▼ Gastrointestinal tract infections						
Infection	**Keypoints**	**Medicine**	**Dose**		**Length**	**Visual Summary**
			Adult	**Child**		
Oral candidiasis Public Health England	**Topical azoles** are more effective than topical nystatin Oral candidiasis is rare in immunocompetent adults, consider undiagnosed risk factors, including HIV. Use 50mg fluconazole if extensive/severe candidiasis; if HIV or immunocompromised, use 100mg fluconazole	Miconazole oral gel	2.5ml of 24mg/ml QDS (hold in mouth after food)	BNF for children	7 days; continue for 7 days after resolved	Not available. Access supporting evidence and rationales on the PHE website
		If not tolerated: nystatin suspension	1ml; 100,000units/ml QDS (half in each side)	BNF for children	7 days; continue for 2 days after resolved	
		fluconazole capsule	50mg/100mg OD	BNF for children	7 to 14 days	
Infectious diarrhoea Public Health England	Refer previously healthy children with acute painful or bloody diarrhoea, to exclude *E. coli* O157 infection. **Antibiotic therapy is not usually indicated unless patient is systemically unwell**. If systemically unwell and campylobacter suspected (such as undercooked meat and abdominal pain), consider clarithromycin 250mg to 500mg BD for 5 to 7 days, if treated early (within 3 days). If giardia is confirmed or suspected – metronidazole 2g single dose is the treatment of choice. *Access the supporting evidence and rationales on the PHE website.*					
Traveller's diarrhoea Public Health England	Prophylaxis rarely, if ever, indicated. Consider **standby** antimicrobial only for patients at high risk of severe illness, or visiting high-risk areas. Consider referral of suspected infectious diarrhoea following travel to Department of Infection	**Standby:** azithromycin	500mg OD	-	1 to 3 days	Not available. Access supporting evidence and rationales on the PHE website
		Prophylaxis/treatment: bismuth subsalicylate	2 tablets QDS	-	2 days	
Threadworm Public Health England	**Treat all household contacts at the same time**. **Advise hygiene measures for 2 weeks** (hand hygiene; pants at night; morning shower, including perianal area). Wash sleepwear, bed linen, and dust and vacuum. **Child <6 months**, add perianal wet wiping or washes 3 hourly ***See UKTIS advice for use of mebendazole in pregnancy.***	**Adult/Child >6 months**: mebendazole	100mg stat	BNF for children	1 dose; repeat in 2 weeks if persistent	Not available. Access supporting evidence and rationales on the PHE website
		Child <6 months or pregnant woman (at least in first trimester): only hygiene measure for 6 weeks	-	-	-	

Clostridioides difficile infection NICE Public Health England Last updated: Jul 2021	For suspected or confirmed *C. difficile* infection, see Public Health England's guidance on diagnosis and reporting. **Assess**: whether it is a first or further episode, severity of infection, individual risk factors for complications or recurrence (such as age, frailty or comorbidities). One or more of the following defines severe CDI: • WCC >15 x 109/L • Acutely rising blood creatinine (e.g. >50% increase above baseline) • Temperature >38.5°C • Evidence of severe colitis (e.g. abdominal signs and/or radiology) **Existing antibiotics**: review and stop unless essential. If still essential, consider changing to one with a lower risk of *C. difficile* infection. Review the need to continue: proton pump inhibitors, other medicines with	**First-line for first episode of mild, moderate or severe:** **vancomycin** **(If vancomycin unavailable prescribe metronidazole 400mg TDS until available and vancomycin course remains 10 days)**	125mg QDS	BNF for children	10 days	
		Second-line for first episode of mild, moderate or severe if vancomycin ineffective: fidaxomicin	200mg BD	BNF for children		

	gastrointestinal activity or adverse effects (such as laxatives), medicines that may cause problems if people are dehydrated (such as NSAIDs). Do not offer antimotility medicines such as loperamide. Offer an oral antibiotic to treat suspected or confirmed *C. difficile* infection. For adults, consider seeking prompt specialist advice from a microbiologist or infectious diseases specialist before starting treatment. For children and young people, treatment should be started by, or after advice from, a microbiologist, paediatric infectious diseases specialist or paediatric gastroenterologist. **If antibiotics have been started for suspected *C. difficile* infection, and subsequent stool sample tests do not confirm infection, consider stopping these antibiotics.** *For detailed information click on the visual summary.*	**For alternative antibiotics if first- and second-line antibiotics are ineffective discuss with Department of Infection** **For life-threatening infection refer to hospital immediately**				
Helicobacter pylori Public Health England See PHE quick reference guide for diagnostic	Always test for *H.pylori* before giving antibiotics. Treat all positives, if known DU, GU, or low-grade MALToma. NNT in non-ulcer dyspepsia: Do not offer eradication for GORD. Do not use clarithromycin or metronidazole if used in the past year for any infection. **Penicillin allergy**: use PPI **PLUS** clarithromycin **PLUS** metronidazole. If previous clarithromycin, use PPI **PLUS**	**Always use PPI First line and first relapse and no penicillin allergy** PPI (lansoprazole) **PLUS** 2 antibiotics	- (30mg BD)	BNF for children	7 days MALToma 14 days	
		amoxicillin **PLUS**	1000mg BD	BNF for children		
		clarithromycin **OR**	500mg BD	BNF for children		
		metronidazole	400mg BD	BNF for children		

advice: PHE H. pylori Last updated: Feb 2019	bismuth salt **PLUS** metronidazole **PLUS** tetracycline hydrochloride.[2D,8A-,9D] **Relapse and no penicillin allergy** use PPI **PLUS** amoxicillin **PLUS** clarithromycin or metronidazole (whichever was not used first line) [2D] **Relapse and previous metronidazole and clarithromycin**: use PPI **PLUS** amoxicillin **PLUS** tetracycline **Retest for *H. pylori*:** post DU/GU, or relapse after second-line therapy,[1A+] using UBT or SAT,[10A+,11A+] consider referral for endoscopy and culture.[2D]	**Penicillin allergy and previous clarithromycin**: PPI **WITH** bismuth subsalicylate PLUS 2 antibiotics	-	-		
		bismuth subsalicylate **PLUS**	525mg QDS			
		Metronidazole **PLUS**	400mg BD	BNF for children		
		tetracycline[2D]	500mg QDS			
		Relapse and previous metronidazole and clarithromycin: PPI **PLUS** 2 antibiotics	-	-		
		amoxicillin **PLUS**	1000mg BD[1]	BNF for children		
		tetracycline[2D,7A+] **OR**	500mg QDS			
Acute diverticulitis NICE Last updated: Nov 2019	**Acute diverticulitis and systemically well:** Consider no antibiotics, offer simple analgesia (for example paracetamol), advise to re-present if symptoms persist or worsen. Avoid NSAIDs and opioids. **Acute diverticulitis and systemically unwell, immunosuppressed or significant comorbidity:** offer an antibiotic. Give oral antibiotics if person not referred to hospital for suspected complicated acute diverticulitis.	**First-choice (uncomplicated acute diverticulitis and systemically well):** Consider no antibiotics		-		
		Second-choice (uncomplicated acute diverticulitis) trimethoprim **AND** metronidazole	trimethoprim: 200mg BD metronidazole: 400mg TDS		5 days	
		Trimethoprim unsuitable: cefalexin (caution in penicillin allergy) **AND** metronidazole	cefalexin: 500mg BD or TDS (up to 1g to 1.5g TDS or QDS for severe infections) metronidazole: 400mg TDS	- -		

Humber Area Prescribing Committee – Hull and East Riding Only

Document and version control	**This information is not inclusive of all prescribing information and potential adverse effects. Please refer to the SPC (data sheet) or BNF for further prescribing information.**		
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