



Antibiotic Management Team
NHS Dumfries and Galloway
Empirical Antibiotics Formulary for Secondary
Care (Adult)
Updated 02 June 2025

Document Control			
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Reviewers	Antimicrobial Management Team (AMT) & <i>in particular:</i> Dr Linsey Batchelor (AMT lead) Dr Bryan Marshall Dr Jon Van Aartsen Dr Sharon Irvine Dr Manjul Medhi <i>Special thanks for their contribution to the formulary: Micro/ID team, Dr. Heydtmann, Dr. Moawad Mahgoub, Dr. Ali Atwi, Dr. Abdellatif Tawfik & Mr. Whitelaw</i>	Implementation date	02 June 2025
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Aims

- To provide a simple, best guess approach to the treatment of common infections.
- To promote the safe, effective, and economic use of antibiotics.
- To minimise the emergence of bacterial resistance and hospital acquired infections.

Principles of Treatment

1. The advice given in the antibiotic policy for adults is based on the information available at the time of writing. It should be interpreted by the prescriber in the light of professional judgement and clinical assessment.
2. Prescribe an antibiotic only when there is likely to be a clear clinical benefit. Prescriptions for antibiotics must include documentation of the indication and stop/review date on HEPMA or prescription chart or in the medical notes.
3. In pregnancy, avoid quinolones, tetracycline, aminoglycosides (unless severe/ life threatening infection), high dose metronidazole, trimethoprim (in first trimester - folate antagonist) and nitrofurantoin (at term - risk of neonatal haemolysis, however short term use of nitrofurantoin is unlikely to cause problems to the foetus).
4. Avoid widespread use of topical antibiotics (especially those also available as systemic preparations).
5. Quinolones and tetracycline antibiotics can interact with cations, milk, antacids, and sodium bicarbonate, potentially reducing their absorption and effectiveness. These interactions occur due to the formation of insoluble complexes between the antibiotics and divalent or trivalent cations such as calcium, magnesium, aluminium, iron, and zinc. To minimize these interactions, it's recommended to leave a gap of at least (minimum) 2 hours before or after taking the antibiotic- [refer to link](#)
6. **Avoid prescribing tetracycline antibiotic (e.g. doxycycline) near bedtime** due to risk of oesophagitis. Consider prescribing doxycycline at 8am and 8pm, or 8am or 4pm on HEPMA. Patient should remain upright for at least 30 minutes after taking doxycycline.
7. Gentamicin and Vancomycin therapy requires monitoring. Gentamicin and Vancomycin dosing guidelines can be found in the NHS Dumfries and Galloway Antimicrobial Handbook.
 - For guidance on dosing gentamicin & vancomycin, refer to the [policy](#)
 - Gentamicin for **endocarditis**, [synergistic Gentamicin for endocarditis guidelines](#) should be usedNeonatal ototoxicity has not been observed with use of gentamicin in pregnancy however it has been seen with other aminoglycosides, therefore gentamicin should be used with caution in pregnancy. Where possible use only a stat dose or the shortest effective course.
8. **Doses stated on this formulary are based on normal renal and hepatic function.** If renal function is impaired, discuss antibiotic dose adjustments with your clinical pharmacist/consultant or check the [Renal Drug Database*](#) or [Summary of Product Characteristics \(SPC\)](#).*
 - For most drugs and for most patients of average build and height, eGFR can be used to determine dosage adjustments. However, in elderly patients, extremes muscle mass (BMI <18kg/m² or >40kg/m²), on nephrotoxic drugs/ drugs with narrow therapeutic index, it's advisable to calculate creatinine clearance (CrCl) using the Cockcroft-Gault formula.
 - *Note- The information on dosage adjustments in renal impairment given in Renal Drug Database and SPC are based on Cockcroft-Gault creatinine clearance and not eGFR, since the majority of published information available is based on creatinine clearance.
9. Nitrofurantoin is contraindicated in patients with an estimated CrCl below 30 mls/min.

10. If the patient is penicillin allergic, review the nature of the allergy.
 - If allergy is minor (non-confluent or non-pruritic rash restricted to a small area), it is safe to use Cephalosporins. The information contained in the 56th and subsequent editions of the BNF now states that the hypersensitivity rate between penicillins and cephalosporins is 0.5% - 6.5% (vs 10% previously thought).
 - If patient has had previous Type I anaphylaxis or Severe Type 4 reaction (e.g. Steven-Johnson syndrome, Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS); **DO NOT** use any penicillin or cephalosporins (of any generation). Other beta lactams (e.g. aztreonam, carbapenems) may be used with caution where benefit outweighs risk, as low risk of cross sensitivity ($\leq 1\%$).
 - If a penicillin allergy alternative is not given in this policy, contact microbiology for further advice.
11. All antibiotics have side effects including Clostridioides difficile infection (CDI). In particular, broad spectrum Cephalosporins, Co-Amoxiclav, Piperacillin/Tazobactam, Carbapenems and Quinolones are implicated, and where possible, an alternative antibiotic is recommended. CDI is associated with high mortality; a 2010-2016 study reported a 30-day all-cause mortality rate of 17.5% for CDI patients. Healthcare-associated CDI had a higher mortality rate (21.8%) compared to community-associated CDI (8.3%).
12. Oral Quinolones, Metronidazole and Co-trimoxazole have excellent bioavailability. Although oral Clarithromycin has 50% bioavailability, it has an active metabolite and excellent penetration into pulmonary tissue, hence considered equivalent to IV. For these agents, use IV only if oral route is compromised.
13. Note restrictions on use of fluoroquinolones following [MHRA safety review 2024](#). **Patient information leaflets must be provided and counselling done on quinolone prescriptions.**
14. **Review intravenous antibiotics daily.** Consider switching to oral therapy when the patient is clinically improved and the following criteria are satisfied: Temperature is resolving; patient can tolerate oral therapy; refer to [IV to Oral Antibiotic Switch Therapy \(IVOST\) guidelines](#) on NHS D&G Antimicrobial Handbook if there is no positive microbiology to guide change.
15. In 2019, EUCAST (European Committee on Antimicrobial Susceptibility Testing) redefined 3 primary categories used in antibiotic susceptibility testing: [Refer to link for further information](#)
 - **Susceptible (S):** Indicates that the antibiotic is effective at standard doses.
 - **Susceptible, Increased Exposure (I):** Replaces the previous "Intermediate" category, **suggesting that the antibiotic can be effective at higher doses or with prolonged exposure.**
 - **Resistant (R):** Indicates that the antibiotic is ineffective, even at higher dose.
16. Individuals with myasthenia gravis (MG) should exercise caution when using certain antibiotics, as they can potentially worsen the condition. [Refer to link](#) for more information.
17. If you require advice for any indication not listed here, or for any other advice, please contact the duty consultant microbiologist. Ensure all relevant clinical information is available.
18. Audit of antibiotic prescribing against this policy is carried out on a regular basis.

Useful contact numbers

Duty consultant microbiologist- (Switchboard)

Infectious diseases consultant- Dr Irvine (33656)k

Antimicrobial Pharmacist for secondary care Evelyn Yoong (31315)

Antimicrobial Pharmacy Technician Donna Davidson (32236)

Antimicrobial Stewardship Team email: dg.antimicrobialstewardship@nhs.scot

Out of hours – Clinical queries on call Microbiologist or Pharmacy issues on-call pharmacist via switchboard.

Sepsis

Sepsis is a life-threatening organ dysfunction caused by dysregulated host response to infection. Arises due to injury to tissues, usually as a response to infection. Sepsis has a mortality rate of 30% in the UK.

Septic shock is a subset of sepsis, in which circulatory and metabolic abnormalities are profound enough to substantially increase mortality. End organ damage has occurred as a result of sepsis – lactate remains high, and BP remains low despite adequate fluid resuscitation.

Screen for Sepsis (in all patients with suspected infection). Please refer to D&G sepsis bundle

- ❖ High degree of vigilance required for early identification
- ❖ If presenting with infection and physiological disturbances (NEWS of ≥ 4 , or 3 in one parameter) → **Stop. Think: Could this be Sepsis?**

Presence of Red Flags

- V, P or U on AVPU – responds only to voice or pain, or is unrousable
- SBP ≤ 90 mmHg (or < 40 mmHg from normal)
- HR > 120
- RR ≥ 25
- Requires oxygen to maintain SaO₂ $\geq 92\%$
- Non-blanching rash/ cyanosis/ mottled skin/ ashen looking
- No urine output in last 18 hours
- Urine output < 0.5 ml/kg/hr
- Lactate ≥ 2
- Recent chemotherapy

Any red flags → start Sepsis-6 within 1 hour and request senior review

Presence of Amber Flags

- Relatives concerned about mental status/ confusion
- Acute deterioration in functional ability
- Immunosuppressed
- Trauma/ surgery/ procedure in last 6 weeks
- RR 21-24 OR working hard to breathe
- SBP 91-100mmHg
- HR 91-120 OR new arrhythmia
- Temperature < 36
- No urine output in last 12-18 hours
- Clinical signs of wound, skin or device infection

Any amber flags → take bloods and lactate and senior review within 1 hour and treatment started, if appropriate, within 3 hours or sooner

Take cultures (blood, urine, etc) and measure lactate prior to commencing antibiotic treatment.

Antibiotics of choice for SEPSIS

Indications	1 st line antibiotics	2 nd line antibiotics	Duration
Sepsis of unknown origin			
	IV Amoxicillin 1g 8-hourly AND IV Gentamicin	IV Vancomycin AND IV Gentamicin	Duration depends on source Review after 48 hours and switch if possible
Sepsis and unsure if LRTI or UTI			
	IV Amoxicillin 1g 8-hourly AND IV Gentamicin IV	IV Co-trimoxazole 960mg 12-hourly (and consider IV Gentamicin)	Review at 48hrs and switch
Respiratory tract sepsis			
Community-acquired	IV Amoxicillin 1g 8-hourly or IV Co-amoxiclav 1.2g 8-hourly AND PO Doxycycline 200mg stat, then 100mg bd (as 1 st choice) OR PO Clarithromycin 500mg 12-hourly (as 2 nd choice) - <i>IV if absorption/ swallow issues</i>	PO Levofloxacin 500mg 12-hourly (<i>IV if absorption/ swallow issues</i>)	5 days (including IV and oral) Levofloxacin is the choice of antibiotic if confirmed <i>Legionella pneumonia</i> Duration: 10-14 days of 'atypical cover' (longer duration may be required in severe disease or immunocompromised)
Hospital-acquired	IV Co-trimoxazole 960mg 12-hourly AND IV Gentamicin		5 days (including IV and oral)

Urinary tract sepsis		
Upper UTI/ pyelonephritis (males & non- pregnant females)	With sepsis: IV Gentamicin up to 72 hours as per protocol, consider IVOST* at 48-72 hours If renal impairment CrCl<20mls/min: Single dose IV Gentamicin- take levels q24 hours as per gentamicin protocol, consider IVOST* at 48-72hours <i>Note- clearance of gentamicin in severe renal impairment is significant slower. A single dose can linger in the system for much longer and may be sufficient to cover up to 72hours</i> *Refer to IVOST policy if no positive culture and sensitivity If IVOST criteria not met: refer to 'IV Gentamicin: What to do after 72hours (Adult)' policy OR discuss with infection specialist	7 days (including IV and oral)
Catheter-associated UTI (CAUTI) <i>Change catheter</i>	With sepsis: IV Gentamicin up to 72 hours as per protocol, consider IVOST* at 48-72 hours Change catheter after 1st dose If renal impairment CrCl<20mls/min: Single dose IV Gentamicin- take levels q24 hours as protocol, consider IVOST* at 48-72hrs <i>Note- clearance of gentamicin in severe renal impairment is significant slower. A single dose can linger in the system for much longer and may be sufficient to cover up to 72hours</i> *Refer to IVOST policy if no positive culture and sensitivity If IVOST criteria not met: refer to 'IV Gentamicin: What to do after 72hours (Adult)' policy OR discuss with infection specialist	With sepsis: 7 days (including IV and oral)

Gastrointestinal sepsis			
Initial treatment for intra-abdominal sepsis and infections - Cholangitis - Cholecystitis with sepsis - Appendicitis - Diverticulitis - Peritonitis - Biliary stent infections	IV Amoxicillin IV 8-hourly AND PO Metronidazole 400mg 8-hourly (IV if absorption/ swallow issues) AND IV Gentamicin <i>*PO Metronidazole has about 95- 100% bioavailability;</i>	If CrCl <20mls/min: IV Piperacillin-Tazobactam 4.5g 12-hourly If severe penicillin allergy: IV Vancomycin AND IV Gentamicin AND PO* Metronidazole 400mg 8-hourly (IV- only if absorption/ swallow issues) If severe penicillin allergy and CrCl<20mls/min: PO* Metronidazole 400mg 8-hourly AND PO* Ciprofloxacin 500mg 12-hourly <i>*IV only if absorption/ swallow issues</i>	5 days (including IV and oral) For biliary tract infection- Treatment as recommended except <u>metronidazole not routinely required unless severe</u> Refer to IV Gentamicin: What to do after 72 hours (Adults) policy for further guidance if IVOST criteria not met For IVOST option- refer to IVOST policy on NHS D&G Antimicrobial Handbook
Sepsis from skin or soft tissue infections			
Severe Cellulitis/ Erysipelas For upper limb cellulitis, seek orthopaedic advice	IV Flucloxacillin 2g qds If rapidly progressing: Add IV Clindamycin 600mg 6-hourly	IV Vancomycin If rapidly progressing: Add IV Clindamycin 600mg 6-hourly	7-10 days (including IV and oral)
Necrotising fasciitis <i>Get urgent surgical review</i>	<u>In order of administration:</u> IV Piperacillin-Tazobactam 4.5g 6-hourly (1 st dose can be given as bolus over at least 5 minutes) AND IV Clindamycin 1.2g 6-hourly (40-60mins infusion) AND IV Gentamicin (30mins infusion)	<u>In order of administration: TWO IV LINES REQUIRED</u> IV Vancomycin IV AND IV Clindamycin 1.2g 6-hourly (40-60mins infusion) AND IV Gentamicin (30mins infusion) AND IV Metronidazole 500mg tds (20mins infusion)	Rationalise 48-72 hours of starting antibiotics 10 days or as per Infection specialist

Sepsis from Bone and Joint infection			
Septic arthritis Urgent orthopaedic referral if underlying metal work or recent surgery. Ensure joint aspiration done prior to antibiotics	Native joint: IV Flucloxacillin 2g 6-hourly If high risk for gram negative infection e.g. immunocompromised, recurrent UTI, sickle cell disease: ADD Gentamicin	Native joint: IV Vancomycin If high risk for gram negative infection e.g. immunocompromised, recurrent UTI, sickle cell disease: ADD Gentamicin	Discuss with Microbiology Consultant. Usually 6 weeks total – [usually first 2 weeks as IV]
	Prosthetic joint: Discuss with Microbiology Consultant.		
Osteomyelitis Moderate & Severe infection in acute diabetic foot /osteomyelitis	Take blood cultures (2 sets) prior to starting treatment. Discuss with infection specialist Diabetic foot: Determine severity of wound infection (mild/ moderate/ severe), as per IWGDF/IDSA infection guideline, to determine most appropriate antibiotic therapy: https://iwgdfguidelines.org/wp-content/uploads/2023/07/IWGDF-2023-04-Infection-Guideline.pdf		
Assess ulcer size, probes to bone, neuropathy, peripheral vascular disease, MRSA risk. Refer to diabetic foot MDT, and consider need for podiatry and vascular surgery input. Send specimen for culture and review previous microbiology	IV Flucloxacillin 2g 6-hourly +/- see below If high risk for Gram negative infection (e.g. recent antibiotics, sepsis, haemodynamic compromise, ischaemic limb, necrosis, gas forming): ADD IV Gentamicin If high risk for anaerobic infections (e.g. ischaemic limb/ necrosis/ gas forming): ADD PO Metronidazole 400mg 8-hourly (IV- if absorption/ swallow issues) If CrCl <20ms/min AND combination therapy required: IV Piperacillin-Tazobactam 4.5g 12-hourly <i>*PO Metronidazole has about 95- 100% bioavailability</i>	IV Vancomycin +/- see below If high risk for Gram negative infection (e.g. recent antibiotics, sepsis, haemodynamic compromise, ischaemic limb, necrosis, gas forming): ADD IV Gentamicin If high risk for anaerobic infections (e.g. ischaemic limb/ necrosis/ gas forming): ADD PO Metronidazole 400mg 8-hourly (IV- if absorption/ swallow issues) If eGFR<20ms/min AND combination therapy required: Discuss with Infection Specialist <i>*PO Metronidazole has about 95- 100% bioavailability</i>	10-14 days (including IV and oral) (if osteomyelitis, discuss duration with infection specialist)

Central nervous system sepsis			
Bacteria Meningitis	IV Ceftriaxone 2g 12-hourly ADD IV Dexamethasone 10mg IV 6-hourly (prescribe 3mls of 3.3mg/ml dexamethasone (base) on HEPMA If Listeria suspected/confirmed, >55years, immunocompromised, alcohol excess, liver disease: ADD IV Amoxicillin 2g 4-hourly	Contact Microbiology/ID consultant on choice of antibiotic for patients with severe penicillin allergy ADD IV Dexamethasone 10mg IV 6-hourly (prescribe 3mls of 3.3mg/ml dexamethasone (base) on HEPMA If penicillin allergy and Listeria suspected/confirmed, 55years, immunocompromised, alcohol excess, liver disease: ADD IV Co-trimoxazole 30mg/kg 6 hourly	Discuss with Infectious Disease Specialist/ Microbiology Consultant
Viral Meningitis	Usually diagnosed after empirical management and exclusion bacteria meningitis Stop antiviral if enteroviral or mumps meningitis is diagnosed and manage symptomatically Continuation of antivirals for HSV/ VZV should be discussed with infection specialist		
If suspected encephalitis/ *HSV encephalitis *Discuss with microbiology if suspecting HSV Consider if confusion or reduced level consciousness in suspected CNS infection.	IV Aciclovir 10mg/kg* 8-hourly Obesity is defined by the National Institute for Health and Care Excellence (NICE) as BMI $\geq 30\text{kg/m}^2$ Risk of toxicity is increased when IV Aciclovir is dosed as per actual body weight in obese patients. One pharmacokinetic study has shown that dosing using ideal body weight may lead to sub therapeutic plasma concentration. *It is recommended that adjusted body weight (AdjBW) should be used when calculating doses for obese patients BMI $\geq 30\text{kg/m}^2$ AdjBW= IBW + 0.4 (actual body weight – IBW)		10-21 days
Sepsis from Ophthalmic, ENT and maxillofacial Infections			
	Refer to the Ophthalmic, ENT and maxillofacial section- Page 25-27		

Neutropenic Sepsis (May 2025- Neutropenic guidance being reviewed- use this meantime)			
Definition: Signs of sepsis, Neutrophils <0.5 or <1 if chemotherapy in the last 21 days			
Standard risk Neutropenic sepsis and NEWS ≤ 6	IV Piperacillin-Tazobactam 4.5g 6-hourly If MRSA positive: ADD IV Vancomycin	IV Gentamicin AND IV Vancomycin (irrespective of MRSA status)	7 days
High risk Neutropenic sepsis and NEWS >7 OR Septic shock of leukaemia OR Allogenic stem cell transplant	IV Piperacillin-Tazobactam 4.5g 6-hourly AND IV Gentamicin If MRSA positive: ADD IV Vancomycin	IV Gentamicin AND IV Vancomycin (irrespective of MRSA status) AND PO Ciprofloxacin 500mg 12-hourly (IV-if absorption/ swallow issues) Or discuss with Microbiology Consultant	7 days
Sepsis in pregnancy or post-partum period			
Refer to NHS D&G Obstetrics and Gynaecology Formulary			
Staphylococcus bacteraemia (SAB)			
Refer to NHS D&G Antimicrobial Handbook- SAPG infection specific guidance on SAB			
Needs investigation for source	IV Flucloxacillin 2g 6-hourly	IV Vancomycin	Depends on source MINIMUM of 14 days IV antibiotics
Infective endocarditis			
3 sets of blood cultures (ideally over 48 hours) to be taken prior to antibiotics	Discuss with Microbiology Consultant Note: If IV Flucloxacillin commenced (for Methicillin Sensitive Staphylococcus Aureus [MSSA] endocarditis)- please ensure correct dosing as weight dependant <85kg: 2g 6- hourly (i.e. 8g daily of IV Flucloxacillin) ≥85kg: 2g 4-hourly (i.e. 12g daily of IV Flucloxacillin)		
Line infections			
PVC phlebitis Peripheral line infections Peripheral lines refers to cannula inserted into peripheral veins including PICCs and Midlines	REMOVE LINE. Assess signs of infection If localised infection at PVC exit site present (red, swollen, warm, pus around skin entry site): PO Flucloxacillin 1g PO 6-hourly OR PO Doxycycline 200mg stat, then 100mg 12-hourly Severe infected PVC exit site (+/- sepsis): IV Flucloxacillin 2g 6-hourly OR if penicillin allergy: IV Vancomycin		Duration: Discuss with Microbiology Consultant. Treatment depends on underlying organism
Central line infection	Discuss with Microbiology Consultant. Treatment depends on underlying organism		

Respiratory Tract Infections

Indications	1 st Line antibiotic	2 nd Line antibiotic	Typical Duration
<u>Covid</u> https://www.nhsdghandbook.co.uk/categories/covid19/?handbook=medical <u>Community Acquired Pneumonia</u> Assess severity with CURB-65 score For severe pneumonia → - Urine for legionella and pneumococcal (L&P) antigens D&G Labs will only process this only if CURB65 ≥2- please state CURB65 score on lab request form Consider testing if there is a history of recent travel or bird/animal exposure - Blood cultures - Sputum cultures - Viral specimens - HIV test			
CURB-65 ≤1 Mild CURB-65 = 2 Moderate	PO Amoxicillin 1g 8-hourly (unless H. Influenza has been excluded) OR PO Doxycycline – 200mg stat, then 100mg 12-hourly	PO Clarithromycin 500mg 12-hourly	5 days
CURB-65 ≥3 Severe OR Any CURB65 score with sepsis OR Clinically severe pneumonia in young patients	IV Amoxicillin 1g 8-hourly OR IV Co-amoxiclav 1.2g 8-hourly AND (Add atypical agent) PO Doxycycline 200mg stat, then 100mg 12-hourly (as 1 st choice) OR PO Clarithromycin 500mg 12-hourly (as 2 nd choice)- <i>IV if absorption/ swallow issues</i>	PO Levofloxacin 500mg 12-hourly (IV if absorption/ swallow issues) <i>Levofloxacin has atypical cover</i>	5 days (including IV and oral) Levofloxacin is the choice of antibiotic for confirmed Legionella pneumonia Duration: 10-14 days of 'atypical cover' (longer duration may be required in severe disease or immunocompromised)
Unsure if LRTI or UTI, and no evidence of sepsis	PO Amoxicillin 500mg - 1g 8-hourly AND PO Nitrofurantoin 50mg 6-hourly (<i>*M/R 100mg 12-hourly only if compliance issues</i>)	PO Co-trimoxazole 960mg 12-hourly	Diagnosis needs to be clarified 48-hours into admission and switched to more specific antibiotic coverage

Hospital Acquired Pneumonia (HAP)

Early Onset: ≤ 4 days from admission date

Late Onset: ≥ 5 days from admission date

Assess severity using CURB-65 criteria

Early-Onset:	Early-onset (occurring within 4 days of admission) HAP is usually caused by the same bacteria and viruses as community-acquired pneumonia		
	Follow CAP guidance based on CURB-65 score	Follow CAP guidance based on CURB-65 score	5 days
Late Onset	Late-onset HAP has a worse prognosis and is usually caused by micro-organisms that are acquired from the hospital environment and can be more resistant		
Non-severe Late-Onset	PO Doxycycline 200mg stat then 100mg 12-hourly	PO Co-trimoxazole 960mg 12-hourly	5 days
Severe Late-Onset	IV Co-trimoxazole 960mg 12-hourly AND IV Gentamicin (review after 48-hours) If MRSA positive: ADD Vancomycin	PO Levofloxacin 500mg 12-hourly (<i>IV if absorption/ swallow issues</i>) If MRSA positive: ADD IV Vancomycin	5 days (including IV and oral)

Infective Exacerbation of COPD

Purulent sputum – likely bacterial aetiology	PO Doxycycline 200mg stat then 100mg 12-hourly	PO Amoxicillin 1g 8-hourly Unless H. Influenza has been excluded OR PO Clarithromycin 500mg 12-hourly	5 days <i>Remember to give steroids – 30mg prednisolone daily for 5 days; wean slowly if had multiple steroid courses prior</i>
Non-purulent sputum - likely viral aetiology	No antibiotic coverage required	<i>Prednisolone 30mg PO once daily for 5 days; consider weaning slowly if had multiple steroid courses prior</i>	

Aspiration Pneumonia (AP)

Aspiration pneumonitis (e.g. secondary to aspiration of gastric contents) does not require antibiotic treatment unless secondary infection arises later in the lungs. Prophylactic antibiotics are not recommended

<https://www.brit-thoracic.org.uk/quality-improvement/clinical-statements/aspiration-pneumonia/>

BTS do not recommend routine anaerobic cover for AP. Anaerobes have not been proven to influence outcomes adversely and have become progressively less important pathogens in recent decades. Covering for anaerobes seem unlikely to make a major difference to outcome except those at high risk

Suspected or confirmed on CXR	If occurs ≤4 days from admission (Community acquired): IV/PO* Amoxicillin 1g 8-hourly (*use PO if safe swallow) If occur ≥ 5 days from admission date (Hospital acquired): (if safe swallow) PO* Doxycycline 200mg stat, then 100mg 12 hourly Regardless admission date, if severely ill: ADD IV Gentamicin IV Only if at high risk of anaerobic infections (e.g. obvious dental/periodontal disease, putrid sputum, or suspected lung abscess/empyema): ADD Metronidazole	<u>Alternatives:</u> If occurs ≤4 days from admission (Community acquired): (if safe swallow) PO Doxycycline 200mg stat, then 100mg 12 hourly (if swallow <u>not</u> safe): IV Clarithromycin 500mg 12-hourly (switch to PO when swallow safe) If occur ≥ 5 days from admission date (Hospital acquired): IV/PO* Co-trimoxazole 960mg 12-hourly (*use PO if safe swallow) Regardless admission date, if severely ill: ADD IV Gentamicin IV Only if at high risk of anaerobic infections (e.g. obvious dental/periodontal disease, putrid sputum, or suspected lung abscess/empyema): ADD Metronidazole	5 days (including IV and oral)
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Genito-urinary Tract/Obstetric Infections

Indications	1 st Line Antibiotics	2 nd Line antibiotics	Typical Duration
<u>Urinary Tract Infections</u>			
Obtain urine culture and send to microbiology Dipstick testing should not be used to diagnosed UTI in pts >65yr as they become more unreliable with increasing age over 65 years			
Lower UTI males & non-pregnant females			
LUTI	PO Trimethoprim 200mg 12-hourly OR PO Nitrofurantoin 50mg 6-hourly (*M/R 100mg 12-hourly if compliance issues)	If no severe penicillin allergy: PO Cefalexin 500mg tds; if CrCl <10mls/min: 500mg 12-hourly (Cefalexin is suitable for mild penicillin allergy only) In severe penicillin allergy and with CrCl <20mls/min: PO Ciprofloxacin 500mg 12-hourly	3 days (female) 7 days (male)
Upper UTI/ pyelonephritis (males & non-pregnant females)			
With or Without sepsis	IV Gentamicin up to 72 hours as per protocol, consider IVOST* at 48-72 hours If renal impairment CrCl<20mls/min: Single dose IV Gentamicin- take levels q24 hours as per gentamicin protocol, consider IVOST* at 48-72hours <i>Note- clearance of gentamicin in severe renal impairment is significant slower. A single dose can linger in the system for much longer and may be sufficient to cover up to 72hours</i> *Refer to IVOST policy if no positive culture and sensitivity If IVOST criteria not met: refer to 'IV Gentamicin: What to do after 72hours (Adult)' policy OR discuss with infection specialist	No sepsis: 3 days (female) 7 days (male) Sepsis: 7 days (including IV and oral)	
Catheter-associated UTI (CAUTI) <i>Change catheter</i> With or Without sepsis	IV Gentamicin up to 72 hours as per protocol, consider IVOST* at 48-72 hours Change catheter after 1 st dose If renal impairment CrCl<20mls/min: Single dose IV Gentamicin- take levels q24 hours as protocol, consider IVOST* at 48-72hrs <i>Note- clearance of gentamicin in severe renal impairment is significant slower. A single dose can linger in the system for much longer and may be sufficient to cover up to 72hours</i> *Refer to IVOST policy if no positive culture and sensitivity If IVOST criteria not met: refer to 'IV Gentamicin: What to do after 72hours (Adult)' policy OR discuss with infection specialist	7 days (including IV and oral)	

Acute Prostatitis

Acute Prostatitis <i>Send MSSU</i>	PO Trimethoprim 200mg 12-hourly OR PO Ciprofloxacin 500mg 12-hourly	Minimum 14 days Review after 14 days Can extended to 28 days, if clinically appropriate
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Epididymo-orchitis

Sexual health screen recommended

Epididymo-orchitis ≥35 years age <i>Send MSSU</i>	PO Ofloxacin 400mg 24-hourly	PO Co-amoxiclav 625mg 8-hourly	14 days (10 days for co-amoxiclav)
<35 years age <i>Refer to GUM clinic</i>	PO Doxycycline 200mg stat, then 100mg 12-hourly		14 days

Sexually Transmitted Infections

Offer HIV testing. Guidance is now being maintained regionally.

https://www.wossexualhealthmcn.scot.nhs.uk/?page_id=56

Pelvic Inflammatory Disease

Symptoms of PID:

- Low abdominal pain, abnormal PV discharge (often purulent) or abnormal bleeding (including post coital bleeding(PCB), intermenstrual bleeding (IMB) or menorrhagia) and deep dyspareunia

Signs of PID

Bilateral pelvic pain, cervical excitation and bilateral adnexal tenderness and pyrexia > 38°C

- Sexual health screen including **HIV test is advised**

Mild to Moderate (Swabs before commencing therapy)

<i>Refer to GUM or carry out in-hospital STI testing</i>	IM Ceftriaxone 1g once-off AND PO Doxycycline 100mg 12-hourly AND PO Metronidazole 400mg 12-hourly (Doxycycline is contraindicated in pregnancy) PO Erythromycin 500mg BD should be used instead of doxycycline in pregnancy	OP Ofloxacin 400mg 12-hourly AND PO Metronidazole 400mg 12-hourly This regimen should NOT be used in patients at high risk of gonococcal PID	14 days Failure to improve suggests the need for further investigation, IV therapy and/or surgical intervention Review IV antibiotics 24hours after improvement IVOST option: Doxycycline with Metronidazole
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Severe PID (including sepsis)

Consider surgical exploration and drainage if tubo-ovarian abscess $\geq 5\text{cm}$ or significant bilateral collections or with smaller collections if the patient is peritonitic or there has been a deterioration/ inadequate response to IV antibiotics within 24-48 hours

	IV Ceftriaxone 2g 24-hourly AND PO Metronidazole 400mg 12 hourly (IV- if absorption/ swallow issues) AND PO Doxycycline 100mg 12-hourly	IV Clindamycin 900mg 8-hourly AND IV Gentamicin	Continue IV therapy until 24 hours after clinical improvement IVOST option: PO Doxycycline 100mg 12-hourly And PO Metronidazole 400mg 12-hourly Duration: 14 days in total
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Gastrointestinal Infections

Indications	1 st Line Antibiotics	2 nd Line antibiotics	Typical Duration
<u>Gastroenteritis/ Infected diarrhoea</u>			
Confirm travel history/ other risk factors. Send sample. Antibiotic not normally required and may be deleterious in E.Coli 0157. Consider viral causes. Send sample If systemically unwell- discuss with ID/ Micro			
<u>Intra-abdominal Infections</u>			
Initial treatment for intra-abdominal sepsis and infections - Cholangitis - Cholecystitis with sepsis - Appendicitis - Diverticulitis - Peritonitis - Biliary stent infections	IV Amoxicillin 1g 8-hourly AND PO* Metronidazole 400mg 8-hourly (IV-only if absorption/ swallow issues) AND IV Gentamicin <i>*PO Metronidazole has about 95- 100% bioavailability</i>	If CrCl <20mls/min: IV Piperacillin-Tazobactam 4.5g 12-hourly If severe penicillin allergy: IV Vancomycin AND IV Gentamicin AND PO Metronidazole 400mg 8-hourly (IV if absorption/ swallow issues) If severe penicillin allergy and CrCl<20mls/min: *PO Metronidazole 400mg 8-hourly AND *PO Ciprofloxacin 500mg 12-hourly (*IV only if absorption/ swallow issues)	5 days (including IV and oral) For biliary tract infection- Treatment as recommended except metronidazole not routinely required unless severe Refer to the IV Gentamicin: What to do after 72 hours (Adults) policy for further guidance if IVOST criteria not met IVOST option- refer to IVOS policy on NHS D&G Antimicrobial Handbook
<u>Spontaneous bacterial peritonitis</u>			
See also: BSG-BASL Decompensated Cirrhosis Care Bundle- First 24 Hours- The British Society of Gastroenterology			
If not receiving co-trimoxazole prophylaxis	PO/IV Co-trimoxazole 960mg 12-hourly	PO Levofloxacin 500mg 12-hourly (IV only if absorption issues)	5-7 days (including IV and oral)
If receiving co-trimoxazole prophylaxis	IV Piperacillin-Tazobactam 4.5g 8-hourly		
<u>Decompensated chronic liver disease with sepsis of unknown origin</u>			
Decompensated chronic liver disease with sepsis of unknown origin	IV Piperacillin-Tazobactam 4.5g 8-hourly	PO Levofloxacin 500mg 12-hourly (IV only if absorption issues)	7 days (including IV and oral)

Clostridioides difficile infection (CDI)

Please see: [SAPG Infection-specific guidance for CDI](#)

Start empirical treatment for CDI if patient has loose stools and either a history of recent antibiotic use or hospitalisation (and no alternate diagnosis) or stool positive for C. Difficile toxin.

Where possible, stop/rationalise non-clostridial antibiotics, antimotility agents and gastric acid suppression.

Assess severity markers (below) DAILY:

Evidence of severe colitis in CT/XRay. Temperature >38.5C, Acute rising serum Cr >1.5 x baseline, WBC >15 x 10⁹/L, Suspicion/ confirmed pseudomembranous colitis, toxic megacolon or ileus

First line treatment	Irrespective of severity	Vancomycin PO 125 mg 6-hourly	10 days
Second line treatment	Patients who fail to improve after 7 days or worsen with oral Vancomycin (discuss with infection specialist)	Either PO Fidaxomicin 200mg 12-hourly Or Higher dose Vancomycin with or without IV Metronidazole (Review need for IV metronidazole daily)	10 days
Severe/Life threatening infection	Seek urgent advice Any of the following, related to CDI: Admission to ICU, hypotension, Ileus, WCC >35 or <2, lactate >2.2 or end organ failure	PO Vancomycin 500mg 6-hourly With or without IV Metronidazole 500mg 8-hourly	10 days
Recurrence of CDI within 12 weeks (relapse)	Treatment failure identified as complete treatment course If incomplete course/poor compliance, treat as per first line	PO Fidaxomicin 200mg 12-hourly	10 days
Recurrence of CDI after 12 weeks (recurrence)	Treat with oral Vancomycin as per first line treatment	PO Vancomycin 125 mg 6-hourly	10 days
Second recurrence of CDI	Discuss with infection specialist/ micro consultant	Consider Faecal Microbiota Transplant	

Skin and Soft Tissue Infections

Indications	1 st line antibiotics	2 nd line antibiotics	Duration
<u>Cellulitis</u>			
Mild: systemically well Moderate: systemically well with comorbidity/ systemically unwell Severe: suspicion of sepsis			
Mild-Moderate infection	PO Flucloxacillin 1g 6-hourly	PO Doxycycline 200mg stat then 100mg 12-hourly OR PO Co-trimoxazole 960mg 12-hourly	5-7 days (including IV and oral)
Severe infection	Consider if OPAT candidate		
For upper limb cellulitis, seek orthopaedic advice	IV Flucloxacillin 2g 6-hourly If rapidly progressive: ADD IV Clindamycin 600mg 6-hourly	IV Vancomycin (use if MRSA suspected as 1 st line) If rapidly progressive: ADD IV Clindamycin 600mg 6-hourly	7-10 days (including IV and oral)
<u>Necrotising fasciitis</u>			
Urgent surgical review is imperative			
Refer to above Sepsis section- Page 8			
<u>Surgical Wounds Infection</u>			
Non-contaminated	IV Flucloxacillin 1-2g 6-hourly	If MRSA suspected, or penicillin allergic: PO Doxycycline 200mg stat, followed by 100mg 12-hourly If IV required: IV Co-trimoxazole 960mg 12-hourly	5-7 days (including IV and oral)
Contaminated	IV Flucloxacillin 1-2g 6-hourly AND PO Metronidazole 400mg 8-hourly (IV if absorption/ swallow issues) <u>AND</u> IV Gentamicin	If MRSA suspected, or penicillin allergic: IV Co-trimoxazole 960mg 12 hourly AND PO Metronidazole 400mg 8-hourly (IV if absorption/ swallow issues) <u>ADD</u> IV Gentamicin if septic	

Animal bites

Assess BBV, tetanus and rabies risk

Tetanus prone → any bite or scratch, unless domesticated pet with saliva only

Give tetanus booster to **all** (unless received booster within last 10 years)

Give tetanus immunoglobulin if **not** fully immunised (received 3 primary immunisations)

Risk stratify for when prophylaxis is indicated, as per NICE guidelines:

<https://www.nice.org.uk/guidance/ng184/resources/visual-summary-pdf-8897023117>

Human bites

Assess HIV and hepatitis risk – prophylaxis as required

Non-severe infection	PO Co-amoxiclav 625mg 8-hourly	PO Doxycycline 200mg stat then 100mg 12-hourly AND PO Metronidazole 400mg 8-hourly	Treatment- 5 days Prophylaxis- 3 days
Severe Infection <i>(over joints; requiring washout)</i>	IV Co-amoxiclav 1.2g 8-hourly	IV Vancomycin AND *PO Metronidazole 400mg 8-hourly AND *PO Ciprofloxacin 500mg 12-hourly *IV if absorption/ swallow issues	7 days

Burns, contaminated wounds, and compound fractures

Give tetanus booster to **all** (unless received booster within last 10 years)

Give tetanus immunoglobulin if **not** fully vaccinated (received 3 primary immunisations)

Burn injury	Routine use of prophylactic antibiotics is not recommended for burn patients		
Contaminated wounds and compound fractures	At presentation antibiotics within 3 hours of injury: Continue antibiotics until first debridement (excision) At the time of first debridement: Continue antibiotics until soft tissue closure or for a maximum of 72 hours whichever is sooner At surgery for skeletal stabilisation and definitive tissue closure: Single dose only- do not continue post-surgery		
	IV Co-amoxiclav 1.2g 8-hourly If severely contaminated: ADD IV Gentamicin	IV Clindamycin 600mg 6-hourly AND PO Metronidazole 400mg 8-hourly <i>(IV if absorption/ swallow issues)</i> If severely contaminated: ADD IV Gentamicin	See above

Facial cellulitis

Refer to ophthalmic, ENT and Maxillofacial Infection Page 27

Varicella Zoster Infections

Chickenpox	PO Aciclovir 800mg PO 5 times a day OR IV Aciclovir 5mg/kg 8-hourly (Use Adjusted Body Weight if BMI ≥30m ²) If lesions are infected: ADD PO Flucloxacillin 1g 6-hourly OR PO Clarithromycin 500mg PO 12-hourly	7 days
<i>Seek advice if pregnant</i>		
Shingles	Aciclovir 800mg PO 5 times a day OR IV Aciclovir 5mg/kg 8-hourly (Use Adjusted Body Weight if BMI ≥30m ²)	5 days

Infected eczema

<i>Take swabs</i> <i>Manage underlying condition with topical steroid, emollients</i>	Fusidic acid 2% topically 8-hourly If unresponsive: PO Flucloxacillin 1g 6-hourly	If penicillin allergic and needs oral antibiotic: PO Clarithromycin 500mg 12-hourly	5-7 days
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Bone and Joint Infections

Indications	1 st line antibiotics	2 nd line antibiotics	Duration
<u>Septic Arthritis</u> Aspirate joint and send cultures prior to commencing antimicrobial therapy Urgent orthopaedic referral if underlying metal work or recent surgery. Ensure joint aspiration prior to antibiotics			
Native joint	Flucloxacillin 2g IV 6-hourly If high risk for gram-negative infection e.g. immunocompromised, recurrent UTI or sickle cell disease: ADD IV Gentamicin	IV vancomycin If high risk for gram-negative infection e.g. immunocompromised, recurrent UTI or sickle cell disease: ADD IV Gentamicin	6 weeks total 2 weeks IV therapy 4 weeks PO therapy
Prosthetic joint	Discuss with microbiology		
<u>Osteomyelitis</u> For all patients: Take blood cultures (2 sets) prior to starting treatment. Discuss with microbiology <u>Diabetic foot infection/ osteomyelitis</u> Assess ulcer size, probes to bone, neuropathy, peripheral vascular disease, MRSA risk. Refer to diabetic foot MDT, and consider need for podiatry and vascular surgery input. Send specimen for culture and review previous microbiology			
Mild infection	IV Flucloxacillin 1g 6-hourly	PO Doxycycline 200mg stat then 100mg 12-hourly OR IV Vancomycin (if PO unsuitable)	5-7 days

(Con't) Diabetic foot infection/ osteomyelitis

Moderate & Severe infection in acute diabetic foot /osteomyelitis Refer to diabetic foot MDT, and consider need for podiatry and vascular surgery input.	Diabetic foot: Determine severity of wound infection (mild/ moderate/ severe), as per IWGDF/IDSA infection guideline, to determine most appropriate antibiotic therapy: https://iwgdfguidelines.org/wp-content/uploads/2023/07/IWGDF-2023-04-Infection-Guideline.pdf		
	IV Flucloxacillin 2g 6-hourly +/- see below If high risk for Gram negative infection (e.g. recent antibiotics, sepsis, haemodynamic compromise, ischaemic limb, necrosis, gas forming): ADD IV Gentamicin If high risk for anaerobic infections (e.g. ischaemic limb/ necrosis/ gas forming): ADD PO* Metronidazole 400mg 8-hourly (IV- if absorption issues) If CrCl<20ms/min AND combination therapy required: IV Piperacillin-Tazobactam <i>*PO Metronidazole has about 95- 100% bioavailability</i>	IV Vancomycin +/- see below If high risk for Gram negative infection (e.g. recent antibiotics, sepsis, haemodynamic compromise, ischaemic limb, necrosis, gas forming): ADD IV Gentamicin If high risk for anaerobic infections (e.g. ischaemic limb/ necrosis/ gas forming): ADD PO* Metronidazole 400mg 8-hourly (IV- if absorption issues) If eGFR<20ms/min AND combination therapy required: Discuss with Consultant microbiologist <i>*PO Metronidazole has about 95- 100% bioavailability</i>	7- 14 days (if osteomyelitis, discuss duration with infection specialist)

Central Nervous System Infections

Indications	1 st Line antibiotics	2 nd line antibiotics	Duration
<u>Bacterial Meningitis</u>			
Meningitis	IV Ceftriaxone 2g 12-hourly ADD IV Dexamethasone 10mg IV 6-hourly (prescribe 3mls of 3.3mg/ml dexamethasone (base) on HEPMA If Listeria suspected/confirmed, >55years, immunocompromised, alcohol excess, liver disease: ADD IV Amoxicillin 2g 4-hourly	Contact Microbiology/ID consultant on choice of antibiotic for patients with severe penicillin allergy ADD IV Dexamethasone 10mg IV 6-hourly (prescribe 3mls of 3.3mg/ml dexamethasone (base) on HEPMA If severe penicillin allergy and Listeria suspected/confirmed, >55years, immunocompromised, alcohol excess, liver disease: ADD Co-trimoxazole 30mg/kg IV 6 hourly	Duration: Discuss with Infectious Disease Specialist/ Microbiology Consultant
<u>Viral Meningitis</u>			
Usually diagnosed after empirical management and exclusion bacteria meningitis Stop antiviral if enteroviral or mumps meningitis is diagnosed and manage symptomatically Continuation of antivirals for HSV/ VZV should be discussed with infection specialist			
<u>Viral Encephalitis</u>			
If suspected encephalitis/ *HSV encephalitis *Discuss with microbiology if suspecting HSV Consider if confusion or reduced level consciousness in suspected CNS infection.	IV Aciclovir 10mg/kg* 8-hourly Obesity is defined by the National Institute for Health and Care Excellence (NICE) as BMI $\geq 30\text{kg/m}^2$ Risk of toxicity is increased when IV Aciclovir is dosed as per actual body weight in obese patients. One pharmacokinetic study has shown that dosing using ideal body weight may lead to sub therapeutic plasma concentration. *It is recommended that adjusted body weight (AdjBW) should be used when calculating doses for obese patients BMI $\geq 30\text{kg/m}^2$ AdjBW= IBW + 0.4 (actual body weight – IBW)	10-21 days	

Ophthalmic, ENT and maxillofacial Infections

Indications	1 st line antibiotics	2 nd line antibiotics	Duration
<u>Tonsillitis</u> Most cases are viral and do not require antibiotics Calculate CENTOR or FEVERPAIN criteria to assist with decision-making			
Evidence of sepsis	IV Benzylpenicillin 2.4g 6-hourly AND IV Clindamycin 600mg 6-hourly	IV Vancomycin AND IV Clindamycin 600mg 6-hourly	10 days IVOST option: Penicillin V or Clindamycin
No evidence of sepsis	PO Phenoxymethylpenicillin 500mg 6-hourly or 1g 12-hourly	PO Clarithromycin 500mg 12-hourly	10 days 5 days for clarithromycin
Quinsy <i>Drain abscess immediately</i>	IV Benzylpenicillin 2.4g 6-hourly AND IV Clindamycin 600mg 6-hourly	IV Vancomycin AND IV Clindamycin 600mg 6-hourly	10 days IVOST option: Penicillin V or Clindamycin
<u>Epiglottitis and Supraglottitis</u> Urgent anaesthetics review if any airway concerns or stridor occurs			
	IV Ceftriaxone 2g 24-hourly	IV Clindamycin 900mg 8-hourly AND IV Ciprofloxacin 400mg 12-hourly (IV due to risk of airway obstruction)	7-10 days Review IV antibiotic daily. Consider IVOST if able IVOST option: Co-amoxiclav or Ciprofloxacin
<u>Preseptal/Orbital cellulitis</u> Urgent CT scan to assess extent and for intracranial extension			
	IV Flucloxacillin 2g 6-hourly OR IV Ceftriaxone 2g 24-hourly or 12-hourly if intracranial extension	IV vancomycin AND PO Ciprofloxacin 500mg 12-hourly (IV- if absorption/ swallow issues)	10-14 days IVOST option: Flucloxacillin or Ciprofloxacin
<u>Acute otitis media</u> Avoid antibiotics if able – usually only given if systemically unwell or >5 days duration of illness			
	PO Co-amoxiclav 625mg 8-hourly OR IV Co-amoxiclav 1.2g 8-hourly if severe	PO Clarithromycin 500mg 12-hourly OR IV Clindamycin 900mg 6-hourly if severe	5 days

Sinusitis

Acute ≤6 weeks duration	PO Amoxicillin 1g 8-hourly If severe: PO Co-amoxiclav 625mg 8-hourly	PO Doxycycline 200mg stat then 100mg 12-hourly	5 days
Chronic >6 weeks duration	No antibiotics needed Treat with saline rinses, nasal steroids and one week of decongestant		

Otitis externa

Acute infection	Acetic acid 2% topically 8-hourly If fungal: ADD Clotrimazole drops 8-hourly	Neomycin sulphate with steroid topically 8-hourly	7 days
Acute, severe infection	As above and ADD: PO Flucloxacillin 1g 6-hourly	As above and ADD: PO Clarithromycin 500mg 12-hourly	7 days
Malignant otitis externa	Discuss with OPAT/Microbiology		6 weeks

Acute Mastoiditis

Requires urgent CT scan to assess intracranial involvement and extent of infection

	IV Co-amoxiclav 1.2g 8-hourly	PO Ciprofloxacin 500mg 12-hourly (V- if absorption/ swallow issues) AND IV Clindamycin 900mg 6-hourly	10-14 days
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Suppurative parotitis

<i>Review culture results Check for mumps and other causes</i>	IV Co-amoxiclav 1.2g 8-hourly	IV Clindamycin 900mg 6-hourly	10-14 days
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Dental abscess

For immunocompetent persons with no systemic upset, no antibiotics are required

Requires urgent dental review

<https://www.sapg.scot/media/5473/statement-on-pen-v-in-dental-infections.pdf>

<http://www.sdcep.org.uk/wp-content/uploads/2016/03/SDCEP-Drug-Prescribing-for-Dentistry-3rd-edition.pdf>

	PO Phenoxymethylpenicillin (Penicillin V) 500mg 6-hourly	Metronidazole 400mg PO 8-hourly	5 days
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Facial cellulitis			
	IV Flucloxacillin 2g 6-hourly AND IV Clindamycin 900mg 6-hourly	IV Vancomycin AND IV Clindamycin 900mg 6-hourly	7 days
Retropharyngeal Abscess			
If any airway concerns, get urgent anaesthetic review			
<i>Surgical review for drainage</i>	IV Ceftriaxone 2g 12-hourly AND IV Metronidazole 500mg 8-hourly	IV Clindamycin 900mg 6-hourly AND IV Ciprofloxacin 400mg 12-hourly (IV due to risk of airway obstruction)	10-14 days Review IV antibiotic daily. Consider IVOST if able IVOST option: Co-amoxiclav OR clindamycin with ciprofloxacin
Eye infections			
Bacterial conjunctivitis, blepharitis	Topical Chloramphenicol 1% ointment: apply 6-hourly		7 days
Gonococcal conjunctivitis <i>Urgent referral to ophthalmology</i>	IM Ceftriaxone 1g once-off dosing	IM Gentamicin 240mg once-off AND PO Azithromycin 1g once-off	Discuss with microbiology prior to giving 2 nd line treatment if not true anaphylaxis to penicillin
Chlamydial conjunctivitis <i>Urgent referral to ophthalmology</i>	PO Azithromycin 1g once off dosing	PO Doxycycline 200mg stat then 100mg 12-hourly for 5 days	Discuss with ophthalmology specialist/ Micro
Viral conjunctivitis	Self-limiting. Cool compresses and antihistamines usually sufficient. Give chloramphenicol if any doubt		7 days
Bacterial keratitis <i>Urgent referral to ophthalmology</i>	If not same day review: Topical ofloxacin 2-4 hourly until reviewed		
Ocular herpes/ HSV keratitis <i>Urgent referral to ophthalmology</i>	If not same day review: Topical acyclovir 5 times daily until reviewed		
Endophthalmitis <i>Urgent referral to ophthalmology</i>	Admission required If not same day review: IV Cefazolin 2g once-off AND IV Gentamicin		Discuss with ophthalmology specialist/ Micro
		PO Ciprofloxacin 750mg PO once-off AND IV Gentamicin	

MRSA Policy – Best Practice Guidelines (Extract)

Decolonisation

If a patient is found to be MRSA positive from an admission screen (or any other skin site swab not indicative of infection) treatment will consist of a decolonisation regime.

Decolonisation treatment is as follows:

Treatment – for five days

Product	Bactroban Nasal Mupiricin 2%	Antimicrobial Chlorhexidine 4% body wash
Where it's for	Nasal passages	All over body wash (including hair)
When to use	3 x daily (morning afternoon & Night)	1 x daily
How to apply	A small amount (about the size of match head) should be placed on a cotton bud or tip of little finger & applied to each nostril. The sides of the nose should be pinched together to spread ointment.	Shower in warm water for 1-3 minutes. Apply body wash (40- 50ml if liquid) (25- 33ml if foam) head to toe. Wash off after 1-2 minutes.

Clearance from MRSA will consist of three consecutive negative swabs, each taken at least 48 hours apart. If decolonisation is unsuccessful after two attempts a third attempt should not be made. If the patient is to undergo a high risk procedure and decolonisation has been unsuccessful after 2 attempts please contact the Infection Control Team.

Patients who are being discharged to their own home may not require decolonisation if risk is low.

<http://www.sdcep.org.uk/wp-content/uploads/2016/03/SDCEP-Drug-Prescribing-for-Dentistry-3rd-edition.pdf>