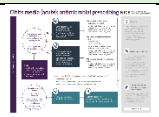
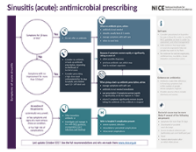
Infection	Key points	Medicine	Doses		Length	Evidence links
			Adult	Child		
▼ **Upper respiratory tract infections**						
Acute sore throat	**Avoid antibiotics** as 90% resolve in 7 days without, and pain only reduced by 16 hours Advise paracetamol, or if preferred and suitable, ibuprofen for pain. Medicated lozenges may help pain in adults (OTC). Use FeverPAIN or Centor to assess symptoms: **FeverPAIN 0-1 or Centor 0-2**: no antibiotic; **FeverPAIN 2-3**: no or back-up antibiotic; **FeverPAIN 4-5 or Centor 3-4:** immediate or back-up antibiotic. **Systemically very unwell or high risk of complications:** immediate antibiotic. *5 days of phenoxymethylpenicillin may be enough for symptomatic cure; but a 10-day course may increase the chance of microbiological cure. *For detailed information click the visual summary icon.*	**First choice**: phenoxymethylpenicillin	500mg QDS		5 to 10 days*	
		Penicillin allergy: clarithromycin **OR**	250mg to 500mg BD		5 days	
		erythromycin (preferred if pregnant)	250mg to 500mg QDS		5 days	

<table>
<tr><th>Infection</th><th>Key points</th><th>Medicine</th><th colspan="2">Doses
Adult | Child</th><th>Length</th><th>Evidence links</th></tr>
<tr><td>Influenza

Public Health England</td><td colspan="6">Annual vaccination is essential for all those ‘at risk’ of influenza. Antivirals are not recommended for healthy adults.
Treat ‘at risk’ patients with 5 days oseltamivir 75mg BD, when influenza is circulating in the community, and ideally within 48 hours of onset (36 hours for zanamivir treatment in children), or in a care home where influenza is likely.
At risk: pregnant (and up to 2 weeks post-partum); children under 6 months; adults 65 years or older; chronic respiratory disease (including COPD and asthma); significant cardiovascular disease (not hypertension); severe immunosuppression; chronic neurological, renal or liver disease; diabetes mellitus; morbid obesity (BMI>40). See the PHE Influenza guidance for the treatment of patients under 13 years.[4D] In severe immunosuppression, or oseltamivir resistance, use zanamivir 10mg BD (2 inhalations twice daily by diskhaler for up to 10 days) and seek advice.
Access supporting evidence and rationales on the PHE website.
Oseltamivir requires dose reductions in renal impairment
<table>
<tr><th>CrCl</th><th>Oseltamivir PO treatment for 5 days</th><th>Oseltamivir PO prophylaxis for 10 days</th></tr>
<tr><td>≥30ml/min</td><td>75mg BD</td><td>75mg OD</td></tr>
<tr><td>11ml/min – 29ml/min</td><td>75 mg once daily or 30 mg twice daily</td><td>75 mg every 48 hours or 30 mg once daily</td></tr>
<tr><td>≤10ml/min</td><td>75 mg as a single dose</td><td>30 mg once a week (2 doses)</td></tr>
<tr><td>Haemo-dialysis</td><td>75 mg three times a week post dialysis</td><td>30 mg three times a week post dialysis</td></tr>
<tr><td>Peritoneal dialysis</td><td>30mg ONCE (STAT dose)</td><td>30mg ONCE, repeated after 7 days</td></tr>
</table>
</td></tr>
<tr><td>Scarlet fever (GAS)</td><td rowspan="3">Prompt treatment with appropriate antibiotics significantly reduces the risk of complications. Vulnerable individuals (immunocompromised, the comorbid, or those with skin disease) are at increased risk of developing complications.</td><td>Phenoxymethylpenicillin</td><td>500mg QDS</td><td>BNF for children</td><td>10 days</td><td></td></tr>
<tr><td>Penicillin allergy: clarithromycin</td><td>250mg to 500mg BD</td><td>BNF for children</td><td>5 days</td><td></td></tr>
<tr><td colspan="4">Optimise analgesia and give safety netting advice</td><td></td></tr>
<tr><td>Acute otitis media</td><td>Avoid antibiotics as 60% are better in 24 hours without: they only reduce pain at 2 days and do not prevent deafness.</td><td>First choice: amoxicillin</td><td>500mg TDS</td><td rowspan="3">  </td><td rowspan="3">5 days (7 days in severe infection)</td><td rowspan="3">  </td></tr>
<tr><td>Penicillin allergy: clarithromycin OR</td><td>500mg BD</td></tr>
<tr><td>erythromycin (preferred if pregnant)</td><td>500mg QDS</td></tr>
</table>

Infection	Key points	Medicine	Doses		Length	Evidence links
			Adult	Child		
	Often viral and/or self limiting. Most episodes will resolve within 3 days without antibiotic therapy. Regular paracetamol or ibuprofen for pain (right dose for age or weight at the right time and maximum doses for severe pain). Consider ear drops containing an anaesthetic and an analgesic for pain if an immediate antibiotic is not given and there is no ear drum perforation or otorrhoea. (Phenazone 40 mg/g with lidocaine 10 mg/g apply 4 drops BD-TDS for up to 7 days). **Otorrhoea or under 2 years with infection in both ears**: either no, back-up or immediate antibiotic. **Systemically very unwell or high risk of complications**: immediate antibiotic. **Otherwise**: no or back-up antibiotic. *For detailed information click on the visual summary.*	**Second choice**: co-amoxiclav for severe cases only	625mg TDS		5 to 7 days	
Acute otitis externa	**First line**: analgesia for pain relief, and apply localised heat (such as a warm flannel). **Second line**: topical acetic acid or topical antibiotic +/- steroid: similar cure at 7 days.	**Second line**: Mild cases only topical acetic acid 2%[2D,4B-]	1 spray TDS	BNF for children	7 days	CKS
		Moderate cases: Cetraxal Plus® ear drops **OR**	1 ampoule BD		7 days	

Infection	Key points	Medicine	Doses		Length	Evidence links
			Adult	Child		
	If cellulitis or disease extends outside ear canal, or systemic signs of infection, start oral flucloxacillin and refer to exclude malignant otitis externa. Acute otitis externa rarely happens in children – consider if acute otitis media	Sofradex® (consider safety issues if perforated tympanic membrane)	2 drops QDS	BNF for children	7 days	
		If cellulitis: flucloxacillin	500mg QDS	BNF for children	7 days	
Acute Sinusitis	**Usually viral and/or self limiting – most get better without antibiotics. Bacterial complication is rare - about 2 per 100 cases.** Advise paracetamol or ibuprofen for pain. Little evidence that nasal saline or nasal decongestants help, but people may want to try them (OTC). **Symptoms for 10 days or less**: no antibiotic. **Symptoms with no improvement for more than 10 days**: no antibiotic or back-up antibiotic depending on likelihood of bacterial cause. Consider high-dose nasal corticosteroid (if over 12 years) e.g. mometasone 50microg/spray. **Systemically very unwell or high risk of complications**: immediate antibiotic. *For detailed information click on the visual summary.*	**First choice**: Amoxicillin	500mg TDS		5 days	
		Penicillin allergy: doxycycline (not in under 12s) **OR**	200mg on day 1, then 100mg OD		5 days	
		clarithromycin **OR**	500mg BD			
		erythromycin (preferred if pregnant)	250 to 500mg QDS or 500 to 1000mg BD			
		Second choice or first choice if systemically very unwell or high risk of complications: co-amoxiclav	500/125mg TDS		5 days	

APPROVAL PROCESS

Written by:	**Jane Morgan, Principal Pharmacist**
Consultation process:	**ACAT**
Approved by:	**HAPC guideline group**
Ratified by:	**HAPC**
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