



North Central London Joint Formulary Committee

Protecting and improving the nation's health

Management and treatment of common infections in North Central London

Antibiotic guidance for primary care

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Groups which were consulted and have given approval:	NCL Clinical Commissioning Groups		
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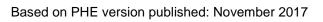
Summary table - Infections in primary care

Principles of treatment:

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- 1. This guidance is based on the best available evidence, but use professional judgement and involve patients in management decisions.
- 2. This guidance should not be used in isolation; it should be supported with patient information about safety netting, delayed/back-up antibiotics, selfcare, infection severity and usual duration, clinical staff education, and audits. Materials are available on the RCGP TARGET website.
- 3. Prescribe an antibiotic only when there is likely to be clear clinical benefit, giving alternative, non-antibiotic self-care advice, where appropriate.
- 4. Consider a 'no' or 'delayed/back-up' antibiotic strategy for acute self-limiting upper respiratory tract infections and mild UTI symptoms.
- 5. In severe infection, or immunocompromised, it is important to initiate antibiotics as soon as possible, particularly if sepsis is suspected. If patient is not at moderate to high risk for sepsis, give information about symptom monitoring, and how to access medical care if they are concerned.
- Where an empirical therapy has failed or special circumstances exist, microbiological advice can be obtained from:
 - a. Royal Free Hospital: 020 3758 2000 ext 33973 or 07770 678696; out of hours on-call Microbiologist via 020 3758 2000
 - b. Barnet Chase Farm: 020 3758 2000 ext 64384; out of hours on-call Microbiologist via 020 3758 2000
 - c. University College London Hospitals: 020 3456 7890 ext 79515; out of hours on-call Microbiologist via 020 3456 7890
 - d. North Middlesex Hospital: 020 887 2000 bleep 225 or 020 887 2472; out of hours on-call Consultant Microbiologist via 020 887 2000
 - e. Whittington Hospital: 0207 288 5085/5780; out of hours on-call Microbiologist via hospital switchboard on 0207 272 3070
 - Limit prescribing over the telephone to exceptional cases.
- 8. 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 the risk of *Clostridium difficile*, MRSA and resistant UTIs.
- 9. Always check for antibiotic allergies. A dose and duration of treatment for adults is usually suggested, but may need modification for age, weight, renal function, or if immunocompromised. In severe or recurrent cases, consider a larger dose or longer course.
- 10. Child doses are provided when appropriate, and can be accessed through the © symbol.
- 11. Refer to the BNF for further dosing and interaction information (eg the interaction between macrolides and statins), and check for hypersensitivity.
- 12. Have a lower threshold for antibiotics in immunocompromised, or in those with multiple morbidities; consider culture/specimens, and seek advice.
- Avoid widespread use of topical antibiotics, especially in those agents also available systemically; in most cases, topical use should be limited.
 In pregnancy, take specimens to inform treatment. Where possible, avoid tetracyclines, aminoglycosides, quinolones, azithromycin (except in chlamydial infection), clarithromycin, and high dose metronidazole (2g stat), unless the benefits outweigh the risks. Penicillins, cephalosporins, and erythromycin are safe in pregnancy. 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.
- 15. This guidance is developed alongside the NHS England Antibiotic Quality Premium. The required performance in 2017/19 is: a 10% reduction (or greater) in the number of *E. coli* blood stream infections across the whole health economy; a 10% reduction (or greater) in the trimethoprim:nitrofurantoin prescribing ratio for UTI in primary care, and a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater; sustained reduction of inappropriate prescribing in primary care.

ILLNESS	GOOD PRACTICE POINTS	TREATMENT	ADULT DOSE (click on [©] for child doses)	DURATION OF TREATMENT	
UPPER RESPI	RATORY TRACT INFECTIONS				
Influenza PHE Influenza	Uncomplicated influenza: Influenza presenting with fever, coryza, generalised symptoms (headache, malaise, myalgia, arthralgia) and sometimes gastrointestinal symptoms, but without any features of complicated influenza. Complicated influenza: Influenza requiring hospital admission and/or with symptoms and signs of lower respiratory tract infection				
Influenza prophylaxis	(hypoxaemia, dyspnoea, lung infiltrate), central nervo medical condition.	ous system involvement and/o	r a significant exacerbation of ar	nunderlying	
NICE Influenza	See <u>PHE Influenza</u> guidance for advice on suitable to influenza are oseltamivir 75mg PO BD for 5 days, or dysfunction and use in children are provided in the <u>P</u>	zanamivir 10mg INH BD for 5			
Acute sore throat NICE NG84	Refer to NICE guidance <u>https://www.nice.org.uk/guic</u>	lance/ng84/resources/visual-s	ummary-pdf-4723226606		
Scarlet fever (GAS) PHE Scarlet fever	Prompt treatment with appropriate antibiotics significantly reduces the risk of complications. ^{1D} Observe immunocompromised individuals (diabetes; women in the puerperal period;	<i>First line (mild)</i> : analgesia ^{2D} Phenoxymethylpenicillin ^{2D}	500mg QDS ^{1D} ©	10 days ^{3A+,4A+,5A+}	
level	chickenpox) as they are at increased risk of developing invasive infection. ^{1D}	<i>Penicillin allergy:</i> clarithromycin ^{1D}	500mg BD ^{1D} ©	5 days ^{1D,5A+}	
Acute otitis media (child doses) NICE NG91	Refer to NICE guidance https://www.nice.org.uk/guic	ance/ng91/resources/visual-s	ummary-pdf-4787282702	•	
Acute otitis externa CKS Otitis	First line: analgesia for pain relief, ^{1D,2D} and apply localised heat (eg a warm flannel). ^{2D} Second line: topical acetic acid or topical antibiotic	First line: analgesia and localised heat			
externa	+/- steroid: similar cure at 7 days. ^{2D,3A+,4B-} If cellulitis or disease extends outside ear canal , or systemic signs of infection, start oral flucloxacillin and refer to exclude malignant otitis externa. ^{1D}	Second line: topical acetic acid 2% ^{2D,4B-} Topical neomycin sulphate with corticosteroid ^{2D,5A-}	1 spray TDS ^{5A-} ☺ 3 drops TDS ^{5A-} ☺	7 days ^{5A-} 7 days (min) to 14 days (max) ^{3A+}	
		Alternative topical antibiotic + steroid If perforated tympanic membrane: Topical ciprofloxacin 0.3% with dexamethasone 0.1%	4 drops BD ©	7 days	
		If cellulitis: flucloxacillin ^{6B+}	500mg QDS ^{2D} ©	7 days ^{2D}	









NICE NG79		lance/ng79/resources/visual-s	<u>,,</u>	
	RATORY TRACT INFECTIONS			
Note: Low doses	of penicillins are more likely to select for resistance. ^{1D} I	Do not use quinolones (ciprofle	oxacin, ofloxacin) first line as the	ere is poor
	tivity. ^{2B-} Reserve all quinolones (including levofloxacin)		s. ¹⁰	T
Acute cough &	Antibiotics have little benefit if no co-morbidity. ^{14+,24-}	First line: self-care ^{1A+} and		
bronchitis NICE RTIs	Second line: 7 day delayed antibiotic, ³⁰ safety net, and advise that symptoms can last 3 weeks. ³⁰	safety netting advice ^{3D}		
	Consider immediate antibiotics if >80 years of age	Second line:		
	and one of: hospitalisation in past year; taking oral	amoxicillin ^{3D,6D}	500mg TDS ^{3D,6D} ③	5 days ^{3D,6D}
	steroids; insulin-dependent diabetic; congestive		_	-
	heart failure; serious neurological disorder/stroke, ^{3D} or >65 years with two of the above. ^{3D}	Penicillin allergy: doxycycline ^{3D,6D}	200mg stat than 100mg	5 days ^{3D,6D}
	Consider CRP if antibiotic is being considered. ^{4A-}	doxycycline	200mg stat then 100mg OD ^{3D,6D}	5 days
	No antibiotics if CRP<20mg/L and symptoms for		02	
	>24 hours; delayed antibiotics if 20-100mg/L;			
-	immediate antibiotics if >100mg/L. ^{5D}			~
Acute	Treat with antibiotics ^{1A+,2A-} if purulent sputum and increased shortness of breath and/or increased	amoxicillin ^{4D} OR doxycycline ^{4D} OR	500mg TDS ^{8A-} ☺ 200mg stat then 100mg OD ^{8A-}	5 days ^{7A+}
exacerbation of COPD	sputum volume. ^{14+,3D,4D}	clarithromycin ^{7A+}	500mg BD ^{7A+} ©	5 days
NICE COPD	Risk factors for antibiotic resistance: ^{5A+} severe	olantinoinyoin	Coording DD)
	COPD (MRC>3): ^{6B+} co-morbidity: frequent	If at risk of resistance:		74.
GOLD COPD	exacerbations; ^{3D} antibiotics in the last 3 months. ^{4D}	co-amoxiclav ^{4D}	500/125mg TDS ^{4D} ©	5 days ^{7A+}
Community-	Use CRB65 score to guide mortality risk, place of	CRB65=0: amoxicillin ^{1D,4D}	500mg TDS ^{5A+} ©	5 days; reviev
acquired pneumonia	care, and antibiotics. ^{1D} Each CRB65 parameter scores one: C onfusion (AMT <u>≤</u> 8 or new	<i>OR</i> clarithromycin ^{2A+,4D,5A+} <i>OR</i> doxycycline ^{2A+,4D}	500mg BD ^{5A+} ☺ 200mg stat then 100mg OD ^{6A-}	at 3 days; ^{1D} 7-10 if poor
NICE	disorientation in person, place or time); R espiratory	ON doxycycline	200mg stat then roomg OD	response ^{1D}
Pneumonia	rate >30/min; BP systolic <90, or diastolic <60; age	CRB65=1-2 and at home		5p
	≥65. Score 0: low risk, consider home-based care;	(clinically assess need for		
	1-2: intermediate risk, consider hospital	dual therapy for atypicals): amoxicillin ^{1D,4D} AND	500ma TDS ^{5A+}	2
	assessment; 3-4: urgent hospital admission. ^{1D} Give safety-net advice ^{1D} and likely duration of	clarithromycin ^{2A+,4D,5A+}	500mg TDS ^{5A+} ☺ 500mg BD ^{5A+} ☺	7-10 days ^{1D}
	different symptoms, eg cough 6 weeks. ^{1D}	OR doxycycline alone ^{4D}	200mg stat then 100mg OD ^{6A-}	1 To days
	Mycoplasma infection is rare in over 65s. ^{2A+,3C}			-
Bronchiectasis	Responsible Respiratory Prescribing Group guideline			
	https://www.ncl-mon.nhs.uk/wp-content/uploads/Gui			
	 This document is currently under review – 	as some of the content may b	e out of date, it should be viewed	d as an archive
	document for information only			
URINARY TRA	c resistance and Escherichia coli bacteraemia in the co	mmunity is increasing, use niti	rofurantoin first line, ^{1D} always giv	ve safety net and
Note: As antibiotic self-care advice, a	c resistance and Escherichia coli bacteraemia in the co and consider risks for resistance. ^{2D} Give TARGET UTI	leaflet, ^{3D} and refer to the PHE	UTI guidance for diagnostic info	rmation. ^{4D}
Note: As antibiotic self-care advice, a UTI in adults	c resistance and Escherichia coli bacteraemia in the co and consider risks for resistance. ^{2D} Give TARGET UTI All patients first line antibiotic:	leaflet, ^{3D} and refer to the PHE First line: nitrofurantoin ^{15A-}	UTI guidance for diagnostic info 100mg m/r BD. OR 50mg i/r Q	rmation. ^{4D}
Note: As antibiotic self-care advice, a UTI in adults (lower)	c resistance and Escherichia coli bacteraemia in the co and consider risks for resistance. ^{2D} Give TARGET UTI All patients first line antibiotic: nitrofurantoin if GFR >45mls/min. ^{1A+,2A+}	leaflet, ^{3D} and refer to the PHE First line: nitrofurantoin ^{15A} (do not use if suspect upper	UTI guidance for diagnostic info 100mg m/r BD, OR 50mg i/r Q (BD dose increases compliand	rmation. ^{4D}
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Note: As antibiotic self-care advice, a JTI in adults (lower) PHE UTI Diagnosis TARGET UTI RCGP UTI SIGN UTI NHS Scotland JTI IN patients w Do not use prophy Take sample if ne JTI in pregnancy SIGN UTI	c resistance and Escherichia coli bacteraemia in the co and consider risks for resistance. ^{2D} Give TARGET UTI All patients first line antibiotic: nitrofurantoin if GFR >45mls/min. ^{1A+,2A+} If GFR 30-45, only use if no alternative. ^{2A+,3D} Women < 65 years: If severe or ≥3 symptoms treat with antibiotic. ^{4D,5B-} If mild or ≤2 symptoms: ^{4D} pain relief, ^{6A-,7A+,8B-} and consider delayed antibiotic. ^{9B-,10A+} If urine not cloudy, 97% NPV of no UTI. ^{11A-} If urine not cloudy, 97% NPV of no UTI. ^{11A-} if urine cloudy, use dipstick to guide treatment: ^{4D,11A-} nitrite, leukocyctes, blood all negative 76% NPV; ^{11A-} nitrite plus blood or leukocytes 92% PPV of UTI. ^{11A-} Men <65 years: consider prostatitis and send MSU, ^{4D,12D} or if symptoms mild or non-specific, use negative dipstick to exclude UTI. ^{12D} >65 years: ^{13A-} treat if fever ≥38°C, or 1.5°C above base twice in 12 hours, and >1 other symptom. ^{14B-} If treatment failure: always perform culture. ^{4D} If treatment failure: always perform culture. ^{4D} ith catheters: antibiotics will not eradicate asymptomat/ actic antibiotics for catheter change unless there is a w onset of delirium, or one or more symptoms of UTI. ³ Send MSU for culture; ^{1D} start antibiotics in all with significant positive urine culture, even if asymptomatic. ^{1D} First line: nitrofurantoin, unless last trimester. ^{2A-,3D} Second line: trimethoprim; avoid if low folate status, ^{2A,4D,5D} or on folate antagonist. ^{4D,5D} Alternative: cephalosporins. ^{6C} Send MSU for culture and start antibiotics. ^{1D} 4 week course may prevent chronic prostatitis. ^{1D,2D} Quinolones achieve high prostate concentrations. ^{2D} Child <3 months: refer urgently for assessment. ^{1D} Child ≥3 months: use positive nitrite to guide antibiotic use; ^{1A-} send pre-treatment MSU. ^{1D} Imaging: refer if child <6 months, or recurrent or	leaflet, ^{3D} and refer to the PHE First line: nitrofurantoin ^{15A-} (do not use if suspect upper UTI) ^{15A-} If low risk of resistance: ^{16B+} trimethoprim ^{17D,18A+} If first line unsuitable: ^{2A+} pivmecillinam ^{19B+,20D,21A+} If organism susceptible: amoxicillin ^{22A+,23A+} If high resistance risk: fosfomycin ^{16B+,24A+,25B-,26B-} Low risk of resistance: you Risk factors for increased recurrent UTI; hospitalisatior urinary symptoms; recent tra previous UTI resistant to trim If risk of resistance: send u tic bacteriuria; ^{1D,2D,3A-} only treas history of catheter-change-ass A,6B-,7D <i>First line:</i> nitrofurantoin (avoid in last trimester) ^{2A-} , ^{3D,7A+} Second line: trimethoprim ^{2A-,4D,7A+} (avoid in first trimester) ^{5D} Alternative: cefalexin ^{4D,8D} Ciprofloxacin ^{1D,3D} Second line: trimethoprim ^{1D} Lower UTI: nitrofurantoin (ta <i>OR</i> trimethoprim (tabs/liquid Second line: cefalexin (tabs/ If organism susceptible: amo	UTI guidance for diagnostic info 100mg m/r BD, <i>OR</i> 50mg i/r Q (BD dose increases compliant 200mg BD ^{23A+} 400mg stat then 200mg TDS ²⁵ 500mg TDS ^{23A+} Women and men: 3g stat ^{26B-} Men: a second 3g stat on da unger women with acute UTI and resistance include : care home in for >7 days in the last 6 months invel to a country with increased r hethoprim, cephalosporins, or qu urine for culture and susceptibiliti ti f systemically unwell or pyelor sociated UTI or trauma. ^{4D,5A+} 100mg m/r BD ^{2A-,9C} <i>OR</i> 50mg BD (off-label) ^{7A+} 500mg BD ^{1D} 200mg BD (off-label) ^{7A+} 500mg BD ^{1D} 200mg BD ^{1D}	$\frac{rmation.^{4D}}{rmation.^{2D}}$ $\frac{rmation.^{4D}}{rmation.^{4D}}$ $\frac{rmation.^{4D}}{rmation.^{4D}}}$ $\frac{rmation.^{4D}}{rmation.^{4D}}}$ $$





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Acute pyelonephritis	If admission not needed, send MSU for culture and susceptibility testing, ^{1D} and start antibiotics. ^{1D} If no response within 24 hours, seek advice. ^{1D,2D}	First line: Ciprofloxacin ^{2D,5A-,6D}	500mg BD ^{2D,5A-,6D}	7 days ^{2D,5A-,7A+}
	If ESBL risk, ^{3A+} and on advice from a microbiologist, consider IV antibiotic via OPAT. ^{4D}	Second line: co-amoxiclav ^{2D,5A-}	500/125mg TDS ^{2D}	7 days ^{5A-,7A+}
Recurrent UTI in		Antibiotic prophylaxis:	300/123/lig 103	7 uays
non-pregnant women (2 in 6 months or \geq 3 in a year) TARGET UTI	First line : advise simple measures, ^{1D} including hydration; ^{1D,2D,3D} ibuprofen for symptom relief. ^{4A,5A-} Cranberry products work for some women. ^{6D,7A+,8A+} Second line : stand-by ^{1D} or post-coital antibiotics (single dose). ^{9A+} Third line : antibiotic prophylaxis. ^{1D,9A+,10D} Consider	First line: nitrofurantoin ^{9A+} Second line: trimethoprim ^{9A+}	50-100mg IR ^{9Å+} 100mg ^{9A+}	3-6 months, ^{1D} then review recurrence rate and need ^{1D,9A+}
	methenamine if no renal/hepatic impairment. ^{11A+}	<i>Third line:</i> Methenamine hippurate ^{11A+}	1g BD ^{11A+}	6 months ^{1D,11A+}
		OR cefalexin	125mg ON (off-label use; prescribe 250mg TABLETS with a tablet cutter)	3-6 months, ^{1D} then review recurrence rate and need ^{1D,9A+}
MENINGITIS				<u> </u>
Suspected	Transfer all patients to hospital immediately. ^{1D}	IV or IM	Child <1 year: 300mg ^{5D})
meningococcal disease NICE Meningitis	If time before hospital admission, ^{2D,3A+} and non- blanching rash, ^{2D,4D} give IV benzylpenicillin ^{1D,2D,4D} or IV cefotaxime. ^{2D} Do not give IV antibiotics if	benzylpenicillin ^{1D,2D} OR	Child 1-9 years: 600mg ^{5D} Adult/child 10+ years: 1.2g ^{5D}	Stat dose; ^{1D} give IM, if vein cannot
NICE Meninguis	there is a definite history of anaphylaxis; ^{1D} rash is not a contraindication. ^{1D}	IV or IM cefotaxime ^{2D}	Child <12 years: 50mg/kg ^{5D} Adult/child 12+ years: 1g ^{5D}	be accessed ^{1D}
	condary case of meningitis: Only prescribe followi		h protection specialist/consultar	nt.
	rth Central London Health Protection team: 9am-5pm TINAL TRACT INFECTIONS	: 020 3837 7084; Out of hours	: 020 7191 1860	
Oral	Topical azoles are more effective than topical	Miconazole oral gel ^{1A+,4D,5A-}	2.5ml of 24mg/ml QDS (hold) 7 days; ^{4D,6D}
candidiasis CKS Candida	nystatin. ^{1A+} Oral candidiasis is rare in immunocompetent adults; ^{2D} consider undiagnosed risk factors, including HIV. ^{2D} Use 50mg fluconazole if extensive/severe candidiasis: ^{3D,4D} if HIV or	<i>If not tolerated:</i> nystatin suspension ^{2D,6D,7A-}	in mouth after food) ^{4D} © 1ml; 100,000 units/mL QDS (half in each side) ^{2D,4D,7A-} ©	coninue nystatin 2d & miconazole 7d after
	immunocompromised, use 100mg fluconazole. ^{3D,4D}	Fluconazole capsules ^{6D,7A-}	50mg/100mg OD ^{3D,6D,8A-} ©	resolved ^{4D} 7-14 days ^{6D,7A-,8A-}
Helicobacter pylori NICE GORD and dyspepsia PHE <i>H. pylori</i> Infectious	Follow PHE <i>H. pylori</i> guidance Refer previously healthy children with acute painful of	or bloody diarrhoea, to exclude	E coli 0157 infection ^{1D} Antibia	otic therapy is not
diarrhoea PHE Diarrhoea	usually indicated unless patient is systemically u meat and abdominal pain), ^{3D} consider clarithromycin	Inwell. ^{2D} If systemically unwell 500mg BD for 5-7 days, if treated	and campylobacter suspected	(eg undercooked
Clostridium difficile PHE Clostridium	Stop unneccesary antibiotics, ^{1D,2D} PPIs, ^{3B-} and antiperistaltic agents. ^{2D} Mild cases (<4 episodes of diarrhoea/day) may respond without	First episode non-severe: Metronidazole	400 mg TDS ^{1D,2D} ©	10-14 days ^{1D,4B-}
difficile	metronidazole; ^{2D} 70% respond to metronidazole in 5 days; 92% respond to metronidazole in 14 days. ^{4B-} If severe (T>38.5, or WCC>15, rising creatinine, or signs/symptoms of severe colitis): ^{2D} treat	Second episode/severe: oral vancomycin Recurrent disease	125mg QDS ^{1D,2D,5A-} ©	10-14 days ^{1D,2D}
	with oral vancomycin, ^{1D,2D,5A-} review progress closely, ^{1D,2D} and consider hospital referral. ^{2D}	(discuss with a specialist before starting treatment): oral vancomycin or combination therapy or fidaxomicin [≥3 recurrence]		
Traveller's diarrhoea	Prophylaxis rarely, if ever, indicated. ^{1D} Consider stand-by antimicrobial only for patients at high risk of severe illness, ^{2D} or visiting remote or high risk	Stand-by: azithromycin ^{1D,3A+} (private prescription) Prophylaxis/treatment:	500mg OD ^{1D,2D,3A+}	1-3 days ^{1D,2D,3A+}
	areas. ^{1D,2D} , or for whom travellers diarrhoea would be major inconvenience (eg short term business travellers)	bismuth subsalicylate ^{1D,4A-}	2 tablets QDS ^{1D,2D}	2 days ^{1D,2D,4A-}
Threadworm CKS Threadworm	Treat all household contacts at the same time. ^{1D} Advise hygiene measures for two weeks ^{1D} (hand hygiene; ^{2D} pants at night; morning shower, including perianal area). ^{10,2D} Wash sleepwear, bed	Child >6 months and adults: mebendazole	100mg stat ^{3B-}	Stat dose to entire
	including perianal area). ^{10,2D} Wash sleepwear, bed linen, and dust and vacuum. ^{1D} Child <6 months, add perianal wet wiping or washes three hourly. ^{1D}	<i>Child</i> <6 months or pregnancy (at least in 1 st trimester): only hygiene measure for 6 weeks ^{1D}		household. For index case repeat after 2 weeks if persistent







STI screening	People with risk factors should be screened for chlan	nvdia, gonorrhoea, HIV, and s	vphilis. ^{1D} Refer individual and pa	rtners to GUM. ^{1D}
enconcoming	Risk factors: <25 years; no condom use; recent/free			
Chlamydia	Opportunistically screen all patients aged 16-24	First line:		
trachomatis	years. ^{1B-} Treat partners and refer to GUM. ^{2D,3A+}	azithromvcin ^{2D,3A+,5A+,7A+,8A+}	1g ^{2D,3A+,5A+,7A+}	Stat ^{2D,3A+,5A+,7A+,8}
SIGN Chlamvdia	Repeat test for cure in all at three months. ^{1B-,4B-}	OR doxycycline ^{2D,3A+,5A+}	100mg BD ^{2D,3A+,5A+}	7 days ^{2D,3A+,5A+}
oron oniarriyula	Pregnancy/breastfeeding: azithromycin is most	Pregnancy/breastfeeding:		
	effective. ^{5A+,6D,7A+,8A+,9D} As lower cure rate in	Pregnancy/breastfeeding: azithromycin ^{3A+,7A+,8A+,9D}	1g ^{2D,3A+,5A+,7A+}	Stat ^{2D,3A+,5A+,7A+,8}
	programmer toot for ours at least three weeks ofter	OR erythromycin ^{3A+,6D,7A+,8A+}	500mg BD ^{3A+} OR	14 days ^{3A+}
	pregnancy, test for cure at least three weeks after end of treatment. ^{18-,3A+}	OR erythromycin	500mg QDS ^{3A+}	7 days
	end of treatment.	OR	SOUMG QDS	7 days
			500mg TDS ^{7A+,8A+}	7 days ^{7A+,8A+}
		amoxicillin ^{6D,7A+,8A+}		
Undifferentiat-	Antibiotic resistance is now very high. ^{1D,2D} Use IM	First line:		
ed urethritis	ceftriaxone ^{2D} and oral azithromycin; ^{1D,3D} refer to	Azithromycin	1g ^{2D,3A+,5A+,7A+}	Stat ^{2D,3A+,5A+,7A+,8}
	GUM. ^{4B-} Test of cure is essential. ^{3D}	PLUS	-	
		Ceftriaxone ^{1D}	500mg IM ^{1D,2D}	Stat ^{3B-}
Epididymitis	Usually due to Gram-negative enteric bacteria in	Doxycycline ^{1A+,2D,3A+} OR ofloxacin ^{1A+,2D} OR	100mg BD ^{1A+,2D,3A+}	10-14 days ^{1A+,2D}
Epidiayinitis	men over 35 years with low risk of STI. ^{1A+,2D}	ofloxacin ^{1A+,2D} OP	200mg BD ^{1A+,2D}	$14 days^{1A+,2D}$
	If under 35 years or STI risk, refer to GUM. ^{1A+,2D}	ciprofloxacin ^{1A+,2D,3A+}	500mg BD ^{1A+,2D,3A+}	10 days ^{1A+,2D,3A+}
				2
Vaginal	All topical and oral azoles give over 70% cure. ^{1A+,2A+}	Clotrimazole ^{1A+,5D} OR	500mg pessary ^{1A+} OR 5g 10% cream ^{1A+}	Stat ^{1A+}
candidiasis	Pregnancy: avoid oral azoles, ^{1A+,3D} and use intravaginal treatment for 7 days. ^{4A+}		5g 10% cream	J
BASHH	intravaginal treatment for 7 days.	44.		14.
Vulvovaginal	Recurrent (>4 episodes per year): ^{5D} 150mg oral	miconazole ^{1A+} OR	5g 20mg/g vaginal cream 1A+	14 nights ^{1A+}
candidiasis	fluconazole every 72 hours for three doses	oral fluconazole (not in	150mg ^{1A+,3D}	Stat ^{1Ă+,3D}
	induction, ^{1A+} followed by one dose once a week for	pregnancy) ^{1A+,3D}		
	six months maintenance. ^{1A+,5D}			
		Recurrent: fluconazole	150mg every 72 hours THEN	3 doses ^{1A+}
		(induction/maintenance) ^{1A+}	150mg once a week ^{1A+,3D,5D}	6 months ^{1A+,5D}
Bacterial	Oral metronidazole is as effective as topical	Oral metronidazole ^{1A+,3A+}	400mg BD ^{1A+,3A+}	7 days ^{1A+}
vaginosis	treatment, ^{1A+} and is cheaper. ^{2D} Seven days results	OR	2g ^{1A+,2D}	Stat ^{2D}
BASHH	in fewer relapses than 2g stat at four weeks. ^{1A+,2D}		zg	Stat
	Pregnant/breastfeeding: avoid 2g dose.	metronidazole 0.75% vaginal gel ^{1A+,2D,3A+} OR	5g applicator at night ^{1A+,2D,3A+}	5 nights ^{1A+,2D,3A+}
Bacterial	Pregnant/breastreeding: avoid 2g dose.		5g applicator at hight	5 nights
vaginosis	Treating partners does not reduce relapse. ^{5A+}	dequalinium vaginal tablet	10mg at night	6 nights
		OR clindamycin 2% cream	5g applicator at night ^{1A+,2D,3A+}	5 nights ^{1A+,2D,3A+}
Genital herpes	Advise: saline bathing, ^{1A+} analgesia, ^{1A+} or topical	First line:		
BASHH	lidocaine for pain, ^{1A+} and discuss transmission. ^{1A+}	oral aciclovir ^{1A+,2D,3A+,4A+}	400mg TDS ^{1A+,3A+}	5 days ^{1A+}
Anogenital	First episode: treat within five days if new lesions	OR	800mg TDS (if recurrent) ^{1A+}	2 days ^{1A+}
herpes	or systemic symptoms, ^{1A+,2D} and refer to GUM. ^{2D}	valaciclovir ^{1A+,3A+,4A+}	500mg BD ^{1A+}	5 days ^{1A+}
noipeo	Recurrent: self-care if mild, ^{2D} or immediate short	OR	cooling DD	o dayo
	course antiviral treatment, ^{1A+,2D} or suppressive	famciclovir ^{1A+,4A+}	250mg TDS ^{1A+}	5 days ^{1A+}
	therapy if more than six episodes per year. ^{1A+,2D}	lamololovii	1g BD (if recurrent) ^{1A+}	1 day ^{1A+}
Conorrhooo	Antibiotic registeres is new yery bigh ^{1D,2D} Lies IM	Ceftriaxone ^{1D,2D,3D,4B-}	500mg IM ^{1D,2D}	Stat ^{3B-}
Gonorrhoea	Antibiotic resistance is now very high. ^{1D,2D} Use IM ceftriaxone ^{2D} and oral azithromycin; ^{1D,3D} refer to		Souring IM	Siai
	cettriaxone and oral azithromycin; refer to	PLUS	• 1P	o
	GUM. ^{4B-} Test of cure is essential. ^{3D}	oral azithromycin ^{1D,3D,4B-}	1g ^{1D}	Stat ^{3B-}
Trichomoniasis	Oral treatment needed as extravaginal infection	Metronidazole ^{1A+,2A+,3D,6A+}	400mg BD ^{1A+,6A+}	5-7 days ^{1A+}
BASHH	common. ^{1D} Treat partners, ^{1D} and refer to GUM for		2g (more adverse effects) ^{6A+}	Stat ^{1A+,6A+}
Trichomoniasis	other STIs. ^{1D}	Pregnancy for symptoms:		
	Pregnancy/breastfeeding: avoid 2g single	clotrimazole ^{2A+,4A-,5D}	100mg pessary at night ^{5D}	6 nights ^{5D}
	dose metronidazole; ^{2A+,3D} clotrimazole for symptom		51 , 5	0
	relief (not cure) if metronidazole declined. ^{2A+,4A-,5D}			
Pelvic	Refer women and sexual contacts to GUM. ^{1A+}	metronidazole PLUS	400mg BD ^{1A+}	14 days ^{1A+}
inflammatory	Always send samples for gonorrhoea and	doxycycline [,] PLUS	100mg BD ^{1A+}	14 days ^{1A+}
disease	chlamydia. ^{1A+} If gonorrhoea likely (partner has it;	ceftriaxone ^{1A+}	500mg IM ^{1A+}	Stat ^{1A+}
BASHH PID	chianiyula. II gulullilea likely (partiter has it;			Jiai
DAORE FID	sex abroad; severe symptoms), ^{2A-} use regimen with			
	ceftriaxone, as resistance to quinolones is high. ^{1A+,2A-,3C,4C}			
	•	Low risk of GC		1 4 4 4 5 1 4 1
	Mycoplasma genitalium is under discussion as a	Metronidazole PLUS	400mg BD ^{1A+}	14 days ^{1A+}
	possible cause of PID but diagnostic tests are not	ofloxacin 1A+	400mg BD ^{1A+}	14 days ^{1A+}
	widely available in the NHS and may only be			
	available in referral centres. The importance of M.			
	Genitalium is currently under review by BASHH.	Low risk of GC (high		
	· · ·	activity against M.		
		genitalium)		
		Moxifloxacin ^{1A+}	400mg OD ^{1A+}	14 days ^{1A+}
	T TISSUE INFECTIONS		P	
	GP Skin Infections online training. ^{1D} For MRSA, discus			·····
	Reserve topical antibiotics for very localised lesions	Topical fusidic acid ^{2D,3A+}	Thinly TDS ^{4D} ☺	5 days ^{1D,2D}
Impetigo	to reduce risk of bacteria becoming resistant. ^{1D,2B+}	MRSA: topical mupirocin ^{3A+}	2% ointment TDS ^{3A+}	5 days ^{1D,2D,3A+}
		Oral (hashers attill 10.3A+	© 250-500mg	7 days ^{3A+}
Impetigo PHE Impetigo	Only use mupirocin if caused by MRSA. 10,344	Oral flucioxacillin		
	Only use mupirocin if caused by MRSA. ^{1D,3A+} Extensive, severe, or bullous: oral antibiotics ^{4D} .	Oral flucloxacillin ^{1D,3A+} Oral clarithromycin ^{1D,4D}		7 days ^{4D}
	Only use mupirocin if caused by MRSA. ^{10,344} Extensive, severe, or bullous: oral antibiotics ^{4D} .	Oral flucioxaciiin ^{1D,4D} Oral clarithromycin ^{1D,4D}	QDS ^{3A+} ँ☺	7 days ^{4D}
	Only use mupirocin if caused by MRSA. ^{10,3A4} Extensive, severe, or bullous: oral antibiotics ^{4D} . Most resolve after 5 days without treatment. ^{1A,2A-} To	Oral clarithromycin ^{1D,4D}	QDS ^{3A+} ☺ 250-500mg BD ^{4D} ☺	7 days



5



Suppression therapy should only be stand after primary infection has resolved, as ineffective likens are still leaking. ⁴⁰ Risk factors PVL: recurrent ball Ezzma No visible signs of infection: ambiotic use (alone or with steroids). ⁴⁰ contacts). ⁴⁰ If there is more than one case in a home contacts. ⁴⁰ If there is more than one case in a home contact is a solution on the case in the totact and there is an an harding of there is more than one case in a home contact is a solution on the case in the totact and there is more than one case in the home contact is a solution on the case is a home contact is a solution on the case is a home contact is a solution on the case is a home contact is a solution on the case is a home contact is a solution on the case is home contact is a solution on the case is a home contact is a sol	PVL-SA PHE PVL-SA	Panton-Valentine leukocidin (PVL) is a toxin produce in healthy people, but severe. ²⁸⁺	d by 20.8-46% of <i>S. aureus</i> fr	om boils/abscesses. ^{1B+,2B+,3B-} P	/L strains are rare
Eczema No visible signs of infection: antibicit use (alone or with steriols) ^{1/*} encourages resistance and does not improve healing. NOCE Eczema Mid (open and closed comedones) ^{1/*} or modorate (inflammatory lessions): First line: self-care ⁽¹⁾ (wash with mild song; do not scub; avid and bopical antibiotic; addition of oral antibiotic; first antibiotic portion of the antibiotic; first antibiotic addition of antibiotic; first antibiotic; first antibiotic; continue topical retinoid of antibiotic addition of oral antibiotic; first antibiotic addition of antibiotic; first antibiotic addition of antibiotic; first antibiotic; first antibiotic addition of antibiotic; first antibiotic; first antibiotic addition of antibiotic; first antibiotic addition addition; first antibiotic prophysizes is advised; first antheapsy advised; first antibiotic prophysizes is advised; first a		Suppression therapy should only be started after purchase in the started after purchase for PVL: recurrent skin infections; ²⁸⁺ in community ^{28+,38-} (school children; ³⁸⁻ millitary persone	vasive infections; ^{2B+} MSM; ^{3B-} if II; ^{3B-} nursing home residents; ^{3E}	f there is more than one case ir	a home or close
CKS Acee moderate (inflammatory lesions): ¹⁰ / ₁₀ Second line: Thirst line: selectarel ¹⁰ (usable, optical control (us		No visible signs of infection: antibiotic use (alone of	or with steroids) ^{1A+} encourages in ^{2D} or clarithromycin, ^{2D} or topi	s resistance and does not impro cal treatment (as in impetigo). ²¹	ove healing. ^{1A+}
vulgaris First line: self-care [®] (wesh with mild scap: do not scrub; avoid make-up.) ¹⁰ for care of the self-care [®] (wesh with mild scap: do not scrub; avoid make-up.) ¹⁰ for care of the self-care [®] (wesh with mild scap: do not scrub; avoid do not care analysic. ¹⁰ for care of the self-care [®] (wesh with mild scap: do not scrub; avoid do not care analysic. ¹⁰ for care of the self-care of the s	Acne		First line: self-care ^{1D}	, , , , ,	
scrub, avoid make-up). ¹⁰ Second ine: topical reliabidic. ^{10,20,40,40} Third-line: dot local antibidic. ^{10,20,40,40} or of antibidic. ^{10,20,40,40} (for 3 months max). ^{10,45} and refer. ^{10,40} (for 3 months). ^{10,40} (for 4 months).		moderate (inflammatory lesions): ^{1D}	Second line:	24.	10
Second line: topical retinoid of benzyl perxide. ¹⁰ Third-line: add topical antibiotic, ¹⁰⁰ sever (nodules and cysts): ¹⁰ add or an antibiotic, ¹⁰⁰ (for 3 months max) ^{10,00} and refer. ^{10,00} (for 5 months max) ^{10,00} and refer. ^{10,00} (for 5 months max) ^{10,00} (for 4 months) ^{10,00} (for 5 months) ^{10,00} (for 4 months) ^{10,00} (for 5 months) ^{10,00} (for 4 months) ^{10,00} (for 4 months) ^{10,00} (for 4 months) ^{10,00} (for 4	vulgaris		topical retinoid 10,20,3A+ OR	Thinly OD ^{3A+} ©	6-8 weeks ^{1D}
Third-line: add topical antibiotic, ^{10,20} or consider addition of relaming the addition and relaming the addition addition and relaming the addition addit addition addition addition addition addi		scrub; avoid make-up). ¹⁰	benzoyl peroxide	5% cream OD-BD	6-8 weeks ^{1D}
addition of oral antibidic. ⁽¹⁾ Severe (nodules and cysts): ⁽ⁿ⁾ and refer. ⁽²ⁿ⁾ If treatment failures/severe: oral doxycycline ⁽²ⁿ⁾ 500mg BD ⁽²ⁿ⁾ (a) 6-12 wi Grad doxycycline ⁽²ⁿ⁾ Cellulitis and erysipelas CREST Cellulitis Class I: patient fabrile and healthy other than cellulitis, use oral fluctoxacillin along: CREST Cellulitis 500mg DD ⁽²ⁿ⁾ (b) (c) CREST Cellulitis If river or sea water exposure: seek advice. ⁽¹⁾ Class II: patient fabrile and lil, or comorbidity, admit for intravenous treatment, ⁽¹⁾ or use Oral fluctoxacillin for non-facial erysipelas; (²ⁿ⁾ true advags colonized (²ⁿ⁾ (c)		Second line: topical retinoid of benzoyl peroxide.		1% croom thinly BD ^{3A+}	12 weeks ^{1A-,2D}
Severe (nodules and cysts): [®] add oral antibiotic (for 3 months max) ^{®,Am} and refer. ^{®,Am} OR (rots 3 months max) ^{®,Am} and refer. ^{®,Am} OR (advsyccline ^{®,Am} ,Am celluitis and erysipelas CREST Celluitis Soomg BD ^{®,Am} © (alss 1: patient abelia and healthy other than celluitis, use oral fluctoxoxilli alone. ^{®,D,Am} ,Am Class II: patient fabrile and healthy other than celluitis, use oral fluctoxoxilli alone. ^{®,D,Am} ,Am Class II: patient fabrile and ll, or comobility, admit for intravenous treatment. [®] or use OPAT. [®] Class II: fook capeerance, admit. [®] Destinition and the comobility, admit for intravenous treatment. ^{®,M} or use OPAT. [®] Class II: fook capeerance, admit. ^{®,M} Destinition addition addition addition and the addition addition addition addition exudate/cdour; increased pain; celluitis; pyrexia). [®] PHE Venous leg Ulcers Soomg BD ^{®,M} Soomg BD ^{®,M} Soomg BD ^{®,M} Soomg BD ^{®,M} Soomg BD ^{®,M} Class III: port addition additadditin addite addition addition addite addition addition addit		addition of oral antibiotic ^{1D}			12 WEEKS
Celluitis and erysipelas CREST Celluitis Class i: patient abelia and healthy other than excluitions use oral fluctoxacillin alone. ^{10,20,34,44} Class II: patient fabrile and III, or comobility, admit for intravenous treatment. ¹⁰ or use OPAT. ¹⁰ Class III: foor appearance, admit ¹⁰ Creas re always colonised. ^{10,20,44} Utcers are always colonised. ^{10,20,44} Antibiotic prophylaxis is advised. ^{10,20,20,44} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40,40,40} Creas III: pathogens are covered. ^{10,20,44} Antibiotic prophylaxis is advised. ^{10,40,40,40} Creas III: pathogens are covered. ^{10,40,40} Creas III: pathogens are covered. ^{10,40,40} Creas III: pathogens are covered. ^{10,40,40,40,40,40,40,40,40,40,40,40,40,40}		Severe (nodules and cysts): ^{1D} add oral antibiotic		500mg BD ^{3A+} ©	6-12 weeks ^{3A+}
Celluitis and erysipelas CREST Celluitis Class i: patient abelia and healthy other than excluitions use oral fluctoxacillin alone. ^{10,20,34,44} Class II: patient fabrile and III, or comobility, admit for intravenous treatment. ¹⁰ or use OPAT. ¹⁰ Class III: foor appearance, admit ¹⁰ Creas re always colonised. ^{10,20,44} Utcers are always colonised. ^{10,20,44} Antibiotic prophylaxis is advised. ^{10,20,20,44} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40} Creas III: porture wound. ^{10,40,40,40,40} Creas III: pathogens are covered. ^{10,20,44} Antibiotic prophylaxis is advised. ^{10,40,40,40} Creas III: pathogens are covered. ^{10,40,40} Creas III: pathogens are covered. ^{10,40,40} Creas III: pathogens are covered. ^{10,40,40,40,40,40,40,40,40,40,40,40,40,40}		(for 3 months max) ^{1D,3A+} and refer. ^{1D,2D}	oral doxycycline ^{3A+,4A-}	100mg OD ^{3A+} ©	6-12 weeks ^{3A+}
erysipelas CREST cellulitis class II: patient febrile and II, or comorbidity, admit for intravenous treated points: each voice. ^{10,20,244,474} Class III: floxic appearance, admit. ¹⁰ Erysipelas: often facial, may be unilateral. ⁴⁴⁴ Use fluctoxacillin for non-facial erysipelas. ^{10,20,244,474} Ulcers are always colonications if morant. ^{10,20,244,474} PHE Venous leg ulcers Soumg 2DS ^{10,20} Soumg 2DS ^{10,20} Soumg 2DS ^{10,20} Ulcers are always colonications if morant. ^{10,20,244,474} Ulcers are always colonications if morant. ^{10,20,244,474} PHE Venous leg ulcers Soumg 2DS ^{10,20} Soumg 2DS ^{10,20} Soumg 2DS ^{10,20} Ulcers are always colonications if morant. ^{10,20,244} Antibiotic prophylaxis. ^{11,20,214} Antibiotic prophylaxis. ^{11,20,214} Antibiotic prophylaxis. ^{11,20,214} Antibiotic prophylaxis. ^{11,20,214} Deg give prophylaxis. ^{11,20,214} Antibiotic apport antibic or prophylaxis. ^{11,20,214} Antibiotic prophylaxis. ^{11,20,214} Deg give prophylaxis. ^{11,20,214} Antibiotic apport antibic or prophylaxis. ^{11,20,214} Antibiotic apport antibic or prophylaxis. ^{11,20,214} Antibiotic apport antibic or prophylaxis. ^{11,20,214} Deg give prophylaxis. ^{11,20,214} Antibiotic apparticle and always colonicates: ^{11,20,214} Antibiotic anteralia alwayscolonicates: ^{11,20,214} Antibiotic appartiso	Cellulitis and	Class I: patient afebrile and healthy other than	Flucloxacillin ^{1D,2D,3A+}	500mg QDS ^{1D,2D} ©)
BLS Cellultis Class II: patient febrile and III, or comorbidity, admit for intravenous treatment. ¹ ¹⁰ or use OPAT. ¹⁰ Creas III: if toxic appearance, admit. ¹⁰ Eryspieas-orten facial, may be unilateral. ⁴⁹⁺ Use fluctoxacillin for non-facial eryspielas. ^{100,004} PHE Venous leg ulcers are always colonised. ^{10,047} Antibiotics do not exudate/odour, increased pain, cellultits; pyrexua). ⁷⁰ Bites: Penicillin allergy and taking statins: doxycollin ²⁰⁰ Unresolving: clindamycin ²⁰⁰⁴ S00mg QDS ¹⁰² S00mg QDS ¹⁰² I As fc cellultis Leg ulcer tuders Human: through irrigation is important. ^{10,007} exudate/odour, increased pain, cellultis; pyrexua). ⁷⁰ Creat always give prophylaxis is advised. ^{10,400} Cat: always give prophylaxis is puncture wound. ^{10,400} Dog; give prophylaxis is puncture wound. ^{10,400} presence of prosthetic valve/joint. ^{10,400} and under alls. ^{10,200} Under 2 years/elderly: also treat face/scalp. ^{10,200} Under 2 wears/elderly: also treat face/scalp. ^{10,200}		cellulitis, use oral flucloxacillin alone. ^{1D,2D,3A+}	Penicillin allergy:		7 days; ^{1D} if
BLS Celluitis Class II: patient redne and in, roomonous intravenous retentent, or presence of prosthetic value/joint, and under nails. Perincinin allergy and and/or statis: doxycordine ¹⁰ 300mg QDS ¹⁰⁰ (and my control intravenous retentent). Common 2005 Common 2005 <t< td=""><td>CREST Cellulitis</td><td></td><td></td><td>500mg BD^{1D,2D} ©</td><td>slow response,</td></t<>	CREST Cellulitis			500mg BD ^{1D,2D} ©	slow response,
BLS Cellulins admit for infrarenous freatment, or use OPAL. statures: coxycycline 200mg dS1 then 100mg OUT admit for infrarenous freatment, or use OPAL. Leg ulcer Users fuctoxacillin for non-tacial erysplase. 0.00m dS1 then 100mg OUT 300mg dS1 then 100mg OUT 300mg dS1 then 100mg OUT admit for infrarenous leg 300mg dS1 then 100mg OUT 300mg dS1 then 100mg OUT 300mg dS1 then 100mg OUT admit for infrarenous leg 0.00mg dS1 then 100mg OUT 300mg dS1 then 100mg OUT 300mg dS1 then 100mg OUT 300mg dS1 then 100mg OUT admit for infrarenous leg 0.00mg dS1 then 100mg OUT 300mg GS1 then 100mg OUT <		Class II: patient febrile and ill, or comorbidity,			
Erysipelas: often facial, may be unitateral. ⁰⁺¹ Use fluctoxacillin for non-facial erysipelas. ^{10,20,4+} Infection: skin and nail infection: skin exclasses terbinaline is fungicial; ¹⁰⁻²⁰ infection: skin and nail infection: skin and/or general making: ¹⁰ tarta tarta strate infection: skin and nail infection: skin and nail infection: skin and nail infection: skin and nail infection: skin infection: skin infe	BLS Cellulitis	admit for intravenous treatment, ¹⁰ or use OPAT. ¹⁰	statins: doxycycline ²⁰	200mg stat then 100mg OD ²⁴	further 7
Use fluctoxacillin for non-facial erysipelas. J02034 co-amoxiclav ^{Es.} 500/125mg TDS ¹⁰ J PHE Venous leg ulcers Ulcers are always colonisad. ^{1C2AA} Anbibiotics do not improve healing unless active infection. ⁴⁴ (purulent ulcers Fluctoxacillin ¹⁰ OR clarithromycin ⁵⁰ 500mg DDS ²⁰ A fa fa Bites: Human: thorough finingation is important. ^{1A4,0DD} Antibiotic prophylaxis is advised. ^{1A4,2DD} Cat: always give prophylaxis is dived. ^{1A4,2DD} Cat: always give prophylaxis if purcture wound: ^{1A4,3DD} bite to hand, foot, face, joint, tendon, or ligament; ^{1A4} immunocompromised. cirrhotic, asplenic, or presence of prosthetic valvejoint. ^{1A4,DD} Penicillin allergy (human bite): Human or animal bite: co-amoxiclav ^{ED,3D} 400mg TDS ²⁰ 5 day Scabies Treat whole body from ear/chin downwards, ^{1D,2D} and under nais: ^{1A5,DD} Home/sexual contacts: treat within 24 hours. ^{1D} Home/sexual common infecting pathogen. ^{1D} (lactating mother) Freat whole body from ear/chin downwards, ^{1D,2D} and/or general malale; ^{2D,2D} Home/sexual common infecting pathogen. ^{1D} if lection common infecting pathogen. ^{1D} if metaction common infection gathogen. ^{1D} if metaction common infection gathogen. ^{1D} if metaction common infection gathogen. ^{1D} if metaction common infection soft from with fungistatic information compon infection soft and near than with fungistatic information common infection soft infection: solit, example, and and biolics are appropriate. ^{1D} if metaction confirmed. ^{1D} coral terbinafine is nore effective than infection: solit, mage. ^{1D} infection is confirmed. ^{1D} coral terbinafine is more effective than infection: solit moral al lacycet is not as defective. ^{1D,2A4,AD,2D} if metacti		Class III: If toxic appearance, admit.	Encial (non dontal):	300mg QDS	days ^{1D}
Leg ulcer PHE Venous leg Ulcers are always colonised. ^{10,24,4} Antibiotics do not improve healing unless active infection ²⁴ (purules). ¹⁰⁰ Cat: always give prophylaxis is advised. ^{10,40,00} Assess risk, of tetanus, rabies, ^{10,41} HIV, and hepatitis B and C. ³⁰ Cat: always give prophylaxis. ^{10,40,00} Assess risk, of tetanus, rabies, ^{10,41} HIV, and hepatitis B and C. ³⁰ Dog: give prophylaxis if: puncture wound; ^{14,430} bite to hand, foot, face, joint, tendon, or ligament; ¹⁴⁴ memoromatical called ^{10,44,4} AND bite to hand, foot, face, joint, tendon, or ligament; ¹⁴⁴ as not all pathogens are covered. ^{10,300} Human or animal bite: co-amoxiclav ^{21,300} 625mg TDS ³⁰ 62 Scables Treat whole body from ear/chin downwards, ^{10,200} and under naits. ^{10,20} Mastitis Treat whole body from ear/chin downwards, ^{10,200} and or general malaise. ¹⁰⁰ a tender, red breast. ¹⁰ Scables Pericillin allergy: methorindazole ^{10,44,4} AND doxycycline ¹³⁰ 400mg TDS ²⁰ 0.5% aqueous liquid ¹⁰ 2 api 1 we o.5% aqueous liquid ¹⁰ Mastitis and under naits. ^{10,20} and breast abscess S. aureus is the most common infecting pathogen. ¹⁰ If candida possible, use imidazole ^{10,10,44} and or general malaise. ¹⁰ or intraconazole ^{10,10,44} Women should continue feeding. ^{10,20} from tearliced breast. ¹⁰ or intraconazole. ^{10,44,44} If randida possible, use imidazole ^{10,10,44} If randida possible, use imidazole ^{10,10,44,444} If randida possible, use imidazole ^{10,10,44} If randida possible, use imidazole ^{10,10,44,444} If randia possible, use imidazole ^{10,44,444} If continmacli ¹⁰		Use fluctoxacillin for non-facial ervsipelas ^{1D,2D,3A+}		500/125mg TDS ^{1D} ③	J
PHE venous leg uicers improve healing unless active infection ²⁺⁴ (purulent exudate/odour; increased pain; cellulitis; pyrexia). ³⁰ 500m g BD ⁵⁰ © f cellu Bites: Human: thorough irrigation is important. ^{15,47,47} of tetanus, rabies, ^{15,47,48} Antibiotic prophylaxis is advised. ^{16,40,60} Cat: always give prophylaxis if: puncture wound; ^{16,47,40,00} Human or animal bite: co-amoxiclav ^{10,30,44} AND doi: give prophylaxis if: puncture wound; ^{16,47,40,00} 625mg TDS ³⁰ © Dog: give prophylaxis if: puncture wound; ^{16,47,40,00} Penicillin allergy (human bite): co-amoxiclav ^{10,30,44} AND doi: anthromycin ^{30,44,4} AND doi: give prophylaxis if: puncture wound; ^{16,47,40} Penicillin allergy: Review all at 24 and 48 hours, ^{10,20} as not all pathogens are covered. ^{10,30,44} Penicillin allergy (human bite): metronidazole ^{10,44,4} AND doi: give prophylaxis 400mg TDS ²⁰ 00mg TDS ²⁰ © Scabies Treat whole body from ear/chin downwards, ^{10,20} and under nails. ^{10,40} Permethrin ^{10,20,34,4} Mome/sexual contacts: treat within 24 hours. ¹⁰ Home/sexual common infecting pathogen. ¹⁰ Suspect if woman has: a painful breast. ¹⁰ fever and/or general maliase ^{10,40} or infraction: solite, use indicazole. ^{10,24,40} Most cases: terbinafine is fungicidal; ¹⁰ treatment infection: solite, use indicazole, ^{10,24,40,40} ff infection confirmed; use oral antibiotics are appropriate, infection: solit herapy, ⁶ and discuss with specialist. ¹⁰ or intraconazole. ^{10,24,40,40} ff infection confirmed; use oral terbinafine ^{10,24,40,40} froat atebings,	l eq ulcer	Licers are always colonised ^{10,24+} Antibiotics do not			As for
ulcers exudate/dour; increased pain; cellulits; pyrexia). ³⁰ uncert Bites: Human: thorough irrigation is important. ^{1/k-20} CKS Bites Human: thorough irrigation is important. ^{1/k-20} Cat: always give prophylaxis is advised. ^{1/k-20/30} Dog: give prophylaxis if: puncture wound; ^{1/k-20} Dog: give prophylaxis if: puncture wound; ^{1/k-20} Penicillin allergy; Review all at 24 and 48 hours, ¹⁰ as not all pathogens are covered. ^{20,30} 625mg TDS ²⁰ 4000mg TDS ²⁰ 0 0 Scables Treat whole body from ear/chin downwards, ^{10,20} Under 2 years/elderly: also treat face/scalp. ^{10,20} Home/sexual contacts: treat while 24 hours. ¹⁰ Pericillin allergy: and under nails. ^{10,20} Under 2 years/elderly: also treat face/scalp. ^{10,20} Home/sexual contacts: treat whole body from ear/chin downwards, ^{10,20} Home/sexual contacts: treat whole continue and breast. ¹⁰ Dermatophyte infection: solar than with fungistatic indicated. ^{20,30,44} th interactable; or scalp: send skin and nail infection: solar than with fungistatic indicated. ^{20,40,44} th candida possible, use imidazole. ^{20,34,40} or itraconazole. ^{20,34,40,40} Scalp: oral therapy, ¹⁰ and fact al. ^{10,20,40,40} Scalp: oral therapy, ¹⁰ and fact al. ^{10,20,40,40} Home/secalp: send skin scrapings. ¹⁰ ff infection: scalp: send skin scrapings. ¹⁰ ff infection is confirmed; use oral terbinafine ^{10,34,40,40} Scalp: oral therapy, ¹⁰ and nail infection: nail CKS Fungal nail infection is confirmed, use oral terbinafine ^{10,34,40,40}					∫ cellulitis ^{5D}
Bites: CKS Bites Human: thorough irrigation is important. " ^{Ax,20} Antibiotic prophylaxis is advised. ^{Ax,20,20} Cat: always give prophylaxis is advised. ^{Ax,20,20} Dog: give prophylaxis if: puncture wound; ^{IAx,20} Dog: give prophylaxis if: puncture wound; ^{IAx,20} Penicillin allergy (numan bite): metronidazel ^{30,44} AND as not all pathogens are covered. ^{20,30} Human or animal bite: co-amoxiclax ^{20,30} 625mg TDS ³⁰ 630mg BD ³⁰ 6) condition
CKS Bites Antibiotic prophylaxis is advised. ^{144,20,30} Assess risk, of tetanus, rabies. ¹⁴⁴ HIV, and hepatitis B and C. ³⁰ Cat: always give prophylaxis f: puncture wound; ^{144,20} Dig: give prophylaxis f: puncture wound; ^{144,20} Pericillin allergy (human bite): 400mg TDS ²⁰ 500mg BD ²⁰ Scabies Treat whole body from ear/chin downwards, ^{10,20} and under nails. ^{10,20} Under 2 years/lederly: also treat face/scalp. ^{10,20} mother) Pericillin allergy: methrin ^{10,20,34+} 5% cream ^{10,20} 2 api 100mg BD ²⁰ Mastitis darbersest S. aureus is the most common infecting pathogen. ¹⁰ cand breast. ²⁰ fever and/or general malaise; ²⁰ at antibiotics are appropriate, where indicated. ^{20,304,44+} Fluctoxacillin ²⁰ feeding; ^{10,204,44+} 500mg QD ²⁰ 2 api 10 di 10 di 2 api 2 api Dermatophyte infection: skin PHE Fungal skin and nail infection: skin PHE fungel skin infection: skin PHE fungel skin and nail infection: skin PHE fungel skin infection: skin PHE	Bites:	Human: thorough irrigation is important. ^{1A+,2D}	Human or animal bite:		ר ר
Cat: always give prophylaxis if: puncture wound; ^{14+,3D} bite to hand, foot, face, joint, tendon, or ligament; ¹⁴⁺ immunocompromised, cirrhotic, asplenic, or presence of prosthetic valve(pinct). ^{14,4+} Penicillin allergy: Review all at 24 and 48 hours, ³⁰ as not all pathogens are covered. ^{20,30} Penicillin allergy (human bite): metronidazole. ^{30,A4+} AND clarithromycin ^{30,A4+} 400mg TDS ²⁰ 500mg BD ³⁰ © Scabies NHS Scabies Treat whole body from ear/chin downwards, ^{10,20} Home/sexual contacts: treat within 24 hours. ¹⁰ Mastitis Pericillin allergy: and under nails, ^{11,20} Under 2 years/elderly: also treat face/scap. ^{10,20} Home/sexual contacts: treat within 24 hours. ¹⁰ Most cases: treat within 24 hours. ¹⁰ Mastitis Permethrin ^{10,20,34+} S. <i>aureus</i> is the most common infecting pathogen. ¹⁰ Suspect if woman has: a painful breast. ²⁰ Pericillin allergy: and/or general malaise, ⁴⁰ a tender, red breast. ²⁰ Pericillin allergy: clarithromycin ²⁰ OR 500mg QDS ²⁰ 2 api 10 di So0mg QDS ²⁰ Permetory in all constraine infection: skin pHE Fungal SLD, scalare, ²⁰ and discuss with specialist. ¹⁰ If infractable, or scalp: send skin scrapings. ¹⁰ If infraction confirmed: use oral terbinafine ^{10,34+,40} or itraconazole. ^{10,34+,40} For athlete's foot: topical undergenets foot: scalp: oral antibiotines in soragings. ¹⁰ If infraction confirmed. ¹⁰ Oral antifungals. ³⁴⁺ If candida on on-dermatophyte infection: shin infection: shin infection all cordinanzale. ¹⁰ Or al antifungals. ³⁴⁺ If candida or non-dermatophyte infection is confirmed, use oral terbinafine ^{10,34+,40} Or al antifungals. ³⁴⁺ If candida on on-dermatophyte infection is confirmed, use oral itraconazole. ^{10,34+,40} Or al antifungals. ³⁴⁺ If candida or non-derematophyte infection infection confirmed, use oral itraconazole.	CKS Bites	Antibiotic prophylaxis is advised. ^{1A+,2D,3D} Assess risk	co-amoxiclav ^{2D,3D}	625mg TDS ^{3D} ©	
Dog: give prophylaxis if: puncture wound: ^{1A+30} bite to hand, foot, face, joint, tendon, or ligament; ^{1A+} memonidazole ^{3D,AA+} AND as not all pathogens are covered. ^{2D,30} bite): bi					
bite to hand, foot, face, joint, tendon, or ligament; ^{1A+} immunocompromised, cirrhotic, asplenic, caplenic, caplen		Cat: always give prophylaxis. ^{1A+,3D}			
immunocompromised, cirrhotic, asplenic, or presence of prosthetic valve/joint. ^{20,44+} 500mg BD ²⁰ Sound BD		Dog: give prophylaxis if: puncture wound; ¹¹		400-m a TDC ^{2D}	
Immediate our province of prostatic value/joint. ^{10,44,44} Pericillin allergy: Review all at 24 and 48 hours, ¹⁰ Pericillin allergy (animal bite): 900mg TDS ^{2D} 9 Scabies Treat whole body from ear/chin downwards, ^{10,2D} Permethrin 01/0201 ⁴⁴ 400mg TDS ^{2D} 9 Scabies Treat whole body from ear/chin downwards, ^{10,2D} Permethrin 02,00,34+ A00mg TDS ^{2D} 9 NHS Scabies Treat whole body from ear/chin downwards, ^{10,2D} Permethrin allergy: 5% cream ^{10,2D} 9 Mastitis Scabes and under naits. ^{10,2D} Under 2 years/elderly: also treat face/scalp. ^{10,2D} Permethrin allergy: 5% cream ^{10,2D} 9 (lactating mother) Suspect if woman has: a painful breast; ²⁰ fever and/or general malaise; ²⁰ at ender, red breast. ²⁰ Permethrin allergy: 500mg QDS ^{2D} 10 dt CKS Mastitis Breastfeeding; cral antibiotics are appropriate, where indicated. ^{20,3A+} Women should continue abscess Topical terbinafine ^{3A+,4D} 1% OD-BD ^{2A+} 9 10 dt Infection: skin Hereiton confirmed: use oral terbinafine ^{10,3A+,4D} Topical terbinafine ^{10,2A+,3A+} 0R 14 wereindicated. ^{20,3A+} 9 1-4 wereindicated. ^{20,3A+,4D,0D} Dermatophyte If infection confirmed: use oral terbinafine ^{10,3A+,4D} Topical terbinafine ¹		bite to hand, root, race, joint, tendon, or ligament;	metronidazole ^{3D,4A+}		5 days ^{3D,5D}
Periodlin allergy: Review all at 24 and 48 hours, 30 as not all pathogens are covered. 20,30Pericillin allergy (animal bite): metronidazole30,44+ AND doxycycline30400mg TDS 30 (00mg BD 30)Image: Comparison of the compar			ciantinomycin		
as not all pathogens are covered. ^{20,30} bite): metronidazole. ^{30,44+} AND doxycyc/line ³⁰ 400mg TDS ²⁰ © Scabies Treat whole body from ear/chin downwards, ^{10,20} and under nails. ^{10,20} Treat whole body from ear/chin downwards, ^{10,20} and under nails. ^{10,20} Permethrin ^{10,20,34+} 5% cream ^{10,20} © 2 apj 1 wee Mastitis S. aureus is the most common infecting pathogen. ¹⁰ Suspect if woman has: a painful breast. ²⁰ fever mother) Permethrin allergy: malathion ¹⁰ 0.5% aqueous liquid ¹⁰ © 1 wee CKS Mastitis S. aureus is the most common infecting pathogen. ¹⁰ Suspect if woman has: a painful breast. ²⁰ and or general malaise. ²⁰ a tender, red breast. ²⁰ abscess Flucloxacillin ²⁰ 500mg QDS ²⁰ 10 dr Dermatophyte infection: skin PHE Fungal skin infections Most cases: terbinafine is fungicidal; ¹⁰ treatment time shorter than with fungistatic imidazole. ¹⁰ Scalp: oral therapy, ⁶⁰ and discuss with specialist. ¹⁰ Scalp: oral therapy, ⁶⁰ and discuss with specialist. ¹⁰ For athiete's foot: topical undecenoates ^{2A+} (eg Mycota ^{9,2A+} 14 wee of therating ^{10,2A+,40,60} 250mg OD ^{10,2A+,60} 4.6 v 24+,50 Dermatophyte infection: nail creat antilungals. ^{A+} If candida or non-dermatophyte infection is confirmed, use oral itraconazole. ^{10,5A+,60} Topical nail lacquer is not as effective than oral azole. ^{10,2A+,40,60} 250mg OD ^{10,2A+,60} Fingers: 2 Dermatophyte infection is confirmed, use oral itraconazole. ^{10,5A+,60} Topical nail la		Penicillin allergy: Review all at 24 and 48 hours. ^{3D}	Penicillin allergy (animal		
Scabies Treat whole body from ear/chin downwards, ^{10,20} and under nails. ^{10,20} Under 2 years/elderly: also treat face/scalp. ^{10,20} Home/sexual contacts: treat within 24 hours. ¹⁰ Permethrin ^{10,20,30+} 5% cream ^{10,20} 2 apl (a catating mother) Mastitis (actating mother) S. aureus is the most common infecting pathogen. ¹⁰ and/or general malaise, ²⁰ a tender, red breast. ²⁰ mother) Permethrin allergy: and/or general malaise, ²⁰ a tender, red breast. ²⁰ redering, ^{10,20} including from the affected breast. ²⁰ feeding, ^{10,20} including from the affected breast. ²⁰ Fluctoxacillin ²⁰ Clarithromycin ²⁰ OR soomg QDS ²⁰ 500mg QDS ²⁰ 10 dz Dermatophyte infection: shin PHE Fungal skin and nail infection sontimed. Scalp: oral therapy, ⁶⁰ and discuss with specialist. ¹⁰ Most cases: terbinafine is fungicidal; ¹⁰ treatment time shorter than with fungistatic imidazole. ^{10,24+,34+} or itraconazole. ^{2A+,34+,50} Scalp: oral therapy, ⁶⁰ and discuss with specialist. ¹⁰ Topical terbinafine ^{3A+,40} clotrimazole, OR miconazole. ^{2A+,34+} (eg Mycota ⁸) ^{2A+} 1% OD-BD ^{2A+} (OD-BD ^{2A+} (a) <i>2</i> 1-4 wea topical anail loppings; ¹⁰ start therapy only if infection is oral azole. ^{10,2A+,3A+,60} Topical nail lacquer is not as effective. ^{10,5A+,40} (infection is confirmed, use oral itraconazole, ^{10,5A+,40} Topical anail lacquer is not as effective. ^{10,5A+,40,60} 10,02,24+,60 (a) terbinafine ^{10,2A+,40,60} Toes: 12 w 250mg OD ^{10,2A+,60} (a) tweek a m { Fingers: 2		as not all pathogens are covered. ^{2D,3D}	bite):		
Scabies NHS Scabies Treat whole body from ear/chin downwards, ^{10,2D} and under nails. ^{10,2D} Under 2 years/elderly: also treat face/scalp. ^{10,2D} Hom/sexual contacts: treat within 24 hours. ¹⁰ Permethrin ill. ^{2D,3A+} Permethrin allergy: malathion ^{1D} 5% cream ^{10,2D} 2 ap (1 we 0.5% aqueous liquid ^{1D} Mastitis (lactating mother) S. aureus is the most common infecting pathogen. ¹⁰ Suspect if woman has: a painful breast; ^{2D} a tender, red breast. ^{2D} and /or general malaise; ^{2D} a tender, red breast. ^{2D} where indicated. ^{2D,3A+} Women should continue feeding; ^{1D,2D} including from the affected breast. ^{2D} bermatophyte infection: skin Flucloxacillin ^{2D} Flucloxacillin ^{2D} 500mg QDS ^{2D} 10 dc Dermatophyte infection: skin Most cases: terbinafine is fungicidal; ^{1D} treatment infection: scalp: send skin scrapings. ^{1D} or itraconazole. ^{2A+,3A+,6D} Scalp: oral therapy, ^{6D} and discuss with specialist. ^{1D} Topical terbinafine ^{3A+,4D} OD-BD ^{2A+} 1% OD-BD ^{2A+} 14 weet of tinfaction confirmed. ^{1D} Cral terbinafine is more effective than oral azole. ^{1D,2A+,3A+,4D} infection is confirmed, use oral traconazole. ^{1D,3A+,4D} oral azole. ^{1D,2A+,3A+,4D} infection is confirmed, use oral itraconazole. ^{1D,3A+,4D} Topical nail lacquer is not as effective. ^{1D,3A+,4D} Topical nail lacquer is			metronidazole ^{3D,4A+} AND	100mg BD ^{2D} ©	
NHS Scabies and under nails. ^{15,20} Under 2 years/elderly: also treat face/scalp. ^{10,20} Home/sexual contacts: treat within 24 hours. ¹⁰ Mastitis Permethrin allergy: malathion ¹⁰ 0.5% aqueous liquid ¹⁰ 2 api 1 we Mastitis (lactating mother) S. aureus is the most common infecting pathogen. ¹⁰ Suspect if woman has: a painful breast; ²⁰ a tender, red breast; ²⁰ and/or general malaise; ²⁰ a tender, red breast; ²⁰ and breast abscess Flucloxacillin ²⁰ 500mg QDS ²⁰ 1 we Dermatophyte infection: skin PHE Fungal skin and nail infection: nail CKS Fungal nail infection Most cases: terbinafine is fungicidal; ¹⁰ treatment time shorter than with fungistatic imidazole. ⁴⁰ Topical terbinafine ^{3A+,40} Clotrimazole, OR or itraconazole. ^{2A+,3A+,50} 1% OD-BD ^{2A+} 1 -4 wee (clotrimazole, OR miconazole, ^{2A+,3A+,50} Dermatophyte infection: nail cKS Fungal nail infection Take nail clippings; ¹⁰ start therapy only if infection oral azole: ^{10,2A+,3A+,00} Liver reactions 0.1 to 1% with oral azole: ^{10,2A+,4D,6D} 200mg BD ^{10,4D} 200mg BD ^{10,4D} Fingers: 2					
Under 2 years/elderly: also treat face/scalp. Home/sexual contacts: treat within 24 hours. Image: mother (lactating mother)Permethrin allergy: malathion 1D0.5% aqueous liquid 1D1Mastitis (lactating mother) and/or general malaise; 2D at ender, red breast. and breast abscessS. aureus is the most common infecting pathogen. Suspect if woman has: a painful breast; 2D at ender, red breast. Breastfeeding: oral antibiotics are appropriate, where indicated. 2D.34+ Women should continue feeding. 10.2D including from the affected breast. Dermatophyte infection: skin PHE Fungal skin and nail infectionsSources: terbinafine is fungicidal; 1D treatment time shorter than with fungistatic imidazoles. 1D.2A+,3A+,4D or itraconazole. Scalp: oral therapy, 6D and discuss with specialist. Take nail clippings; 1D start therapy only if infection is confirmed. '1D Cral terbinafine is more effective than oral azole. '1D,2A+,3A+,4D infection is confirmed, use oral itraconazole. (D2A+,3A+,4D) (EXS Fungal nail infection is confirmed, use oral itraconazole. (D2A+,3A+,4D) (D ral terbinafine is nore effective. (D2A+,4A+,0E)Permethrin allergy: ropical nail lacquer is not as effective. (D2A+,3A+,4D) (D ral terbinafine is nore effective. (D2A+,3A+,4D) (D ral azole. (D2A+,3A+,4D) (D ral terbinafine is nore effective. (D2A+,4A+,0E)First line: (D2A+,3A+,4D,6D) (D2A+,4D,6D)1.0 de (D -BD,2A+,4D,6D) (D -BD,2A+,4D,6D)Dermatophyte infectionTake nail clippings; 1D start therapy only if infection is confirmed. '1D Oral terbinafine is more effective than oral azole. '1D,2A+,3A+,4D, Liver reactions 0.1 to 1% with oral azole. '1D,2A+,3A+,4D, Liver reactions 0.1 to 1% with oral azole. '1D,2A+,4D,4D,4D200mg BD ^{1D,4D} (CAS Fu		Treat whole body from ear/chin downwards, ^{1D,2D}	Permethrin ^{1D,2D,3A+}	5% cream ^{1D,2D} ©	J
Home/sexual contacts: treat within 24 hours. ^{1D} malathion ^{1D} 0.5% aqueous liquid ^{1D} Image: Contact is independent of the image: Contact is independent of	NHS Scabies	and under nails. ^{1D,2D}			2 applications,
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CKS Mastitis and breast abscess Breastfeeding: oral antibiotics are appropriate, where indicated. ^{2D,3A+} Women should continue feeding, ^{1D,2D} including from the affected breast. ^{2D} clarithromycin ^{2D} OR erythromycin ^{2D} OR 500mg QDS ^{2D} Dermatophyte infection: skin PHE Fungal skin and nail infections Most cases: terbinafine is fungicidal; ^{1D} treatment time shorter than with fungistatic imidazoles. ^{1D,2A+,3A+} If candida possible, use imidazole. ^{4D} Topical terbinafine ^{3A+,4D} OR 1% OD-BD ^{2A+} © 1-4 wet or itraconazole. ^{4D} If infection confirmed: infections use oral terbinafine ^{1D,3A+,4D} or itraconazole. ^{2A+,3A+,5D} Scalp: oral therapy, ^{6D} and discuss with specialist. ^{1D} Take nail clippings; ^{1D} start therapy only if infection is confirmed. ^{1D} Oral terbinafine is more effective than oral azole. ^{1D,2A+,3A+,4D} Liver reactions 0.1 to 1% with oral antifungals. ^{3A+} If candida or non-dermatophyte infection is confirmed, use oral itraconazole. ^{1D,3A+,4D} ori and infungals. ^{3A+} If candida or non-dermatophyte infection is confirmed, use oral itraconazole. ^{1D,3A+,4D} oral antifungals. ^{3A+} If candida or non-dermatophyte infection is confirmed, use oral itraconazole. ^{1D,3A+,4D} Topical nail lacquer is not as effective. ^{1D,5A+,6D} First line: itraconazole ^{1D,3A+,4D,6D} 200mg BD ^{1D,4D} © 1 week a m Fingers: 2		and/or general malaise: ^{2D} a tender, red breast ^{2D}	Penicillin alleray:		2 10 days ^{2D}
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Scalp: oral therapy, 6 ^D and discuss with specialist. ^{1D} topical undecenoates ^{2A+} (eg Mycota [®]) ^{2A+} OD-BD ^{2A+} Image: Comparison of the comparison	INTECTIONS	or itraconazole ^{2A+,3A+,5D}	For athlete's foot		
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infection: nail CKS Fungal nail infection infe	Dermatophyte	Take nail clippings; ^{1D} start therapy only if infection is	Eirst line:		
CKS Fungal nail oral azole. ^{1D,2A+,3A+,4D} Liver reactions 0.1 to 1% with oral azole. ^{1D,2A+,3A+,4D} Liver reactions 0.1 to 1% with J Toes: 12 w infection oral antifungals. ^{3A+} If candida or non-dermatophyte Second line: itraconazole ^{1D,3A+,4D,6D} 200mg BD ^{1D,4D} 1 week a m Topical nail lacquer is not as effective. ^{1D,5A+,6D} Topical nail lacquer is not as effective. ^{1D,5A+,6D} Second line: itraconazole ^{1D,3A+,4D,6D} 200mg BD ^{1D,4D} Fingers: 2		confirmed. ^{1D} Oral terbinafine is more effective than	terbinafine ^{1D,2A+,3A+,4D,6D}	250mg OD ^{1D,2A+,6D} © 〕 I	Fingers: 6 weeks ^{1D,6D}
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Topical nail lacquer is not as effective. ^{10,64,60} Fingers: 2	infection		Second line:		. 1D
		Intection is confirmed, use oral itraconazole. ^{10,5A+,6D}	Itraconazole Stort, E, B		I week a month: ^{1D} Fingers: 2 courses ^{1D}
					Fingers: 2 courses
antifungal cream to entire toe area. ^{6D} Stop treatment when continual, new, he		antifungal cream to entire toe area.			
Children: seek specialist advice. ^{4D}				proximal nail growth ^{6D}	a, new, nealiny,







Varicella	Pregnant/immunocompromised/neonate:	Aciclovir ^{3A+,6A+,9A+,12B+,13A-,14A+}	800mg five times daily ^{15A-} ©]13415A
zoster/	seek urgent specialist advice. ^{1D}			7 days ^{13A-,15A-}
chickenpox	Chickenpox: consider aciclovir ^{2A+,3A+,4D} if: onset of	Second line for shingles if		
PHE Varicella	rash <24 hours. ^{3A+} and one of the following: >14	poor compliance:		
	years of age, ^{4D} severe pain; ^{4D} dense/oral rash; ^{4D,5B+} taking steroids; ^{4D} smoker. ^{4D,5B+}	valaciclovir ^{7D,9A+,13A-}	1g TDS ^{13A-} ©	
	taking steroids: ^{4D} smoker. ^{4D,5B+}		5	7
Herpes zoster/	Shingles: treat if >50 years ^{6A+,7D} (PHN rare if <50			
shingles	years) ^{8B+} and within 72 hours of rash, ^{9A+} or if one of			
PCDS Herpes	the following: active ophthalmic; ^{10D} Ramsey Hunt; ^{4D}			
zoster	eczema; ^{4D} non-truncal involvement; ^{7D} moderate or			
	severe pain; ^{7D} moderate or severe rash. ^{5B+,7D}			
	Shingles treatment if not within 72 hours:			
	consider starting antiviral drug up to one week			
	after rash onset. ^{11B+} if high risk of severe			
	shingles ^{11B+} or complications ^{11B+} (continued vesicle formation; ^{4D} older age; ^{6A+,7D,11B+}			
	formation; ^{4D} older age; ^{6A+,7D,11B+}			
	immunocompromised; ^{4D} severe pain). ^{7D,11B+}			
EYE INFECTIO	NS			
Conjunctivitis	First line: bath/clean eyelids with cotton wool	First line: self-care ^{1D}		
AAO	dipped in sterile saline or boiled (cooled) water, to			
Conjunctivitis	remove crusting. ^{1D}	Second line:		
	Treat only if severe, ^{2A+} as most cases are viral ^{3D}	chloramphenicol ^{1D,2A+,4A-,5A+}	2 hourly for 2 days, ^{1D,2A+}	
	or self-limiting. ^{2A+}	0.5% eye drop ^{1D,2A+}	then QDS ^{1D} ©	101 (
	Bacterial conjunctivitis: usually unilateral and			48 hours after
	also self-limiting. ^{2A+,3D} It is characterised by red eye	OR		resolution (max
	with mucopurulent, not watery discharge. ^{3D} 65%	1% ointment ^{1D,5A+}	3-4 times daily, ^{1D} or just at	10-14 days)
	and 74% resolve on placebo by days 5 and 7.4A-,5A+		night if using eye drops	
	Third line: fusidic acid as it has less gram-		during the day ^{1D}	
	negative activity. ^{6A-,7D}	OR	10.24+	
		0.3% ofloxacin	2-4 hourly for 2 days, ^{1D,2A+}	48 hours after
			then QDS ^{1D} ©	resolution (max
		The level of the second		10 days)
		Third line:	BD ^{1D,7D} ©	48 hours after
		fusidic acid 1% gel ^{2A+,5A+,6A-}	BD ^{10,70} ©	
Plopharitic	First line , lid hygiono ^{1D,2A+} for symptom control ^{1D}	First line: self-care ^{1D}		resolution
Blepharitis CKS Blepharitis	First line: lid hygiene ^{1D,2A+} for symptom control, ^{1D} including: warm compresses; ^{1D,2A+} lid massage and	First line: self-care Second line:		
UNO Diephantis	scrubs; ^{1D} gentle washing; ^{1D} avoiding cosmetics. ^{1D}	Second line: Chloramphenicol ^{1D,2A+,3A-}	1% ointment BD ^{2A+,3D} ©	6 week trial ^{3D}
		Chioramphenicol		o week liidi
	Second line: topical antibiotics if hygiene measures are ineffective after 2 weeks. ^{1D,3A+}			
	Signs of Meibomian gland dysfunction, ^{3D} or			
	acne rosacea: ^{3D} seek specialist advice . ^{1D}			
	ache rusacea: seek specialist auvice .			



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Summary table – Suspected dental infections in primary care (outside dental setting)

Derived from the Scottish Dental Clinical Effectiveness Programme (SDCEP) 2013 Guidelines

This guidance is not designed to be a definitive guide to oral conditions, as GPs should not be involved in dental treatment. Patients presenting to nondental primary care services with dental problems should be directed to their regular dentist, or if this is not possible, to the NHS 111 service (in England), who will be able to provided details of how to access emergency dental care.

ILLNESS	GOOD PRACTICE POINTS	TREATMENT	ADULT DOSE	DURATION OF			
			(© = child doses)	TREATMENT			
	Note: Antibiotics do not cure toothache. ^{1D} First line treatment is with paracetamol ^{1D} and/or ibuprofen, ^{1D} codeine is not effective for toothache. ^{1D}						
Mucosal ulceration and inflammation	Temporary pain and swelling relief can be attained with saline mouthwash. ^{1D} Use antiseptic mouthwash if more severe, ^{1D} and if pain limits oral	Saline mouthwash ^{1D} Chlorhexidine 0.2% ^{1D, 2A-}	½ tsp salt in warm water ^{1D} ☺	Always spit out after use ^{1D}			
(simple gingivitis) SDCEP Dental problems	hygiene to treat or prevent secondary infection. ^{1D,2A-} The primary cause for mucosal ulceration or inflammation (aphthous ulcers; ^{1D} oral lichen	^{,3A+,4A+} (do not use within 30mins of toothpaste) ^{1D} Hydrogen peroxide 6% ^{5A-}	1 min BD with 10mL ^{1D} ©	Use until lesions resolve ^{1D} /less pain allows for			
problems	planus; ^{1D} herpes simplex infection; ^{1D} oral cancer) ^{1D} needs to be evaluated and treated. ^{1D}	(spit out after use) ^{1D}	in ½ glass warm water ^{1D} ©	oral hygiene ^{1D}			
Acute necrotising ulcerative	Refer to dentist for scaling and hygiene advice. ^{1D,2D} Antiseptic mouthwash if pain limits oral hygiene. ^{1D} Commence metronidazole in the presence of	Chlorhexidine 0.2% ^{1D} OR hydrogen peroxide 6% ^{1D}	See above dosing for mucosal ulceration ^{6D}	Until pain allows for oral hygiene ^{6D}			
gingivitis	systemic signs and symptoms. ^{1D,2D,3B-,4B+,5A-}	Metronidazole ^{1D,3B-,4B+,5A-}	400mg TDS ^{1D,2D} ©	3 days ^{1D,2D}			
Pericoronitis SDCEP Dental problems	Refer to dentist for irrigation and debridement. ^{1D} If persistent swelling or systemic symptoms, ^{1D} use metronidazole ^{1D,2A+,3B+} or amoxicillin. ^{1D,3B+}	Metronidazole ^{1D,2A+,3B+} OR amoxicillin ^{1D,3B+}	400mg TDS ^{1D} © 500mg TDS ^{1D} ©	3 days ^{1D,2A+} 3 days ^{1D}			
	Use antiseptic mouthwash if pain and trismus limit oral hygiene. ^{1D}	Chlorhexidine 0.2% ^{1D} OR hydrogen peroxide 6% ^{1D}	 See above dosing for mucosal ulceration^{1D} 	Until pain allows for oral hygiene ^{1D}			
Dental abscess SDCEP Dental problems	Regular analgesia should be the first option ^{1A+} until a dentist can be seen for urgent drainage, ^{1A+,2B-,3A+} as repeated courses of antibiotics for abscesses are not appropriate. ^{1A+,4A+} Repeated antibiotics alone, without drainage, are ineffective in preventing the spread of infection. ^{1A+,5C} Antibiotics are only recommended if there are signs of severe infection, ^{3A+} systemic symptoms, ^{1A+,2B-,4A+} or a high risk of complications. ^{1A+} Patients with severe odontogenic infections (cellulitis, ^{1A+,3A+} plus signs of sepsis; ^{3A+,4A+} difficulty in swallowing; ^{6D} impending airway obstruction) ^{6D} should be referred urgently for hospital admission to protect airway, ^{6D} for surgical drainage ^{3A+} and for IV antibiotics. ^{3A+} The empirical use of cephalosporins, ^{6D} co-amoxiclav, ^{6D} clarithromycin, ^{6D} and clindamycin ^{6D} do not offer any advantage for most dental patients, ^{6D} and should only be used if there is no response to first line drugs. ^{6D}						
	If pus is present, refer for drainage, ^{1A+,2B¹} tooth extraction, ^{2B-} or root canal. ^{2B-} Send pus for investigation. ^{1A+} If spreading infection ^{1A+} (lymph node involvement ^{1A+,4A+} or systemic signs, ^{1A+,2B,4A+} ie fever ^{1A+} or malaise) ^{4A+} <i>ADD</i> metronidazole. ^{6D,7B+} Use clarithromycin in true penicillin allergy ^{6D} and, if severe, refer to hospital. ^{3A+,6D}	Amoxicillin ^{66,88+,9C,108+} Metronidazole ^{6D,88+,9C} <i>Penicillin allergy:</i> clarithromycin ^{6D}	500mg-1g TDS ^{6D} © 400mg TDS ^{6D} © 500mg BD ^{6D} ©	Up to 5 days; ^{6D,} ^{10B+} review at 3 days ^{9C,10B+}			



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