All patients first line antibiotic:
nitrofurantoin if GFR >55ml/min; if GFR30- 
45,2B,28-2B+ only use if resistance and no alternative.
Women (mild ≤2 symptoms):1A1 Pain relief 42A-
43A1 and consider back-up/ delayed antibiotic 19A1
If urine not cloudy, 97% NPV of UTI1A1
If urine cloudy, use dipstick to guide treatment: 
nitrite, leucocytes, all blood negative 76% NPV;
nitrite plus blood or leucocytes 92% PPV of UTI.4A1
Women: Consider prophylaxis and send MSU1A1
CKS women
If urine cloudy, use dipstick to guide treatment: 
nitrite, leucocytes, all blood negative 76% NPV;
nitrite plus blood or leucocytes 92% PPV of UTI.4A1
Men: Consider prophylaxis and send MSU1A1
RCPG UTI 
clinical module
If symptoms mild/non-specific, use negative 
dipstick to exclude UTI.
>65 years: treat if fever ≥23.8°C or 1.5°C above base 
twice in 12h AND dysuria OR ≥2 other symptoms.10
If treatment failure: always perform culture.1A1

Acute prostate 
PHE URINE 
BASHELL, CKS
Send MSU for culture and start antibiotics.1C
4 week course may prevent chronic prostatitis.3D
Quinolones achieve higher prostate levels.2D

Acute pneumonia
PHE URINE
NICE
UTI in pregnancy
PHE URINE
UKiks
Send MSU for culture: start antibiotics in all with 
significant bacteriae, even if asymptomatic.1A
Short-term use of nitrofurantoin is unlikely to cause 
problems to the foetus.22A Avoid trimethoprim if 
low folate status or on folate antagonist.

Acute pyelonephritis
CKS
If admission not needed, send MSU for culture & 
susceptibility testing, and start antibiotics.
If no response within 24 hours, seek advice.1D,2D
If ESBL risk and with microbiology advice 
consider IV antibiotic via outpatients (OPAT) 6C

Recurrent UTI in non-
pregnant women:
2 in months or 
≥3 UTIs/year
First line: Advise simple measures, incl. hydration & 
analgesia. - Cranberry products work for some 
women, but good evidence is lacking.
Second line: Standby or post-coital antibiotics 1A,3B+
Third line: Antibiotic prophylaxis 1A,2A Consider 
metamethine if no renal or hepatic impairment 1A,9A

First line: nitrofurantoin 
If resistance: co-amoxiclav
500mg TDS 200mg stat then100mg OD 5 days 4A+
200mg BD (label)

First line: nitrofurantoin 
If recent culture sensitive: trimethoprim
500mg BD 200mg BD (label)
At night OR 
post-coital stat (off-label)3,3B 3-6 months; then 
review recurrence rate and need 1C

If CRB65=0: amoxicillin** or clarithromycin ** 
or doxycycline
500mg TDS 200mg BD 100mg OD 5 days** 5 days**
200mg BD (label)
CRB65≥1: use 5. Days. Review at 3 days & 
extend to 7-10 days if poor response.

CRB65≥2: 4A 7-10 days

Low risk of resistance: younger women with acute UTI and no resistance risks.
Risk factors for increased resistance include: care home resident,1B recurrent UTI (2 in 6 months; ≥3 in 12 months), hospitalisation for >7d in the last 6 months, unresolved urinary symptoms, recent travel to a country with increased resistance, previous UTI resistant to trimethoprim, cephalosporins, or quinolones.1B

If resistance: send urine for culture & susceptibilities, & always safety net.

At night OR 
post-coital stat (off-label)3,3B 3-6 months; then 
review recurrence rate and need 1C
<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>GOOD PRACTICE POINTS</th>
<th>DRUG</th>
<th>ADULT DOSE</th>
<th>DURATION OF TREATMENT</th>
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</thead>
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<tr>
<td><strong>MENINGITIS (NICE fever guidelines)</strong></td>
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<tr>
<td>Suspected meningococcal disease</td>
<td>Transfer all patients to hospital immediately. If time before hospital admission, and non-blanching rash, give IV benzylpenicillin or cefotaxime.</td>
<td>IV or IM benzylpenicillin OR IV or IM cefotaxime</td>
<td>Age 10+ years: 1200mg Children 1-9 yr: 600mg Children &lt;1 yr: 300mg</td>
<td>Give IM if vein cannot be found</td>
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<tr>
<td>PHE Meningo</td>
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<tr>
<td>Prevention of secondary case of meningitis</td>
<td>Only prescribe following advice from Public Health Doctor: 9 am – 5 pm:</td>
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<td>Out of hours: Contact on-call doctor via ……… switchboard</td>
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<tr>
<td><strong>GASTRO INTESTINAL TRACT INFECTIONS</strong></td>
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<tr>
<td>Oral candidiasis</td>
<td>Topical azoles more effective than topical nystatin. Oral candidiasis rare in immunocompetent adults; consider undiagnosed risk factors including HIV. Fluconazole if extensive/severe candidiasis; if HIV or immunosuppression use 100mg.</td>
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<tr>
<td>CKS</td>
<td>Miconazole oral gel 1,2,4,5,6-7 If miconazole not tolerated nystatin suspension 1,2,4,5,6-7. Fluconazole oral tablets 1,2,4,5,6-7</td>
<td>20mg/mL QDS</td>
<td>7 days1A or until 2 days1C after symptoms 7 days1C further 7 days if persistent</td>
<td></td>
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<tr>
<td>Eradication of Helicobacter pylori</td>
<td>Treat all positives if known DU, GU 1A low grade MAL.Toma, 1A or NNT in Non-Ulcer dyspepsia 1,2A,4-6. Do not offer eradication for GORD.1C</td>
<td>All for 7 days 1,1A+</td>
<td></td>
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<tr>
<td>NICE dyspepsia</td>
<td>Do not use clarithromycin, metronidazole or quinolone if used in past year for any infection 5,6A+</td>
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<tr>
<td>NICE H.pylori</td>
<td>Penicillin allergy 1: use PPI + clarithromycin &amp; MTZ. If previous clarithromycin use PPI + bismuth salt + metronidazole + tetracycline. Relapse and previous MTZ &amp; clari: 1 use PPI + amoxicillin + either tetracycline or levofloxacin. Penicillin allergy: PPI + tetracycline + levofloxacin.</td>
<td>Always use PPI: 1A+ PPI WITH amoxicillin or either clarithromycin OR metronidazole1A+</td>
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<tr>
<td>PHE H.pylori</td>
<td>De-no tab (tripotassium dicarbamatb)1</td>
<td>Penicillin allergy &amp; previous clarithromycin 1PPI WITH 1A+</td>
<td>240mg BD</td>
<td></td>
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<tr>
<td>PHE</td>
<td>OR bismuth subsalicylate 1C,2A+ + metronidazole + tetracycline hydrochloride.</td>
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<tr>
<td>Replicate &amp; previous MTZ: clari 1 use PPI + amoxicillin + either tetracycline or levofloxacin.1 Penicillin allergy: PPI + tetracycline + levofloxacin.</td>
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<tr>
<td><strong>INFECTION GUIDANCE</strong></td>
<td>Retest for H.pylori 1 post DU/GU or relapse after second line therapy: using breath or stool test OR consider endoscopy for culture &amp; susceptibility.</td>
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<tr>
<td><strong>Infectious diarrhoea</strong></td>
<td>Refer previously healthy children with acute painful or bloody diarrhoea to exclude <em>E. coli</em> 0157 infection. 1A+</td>
<td>Antibiotic therapy usually not indicated unless systematically unwell. 1C If systematically unwell and campylobacter suspected (e.g. undercooked meat and abdominal pain), consider clarithromycin 250–500 mg BD for 5–7 days, if treated early (within 3 days).1C</td>
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<tr>
<td>CKS</td>
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<tr>
<td><strong>Clostridium difficile</strong></td>
<td>Stop unnecessary antibiotics and/or PPIs. 1A+ 70% respond to MTZ in 5 days; 92% in 14 days. If severe symptoms or signs (below) should treat with oral vancomycin, review progress closely and/or consider referral. Definition of severe: Temperature &gt;38.5°C, or WCC &gt;15, or rising creatinine or signs/symptoms of severe colitis.1C</td>
<td>1st episode: metronidazole (MTZ)1A+ 2nd episode/severe/toxy 027: oral vancomycin 1A+</td>
<td>400mg or 500mg TDS</td>
<td>10-14 days 1C</td>
</tr>
<tr>
<td>DH</td>
<td></td>
<td>Recurrent disease see rational guidelines.</td>
<td>125mg QDS</td>
<td>10-14 days 1C</td>
</tr>
<tr>
<td>PHE</td>
<td>Oral vancomycin or fidaxomicin</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>125mg QDS, consider taper</td>
<td>200mg BD</td>
<td>10-14 days 1C</td>
</tr>
<tr>
<td><strong>Traveller’s diarrhoea</strong></td>
<td>Only consider standby antibiotics for remote areas or people at high-risk of severe illness with travellers’ diarrhoea. 1C+ If standby treatment appropriate give ciprofloxacin 500mg twice a day for 3 days (private Rx).1A+ 1C If quinolone resistance high (eg south Asia): consider bismuth subsalicylate (Pepto Bismol) 2 tablets QDS as prophylaxis1C or for 2 days treatment.1C+</td>
<td>100mg 1C</td>
<td></td>
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<tr>
<td>CKS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Threadworm</strong></td>
<td>Treat all household contacts at the same time.</td>
<td>All patients over 6 months: mebendazole (off-label if &lt;2yrs). Child &lt;6 mths mebendazole is unlicensed, use hygiene measures alone for 6 weeks1C.</td>
<td>100mg 1C</td>
<td>Stat dose, but repeat in 10 days if infestation persists</td>
</tr>
<tr>
<td>CKS threadworm</td>
<td>Treat all household contacts at the same time.</td>
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<tr>
<td><strong>GENITAL TRACT INFECTIONS</strong></td>
<td>Contact UKTIS for information on foetal risks if patient is pregnant.</td>
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<tr>
<td>STI screening</td>
<td>People with risk factors should be screened for chlamydia, gonorrhoea, HIV, syphilis. Refer individual and partners to GUM service. Risk factors: &lt;25yr, no condom use, recent (&lt;12mth)/frequent change of partner, symptomatic partner, area of high HIV.1,2+</td>
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<tr>
<td>Chlamydia trachomatis/urthritis</td>
<td>Opportunistically screen all aged 15-25 years. 1A+ Treat partners and refer to GUM service. 1A+ Pregnancy2C or breastfeeding: azithromycin is the most effective option. 1A+ Due to lower cure rate in pregnancy, test for cure 6 weeks after treatment.1C</td>
<td>Azithromycin 1A+ or doxycycline1A+</td>
<td>1g</td>
<td>Stat 4A+ 7 days</td>
</tr>
<tr>
<td>SIGN, BASHH</td>
<td></td>
<td>Pregnant or breastfeeding: azithromycin1A+ or erythromycin5A+ or amoxicillin1A+</td>
<td>100mg BD</td>
<td>Stat 4A+ 7 days</td>
</tr>
<tr>
<td>PHE, CKS</td>
<td></td>
<td>or doxycycline1A+</td>
<td>100mg BD</td>
<td>Stat 4A+ 7 days</td>
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<td></td>
<td></td>
<td>or fluoroquinolones 1A+</td>
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<td></td>
<td></td>
<td>or oral fluoroquinolones 1A+</td>
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<tr>
<td>Epididymitis</td>
<td>For suspected epididymitis in men over 35 years with low risk of STI1C (High risk, refer GUM).1C</td>
<td>Ofloxacin or doxycycline</td>
<td>200mg BD</td>
<td>14 days</td>
</tr>
<tr>
<td>Vaginal Candidiasis</td>
<td>All topical and oral azoles give 75% cure.1A+ In pregnancy avoid oral azoles 2B, and use intravaginal treatment for 7 days. 1A, 2A, 2B-</td>
<td>Clotrimazole1A+ or oral fluconazole 1A+ or miconazole 2% cream1A+</td>
<td>500mg pess or 10% cream 150mg orally 100mg pessary at night 5 intravaginally BD</td>
<td>Stat 7 days 1C</td>
</tr>
<tr>
<td>BASHH</td>
<td></td>
<td>Pregnant: clotrimazole 3A+ or miconazole 2% cream1A+</td>
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</tr>
<tr>
<td>PHE, CKS</td>
<td></td>
<td>OR MTZ 0.75% vag gel1A+</td>
<td>400mg BD</td>
<td>Stat 3A 7 days</td>
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<tr>
<td></td>
<td></td>
<td>or clindamycin 2% cream1A+</td>
<td>or 2g stat 5 nights</td>
<td></td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>Oral metronidazole7A+ is as effective as topical metronidazole1A+ but is cheaper. Less relapse with 7 days than 2g stat at 4 weeks.3A-</td>
<td></td>
<td>7 days 1C</td>
<td></td>
</tr>
<tr>
<td>BASHH</td>
<td></td>
<td>Pregnant: clotrimazole 3A+ or miconazole 2% cream1A+</td>
<td>150mg orally 100mg pessary at night 5 intravaginally BD</td>
<td>Stat 3A 7 days</td>
</tr>
<tr>
<td>PHE</td>
<td></td>
<td>OR MTZ 0.75% vag gel1A+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKS</td>
<td></td>
<td>or clindamycin 2% crem1A+</td>
<td>5g applicator at night</td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Antibiotic resistance is now very high.1C Use IM ceftriaxone plus azithromycin and refer to GUM 1B</td>
<td>Ceftriaxone1B+ PLUS azithromycin 3B-3B+</td>
<td>500mg IM</td>
<td>Stat</td>
</tr>
</tbody>
</table>
### SKIN INFECTIONS – For MRSA infection see PHE Quick Reference Guide

<table>
<thead>
<tr>
<th>ILLNESS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Impetigo</td>
<td>For extensive, severe, or bullous impetigo, use oral antibiotics.</td>
<td>Oral flucloxacinil (1C)</td>
<td>500mg QDS</td>
<td>7 days</td>
</tr>
<tr>
<td>CKS</td>
<td>Reserve topical antibiotics for very localised lesions to reduce the risk of resistance. (1C, 4B)</td>
<td>If penicillin allergic: (2C) oral clarithromycin</td>
<td>250-500mg BD</td>
<td>7 days</td>
</tr>
<tr>
<td>PHE</td>
<td></td>
<td>Topical fusidic acid (3B)</td>
<td>TDS</td>
<td>5 days</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Class I: patient afebrile and healthy other than cellulitis, use oral flucloxacinil alone. (1,2C)</td>
<td>If penicillin allergic: (2C) metronidazole PLUS doxycycline (cat/dog/man)</td>
<td>500mg QDS</td>
<td>All for 7 days. If skin infection unable to cover 7 days, (4C)</td>
</tr>
<tr>
<td>Leg ulcer</td>
<td>Ulcers always colonised. Antibiotics do not improve healing unless active infection. (1A)</td>
<td>Active infection if cellulitis/increased pain/pyrexia/purulent exudate/odour. (3C)</td>
<td>500mg QDS</td>
<td>2 applications (1C)</td>
</tr>
<tr>
<td>PHE</td>
<td>If indicated: (2C) if recurrent boils/abscesses.</td>
<td>cvfloxacinil or clarithromycin</td>
<td>500mg BD</td>
<td>As for cellulitis</td>
</tr>
<tr>
<td>Scabies</td>
<td>Treat whole body from ear/chin downwards and under nails. If under 2/elderly, also face/scalp. (1C)</td>
<td>Permethrin (5C)</td>
<td>5% cream</td>
<td>2 applications (3B) weekly.</td>
</tr>
<tr>
<td>PHE</td>
<td>As for cellulitis</td>
<td>If allergy: malathion (3C)</td>
<td>0.5% aqueous liquid</td>
<td>1 week apart.</td>
</tr>
<tr>
<td>Dermatophyte infection - skin</td>
<td>Terbinafine is fungicidal; (1C) treatment time shorter than with fungistatic imidazoles.</td>
<td>Topical terbinafine (1A,5C)</td>
<td>BD</td>
<td>1-2 weeks (4A) for 1-2 wks after healing (i.e. 4-6wks) (1A)</td>
</tr>
<tr>
<td>CKS</td>
<td>If candida possible, use imidazoles. (1C)</td>
<td>or topical imidazoles (3A)</td>
<td>BD</td>
<td></td>
</tr>
</tbody>
</table>
| | If intractable, send skin scrapings, \(2C\) and if infection confirmed, use oral terbinafine/itraconazole. \(1B, 3C\) | or (athlete’s foot only): topical unendocanates: Micona
taline | 250mg OD BD | 6 - 12 weeks |
| | For children, seek specialist advice. \(1C\) | First line: terbinafine \(5A\) | fingers | 3 – 6 months |
| Dermatophyte infection - nail | Take nail clippings: start therapy only if infection is confirmed by laboratory. \(1C\) | Second line: itraconazole \(6A\) | 200mg BD | 7 days monthly |
| CKS | Oral terbinafine is more effective than oral azole. \(5\) | Third line for very superficial as limited evidence of effectiveness: amorolfine 5% | 1-2x/weekly | 3 courses |
| | Liver reactions rare with oral antifungals. \(2A\) | nail lacquer \(5B\) | fingers | 12 months |
| Varicella zoster/chicken pox | Pregnant/immunocompromised/neonate: seek urgent specialist advice. \(1B\) | If indicated: aciclovir \(3B\) | 800mg five times a day | 7 days. |
| CKS | Chicken pox: IF onset of rash <24hrs & >14 years or severe pain or dense/oral rash or 2 household cases or steroids or smoker, consider aciclovir. \(1A\) | | | |
| Herpes zoster / shingles | Shingles: treat if >50 years \(3B\) and within 72 hrs of rash, \(4B\) (PHN rare if <50 years \(3\)); or if active | Second line for shingles if compliance a problem, as ten times cost | 1g TDS | 7 days \(10B\) |
| CKS | opthalmic \(4B\) or Ramsey Hunt \(4C\) or eczema. | valaciclovir \(10B\) or famciclovir \(11B\) | 500mg TDS or 750mg BD | 7 days \(11B\) |
| Cold sores | Cold sores resolve after 7–10d without treatment. Topical antiviral applied profoundly reduce duration by 12-24hrs \(1A,2B,4\) | | | |

### EYE INFECTIONS

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>GOOD PRACTICE POINTS</th>
<th>DRUG</th>
<th>ADULT DOSE</th>
<th>DURATION OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td>Treat if severe, as most viral or self-limiting. Bacterial conjunctivitis is usually unilateral and also self-limiting; (5) it is characterised by red eye with mucopurulent, not watery, discharge; (65%) resolve on placebo by day five. (3A)</td>
<td>Chloramphenicol 0.5% drop and 1% ointment</td>
<td>2 hours for 2 days then 4 hourly (whilst awake) at night</td>
<td>All for 48 hours after resolution</td>
</tr>
<tr>
<td>CKS</td>
<td>Fusidic acid has less Gram-negative activity. (5)</td>
<td>Second line: fusidic acid 1% gel</td>
<td>Two times a day</td>
<td></td>
</tr>
</tbody>
</table>
Summary table – dental infections treated in primary care outside dental setting

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>COMMENTS</th>
<th>DRUG</th>
<th>ADULT DOSE</th>
<th>DURATION OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucosal ulceration and inflammation</td>
<td>Temporary pain and swelling relief can be attained with saline mouthwash,¹ ³ ⁴</td>
<td>Simple saline mouthwash ⁴</td>
<td>½ tsp salt dissolved in glass warm water</td>
<td>Always spit out after use.</td>
</tr>
<tr>
<td>(simple gingivitis)</td>
<td>Use antiseptic mouthwash if more severe and pain limits oral hygiene to treat or prevent secondary infection.¹ ³ ⁴</td>
<td>Chlorhexidine ⁰.¹²-0.²% ⁶-⁷</td>
<td>Rinse mouth for 1 minute BD with 5 ml diluted with 5-10 ml water.</td>
<td>Use until lesions resolve or less pain allows oral hygiene</td>
</tr>
<tr>
<td></td>
<td>The primary cause for mucosal ulceration or inflammation (aphthous ulcers, oral lichen planus, herpes simplex infection, oral cancer) needs to be evaluated and treated.</td>
<td>Hydrogen peroxide ⁶% ⁸ ⁹ ¹⁰</td>
<td>Rinse mouth for 2 mins TDS with 15ml diluted in ½ glass warm water</td>
<td></td>
</tr>
<tr>
<td>Acute necrotising ulcerative gingivitis</td>
<td>Commence metronidazole ¹ ² and refer to dentist for scaling and oral hygiene advice.⁵</td>
<td>Metronidazole ¹ ²</td>
<td>⁴⁰⁰mg TDS</td>
<td>³ days</td>
</tr>
<tr>
<td>(apositive Bacteroides, Prevotella spp., Peptostreptococcus spp., Actinomyces spp., Porphyromonas gingivalis)</td>
<td>Use in combination with antiseptic mouthwash if pain limits oral hygiene.</td>
<td>Chlorhexidine or hydrogen peroxide</td>
<td>See above dosing in mucosal ulceration</td>
<td>Until oral hygiene possible</td>
</tr>
<tr>
<td>Pericoronitis</td>
<td>Refer to dentist for irrigation &amp; debridement.¹ ³ ⁴</td>
<td>Amoxicillin</td>
<td>⁵⁰⁰mg TDS</td>
<td>³ days</td>
</tr>
<tr>
<td></td>
<td>If persistent swelling or systemic symptoms use metronidazole ¹ ³ ⁴ ⁵</td>
<td>Metronidazole ¹ ³ ⁴ ⁵</td>
<td>⁴⁰⁰mg TDS</td>
<td>³ days</td>
</tr>
<tr>
<td></td>
<td>Use antiseptic mouthwash if pain and trismus limit oral hygiene.</td>
<td>Chlorhexidine or hydrogen peroxide</td>
<td>See above dosing in mucosal ulceration</td>
<td>Until oral hygiene possible</td>
</tr>
<tr>
<td>Dental abscess</td>
<td>Regular analgesia should be first option until a dentist can be seen for urgent drainage, as repeated courses of antibiotics for abscess are not appropriate.¹</td>
<td>Amoxicillin ² ⁵ or phenoxymethylpenicillin ² ³</td>
<td>⁵⁰⁰mg TDS – ¹g QDS</td>
<td>Up to 5 days review at ³ days¹¹</td>
</tr>
<tr>
<td></td>
<td>Severe odontogenic infections; defined as cellulitis plus signs of sepsis, difficulty in swallowing, impending airway obstruction, Ludwigs angina. Refer urgently for admission to protect airway, achieve surgical drainage and IV antibiotics. The empirical use of cefalexin,⁷ ² ³ co-amoxiclav, clarithromycin, and clindamycin do not offer any advantage for most dental patients and should only be used if no response to first line drugs when referral is the preferred option.⁵ ¹⁰ ¹²</td>
<td>Spreading infection or allergy: metronidazole ² ³ ⁴ ⁵</td>
<td>⁴⁰⁰mg TDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If pus drain by incision, tooth extraction or via root canal.⁴ ⁵ ⁶ ⁷ ⁸ ⁹</td>
<td>True penicillin allergy: clarithromycin</td>
<td>⁵⁰⁰mg BD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Send pus for microbiology.</td>
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<tr>
<td></td>
<td>If spreading infection (lymph node involvement, or systemic signs ie fever or malaise) ADD metronidazole ² ³ ⁴ ⁵</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>True penicillin allergy: use clarithromycin</td>
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<tr>
<td></td>
<td>If severe: refer to hospital.</td>
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</tr>
</tbody>
</table>

Derived from the Scottish Dental Clinical Effectiveness Programme 2011 SDCEP Guidelines

This guidance is not designed to be a definitive guide to oral conditions. It is for GPs for the management of acute oral conditions pending being seen by a dentist or dental specialist. GPs should not routinely be involved in dental treatment and, if possible, advice should be sought from the patient’s dentist, who should have an answer-phone message with details of how to access treatment out-of-hours, or telephone 111 (NHS 111 service in England).