

Summary of antimicrobial prescribing guidance - managing common infections

- See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breastfeeding.

Abbreviations

BD	twice a day
eGFR	estimated glomerular filtration rate
IM	intramuscular
IV	intravenous
MALToma	mucosa-associated lymphoid tissue lymphoma
m/r	modified release
MRSA	methicillin-resistant <i>Staphylococcus aureus</i>
MSM	men who have sex with men
OD	once daily
QDS	four times a day
PPI	proton pump inhibitor
stat	given immediately
TDS	three times a day

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Upper respiratory tract infections

Acute sore throat

(NICE/CKS last updated August 2023)

- Advise paracetamol, or if preferred and suitable, ibuprofen for pain.
- Medicated lozenges may help pain in adults.
- 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.
- For detailed information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice: phenoxymethylpenicillin	500mg QDS or 1000mg BD	See visual summary	5 to 10 days*
Penicillin allergy: clarithromycin	250mg to 500mg BD	See visual summary	5 days
Penicillin allergy alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	250mg to 500mg QDS or 500mg to 1000mg BD	See visual summary	5 days

**Note: 5 days of phenoxymethylpenicillin may be enough for symptomatic cure; but a 10-day course may increase the chance of microbiological cure.*

Influenza

(NICE/CKS last updated January 2023)

- **Annual vaccination is essential for all those ‘at risk’ of influenza.**
- Antivirals are not recommended for healthy adults.
- *For management guidance please refer to [UKHSA guidance on Influenza: treatment and prophylaxis using anti-viral agents](#)*

Acute otitis media

(NICE/CKS last updated July 2023)

- Regular paracetamol or ibuprofen for pain (right dose for age or weight at the right time and maximum doses for severe pain).
- Consider eardrops containing an anaesthetic and an analgesic (Otigo® ear drops containing Phenazone / lidocaine hydrochloride 40 mg/10 mg/g) for pain if an immediate antibiotic is not given, and there is no eardrum perforation or otorrhoea.
- **Otorrhoea or under 2 years with infection in both ears:** no antibiotic, back-up antibiotic or immediate antibiotic.
- **Otherwise:** no antibiotic or back-up antibiotic.
- **Systemically very unwell or high risk of complications:** immediate antibiotic.
- For detailed information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice: amoxicillin	500mg TDS	See visual summary	5 to 7 days
Penicillin allergy: clarithromycin	250 mg BD increased to 500mg BD for severe infections	See visual summary	5 to 7 days
Penicillin allergy alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	250-500mg QDS	See visual summary	5 to 7 days
Second choice: co-amoxiclav	250/125mg TDS increased in severe infections to 500/125mg TDS	See visual summary	5 to 7 days

Acute otitis externa

(NICE/CKS last updated February 2022)

- Provide advice on self-care measures for symptom relief and to reduce risk of recurrent infection.
- Advise on options for analgesia such as paracetamol or ibuprofen for symptom relief, if needed.
- Consider use of over-the-counter acetic acid 2% ear drops or spray (for people aged 12 years and older) morning, evening, and after swimming, showering, or bathing, for a maximum of 7 days.
- Consider prescribing a topical antibiotic preparation with or without a topical corticosteroid for 7–14 days, depending on clinical judgement and symptom response.
- Consider prescribing an oral antibiotic if the patient is immunocompromised, there is severe infection, or there is spread beyond the external ear canal to adjacent tissues, depending on clinical judgement.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Otitis externa](#)

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line: analgesia for pain relief	-	-	-
Second line: topical acetic acid 2%	1 spray TDS	See BNF for children	7 days
Second line alternative: topical neomycin sulphate with corticosteroid (consider safety issues if perforated tympanic membrane)	3 drops TDS	See BNF for children	7 days (min) to 14 days (max)
If Class I cellulitis: flucloxacillin	500-1000mg QDS	See BNF for children	7 days

Scarlet fever (GAS)

(NICE/CKS last updated July 2023)

- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Scarlet fever](#)

Sinusitis

(NICE/CKS last updated July 2023)

- Advise paracetamol or ibuprofen for pain. Little evidence that nasal saline or nasal decongestants help, but people may want to try them.
- **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).
- **Systemically very unwell or high risk of complications:** immediate antibiotic.
- For detailed information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice: phenoxymethylpenicillin	500mg QDS	See visual summary	5 days
Penicillin allergy: doxycycline (not in under 12s) or	200mg on day 1, then 100mg OD	See visual summary	5 days
Penicillin allergy: clarithromycin or	500mg BD	See visual summary	5 days
Penicillin allergy: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	250 to 500mg QDS or 500 to 1000mg BD	See visual summary	5 days
Second choice or first choice if systemically very unwell or high risk of complications: co-amoxiclav	500/125mg TDS	See visual summary	5 days

Lower respiratory tract infections

COVID-19

(NICE/CKS last updated November 2023)

- Antibiotics should not be used for preventing or treating COVID-19 unless there is clinical suspicion of additional bacterial co-infection.
- Do not use azithromycin to treat COVID-19.
- Do not use doxycycline to treat COVID-19 in the community.
- Do not offer an antibiotic for preventing secondary bacterial pneumonia in people with COVID-19.
- If a person in the community has suspected or confirmed secondary bacterial pneumonia, start antibiotic treatment as soon as possible, see [community-acquired pneumonia](#) for choices.
- In hospital, start empirical antibiotics if there is clinical suspicion of a secondary bacterial infection in people with COVID-19, see [hospital-acquired pneumonia](#) for choices. Start antibiotics as soon as possible after establishing a diagnosis of secondary bacterial pneumonia, and certainly within 4 hours. Start treatment within 1 hour if the person has suspected sepsis and meets any of the high-risk criteria for this outlined in the [NICE guideline on sepsis](#).
- *For detailed information, see the [NICE guideline on managing COVID-19](#).*

Acute exacerbation of COPD

(NICE/CKS last updated September 2023)

- Many exacerbations are not caused by bacterial infections so will not respond to antibiotics. Consider an antibiotic, but only after taking into account severity of symptoms (particularly sputum colour changes and increases in volume or thickness), need for hospitalisation, previous exacerbations, hospitalisations and risk of complications, previous sputum culture and susceptibility results, and risk of resistance with repeated courses.
- Some people at risk of exacerbations may have antibiotics to keep at home as part of their exacerbation action plan.
- For detailed information see [visual summary](#). See also the [NICE guideline on COPD in over 16s](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice: amoxicillin or	500mg TDS (see BNF for severe infection)	-	5 days
First choice: doxycycline or	200mg on day 1, then 100mg OD (see BNF for severe infection)	-	5 days
First choice: clarithromycin	500mg BD	-	5 days
Second choice: use alternative first choice	See above	-	5 days
Alternative choice (if person at higher risk of treatment failure): co-amoxiclav or consult with microbiology/ specialist	500/125mg TDS	-	5 days

Acute exacerbation of bronchiectasis (non-cystic fibrosis)

(NICE/CKS last updated July 2023)

- Send a sputum sample for culture and susceptibility testing.
- Offer an antibiotic. When choosing an antibiotic, take account of severity of symptoms and risk of treatment failure. People who may be at higher risk of treatment failure include people who've had repeated courses of antibiotics, a previous sputum culture with resistant or atypical bacteria, or a higher risk of developing complications.
- Course length is based on severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous culture and susceptibility results, and response to treatment.
- Do not routinely offer antibiotic prophylaxis to prevent exacerbations.
- Consider a trial of mucoactive treatment in patients with bronchiectasis who have difficulty in sputum expectoration. If carbocisteine is prescribed, a 6-month trial should be given and continued if there is ongoing clinical benefit.
- British Thoracic Society 2019:
- Seek specialist advice for preventing exacerbations in people with repeated acute exacerbations. This may include a trial of antibiotic prophylaxis after a discussion of the possible benefits and harms, and the need for regular review.
- **When current susceptibility data available: choose antibiotics accordingly.**
- For detailed information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice empirical treatment: amoxicillin (preferred if pregnant) or	500mg TDS	See visual summary	7 to 14 days
First choice empirical treatment: doxycycline (not in under 12s) or	200mg on day 1, then 100mg OD	See visual summary	7 to 14 days
First choice empirical treatment: clarithromycin	500mg BD	See visual summary	7 to 14 days
Alternative choice (if person at higher risk of treatment failure) empirical treatment: co-amoxiclav or	500/125mg TDS	See visual summary	7 to 14 days
Consult with specialist		See visual summary	

Acute cough

(NICE/CKS last updated August 2023)

- Treatment not routinely required.
- **Only treat those with a high risk of complications or systemically unwell.**
- Some people may wish to try honey (in over 1s), cough medicines containing the expectorant guaifenesin (in over 12s) or cough medicines containing cough suppressants, except codeine, (in over 12s). These self-care treatments have limited evidence for the relief of cough symptoms.
- **Acute cough with upper respiratory tract infection:** no antibiotic.
- **Acute bronchitis:** no routine antibiotic.
- **Acute cough and higher risk of complications (at face-to-face examination):** immediate or back-up antibiotic.
- **Acute cough and systemically very unwell (at face-to-face examination):** immediate antibiotic.
- Higher risk of complications includes people with pre-existing comorbidity; young children born prematurely; people over 65 with 2 or more of, or over 80 with 1 or more of: hospitalisation in previous year, type 1 or 2 diabetes, history of congestive heart failure, current use of oral corticosteroids.
- Do not offer a mucolytic, an oral or inhaled bronchodilator, or an oral or inhaled corticosteroid unless otherwise indicated.
- For detailed information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Adults first choice: doxycycline	200mg on day 1, then 100mg OD	-	5 days
Adults alternative first choice: amoxicillin (preferred if pregnant) or	500mg TDS	-	5 days
Adults alternative first choice: clarithromycin or	250mg to 500mg BD	-	5 days
Adults alternative first choice: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	250mg to 500mg QDS or 500mg to 1000mg BD	-	5 days
Children first choice: amoxicillin	-	See visual summary	5 days
Children alternative first choice: clarithromycin or	-	See visual summary	5 days
Children alternative first choice: erythromycin or	-	See visual summary	5 days
Children alternative first choice: doxycycline (not in under 12s)	-	See visual summary	5 days

Hospital-acquired pneumonia

(NICE last updated September 2019)

- If symptoms or signs of pneumonia start within 48 hours of hospital admission, see [community acquired pneumonia](#).
- Offer an antibiotic. Start treatment as soon as possible after diagnosis, within 4 hours (within 1 hour if sepsis suspected and person meets any high-risk criteria – see the [NICE guideline on sepsis](#)).
- When choosing an antibiotic, take account of severity of symptoms or signs, number of days in hospital before onset of symptoms, risk of developing complications, local hospital and ward-based antimicrobial resistance data, recent antibiotic use and microbiological results, recent contact with a health or social care setting before current admission, and risk of adverse effects with broad spectrum antibiotics.
- No validated severity assessment tools are available. Assess severity of symptoms or signs based on clinical judgement.
- Higher risk of resistance includes relevant comorbidity (such as severe lung disease or immunosuppression), recent use of broad-spectrum antibiotics, colonisation with multi-drug resistant bacteria, and recent contact with health and social care settings before current admission.
- If symptoms or signs of pneumonia start within days 3 to 5 of hospital admission in people not at higher risk of resistance, consider following community acquired pneumonia for choice of antibiotic.
- *For detailed information see [visual summary](#).*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice (non-severe and not higher risk of resistance): co-amoxiclav	500/125 mg TDS	See visual summary	5 days then review
Adults alternative first choice (non-severe and not higher risk of resistance): Choice based on specialist microbiological advice and local resistance data. Options include: doxycycline	200mg on day 1, then 100mg OD	-	5 days then review
Adults alternative first choice (non-severe and not higher risk of resistance): Choice based on specialist microbiological advice and local resistance data. Options include: cefalexin (caution in penicillin allergy)	500mg BD or TDS (can increase to 1 to 1.5gram TDS or QDS)	-	5 days then review
Adults alternative first choice (non-severe and not higher risk of resistance): Choice based on specialist microbiological advice and local resistance data. Options include: co-trimoxazole (off-label use)	960mg BD	-	5 days then review
Adults alternative first choice (non-severe and not higher risk of resistance): Choice based on specialist microbiological advice	500mg OD or BD	-	5 days then review

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
and local resistance data. Options include: levofloxacin (only if switching from IV levofloxacin with specialist advice; off-label use; consider safety issues)			
Children alternative first choice (non-severe and not higher risk of resistance): clarithromycin Other options may be suitable based on specialist microbiological advice and local resistance data.	-	See visual summary	-
For first choice IV antibiotics (severe or higher risk of resistance) and antibiotics to be added if suspected or confirmed MRSA infection, see visual summary.	-	-	-

Community-acquired pneumonia (CAP)
(NICE/CKS last updated September 2025)

- Assess severity in adults based on clinical judgement and guided by a mortality risk score (CRB65 or CURB65) when these scores can be calculated:

	Mortality risk assessment in primary care	Mortality risk assessment in hospital
Low severity	CRB65 0	CURB65 0 or 1
Moderate severity	CRB65 1 or 2	CURB65 2
High severity	CRB65 3 or 4 – Urgent hospital admission	CURB65 3 to 5 – Inpatient care with referral to critical care services if appropriate

Each CRB65 parameter scores one:

- Confusion (AMT <8, or new disorientation in person, place or time) - see [NICE's guideline on delirium](#)
- Respiratory rate >30/min
- BP systolic <90mmHg or diastolic ≤60mmHg
- Age >65

Each CURB65 parameter scores one:

- Confusion (AMT <8, or new disorientation in person, place or time) - see [NICE's guideline on delirium](#)
- Urea >7 mmol/l
- Respiratory rate >30/min
- BP systolic <90mmHg or diastolic ≤60mmHg
- Age >65

- Assess severity in children and young people under 18 years based on clinical judgement. For children under 1 month, refer to paediatric specialist.
- Offer an antibiotic. Start treatment as soon as possible after diagnosis, within 4 hours (within 1 hour if sepsis suspected and person meets any high-risk criteria – see the [NICE guideline on sepsis](#)).
- When choosing an antibiotic, take account of severity, risk of complications, local antimicrobial resistance and surveillance data, recent antibiotic use and microbiological results.
- For detailed information see [NICE's guideline on pneumonia in adults: diagnosis and management \(NG250\)](#).

Corticosteroid treatment in hospital

- For adults with high-severity community-acquired pneumonia in hospital, consider a corticosteroid, in addition to antibiotics, for 4 to 7 days or until discharge, if sooner.
- When choosing a corticosteroid, consider starting treatment with IV hydrocortisone. If hydrocortisone is not suitable, consider an alternative corticosteroid such as dexamethasone by the most appropriate route of administration.
- Note: not all treatments are licensed for this indication, so use may be off label
- See [MHRA advice for restrictions and precautions on the coadministration of fluoroquinolone antibiotics and corticosteroids](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice (low severity in adults or non-severe in children): amoxicillin	500mg TDS (higher doses can be used, see BNF)	See visual summary	5 days** Children 3months-11years: 3 days*
Alternative first choice (low severity in adults or non-severe in children): doxycycline (not in under 12s) or	200mg on day 1, then 100mg OD	See visual summary	5 days**
Alternative first choice (low severity in adults or non-severe in children): clarithromycin or	500mg BD	See visual summary	5 days** Children 3months-11years: 3 days*
Alternative first choice (low severity in adults or non-severe in children): erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg QDS	See visual summary	5 days** Children 8-11years: 3 days*
First choice (moderate severity in adults): amoxicillin PLUS ONE of the following (if atypical pathogens suspected)	500mg TDS (higher doses can be used, see BNF)	-	5 days**
clarithromycin or	500mg BD		5 days**
erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg QDS	-	5 days**
Alternative first choice (moderate severity in adults): doxycycline or	200mg on day 1, then 100mg OD	-	5 days**
Alternative first choice (moderate severity in adults): clarithromycin	500mg BD	-	5 days**

*Consider extending use of antibiotics beyond 3 days for babies and children aged 3 months (corrected gestational age) to 11 years if they are not clinically stable.

**Stop antibiotics after 5 days unless microbiological results suggest a longer course is needed or the person is not clinically stable.

Urinary Tract Infections (UTIs)

Lower urinary tract infection

(NICE/CKS last updated June 2023)

- Advise paracetamol or ibuprofen for pain.
- **Non-pregnant women:** back up antibiotic (to use if no improvement in 48 hours or symptoms worsen at any time) or immediate antibiotic.
- **Pregnant women, men, children, or young people:** immediate antibiotic.
- When considering antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data. If clinically indicated, it is reasonable to cover for ESBL if previously isolated in a symptomatic patient.
- If people have symptoms of pyelonephritis (such as fever) or a complicated UTI, see [acute pyelonephritis](#) (upper urinary tract infection) for antibiotic choices.
- For detailed information see [visual summary](#). See also the [NICE guideline on urinary tract infection in under 16s: diagnosis and management](#) and the UK Health Security Agency [urinary tract infection: diagnostic tools for primary care](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Non-pregnant women first choice: nitrofurantoin (if eGFR ≥ 45 ml/minute)	100mg m/r BD (or if unavailable 50mg QDS)	-	3 days
Non-pregnant women first choice alternative: trimethoprim (if low risk of resistance)	200mg BD	-	3 days
Non-pregnant women, second choice nitrofurantoin (if eGFR ≥ 45 ml/minute)	100mg m/r BD (or if unavailable 50mg QDS)	-	3 days
Non-pregnant women second choice alternative: pivmecillinam (a penicillin)	400mg initial dose, then 200mg TDS	-	3 days
Where previous ESBL isolated or where trimethoprim /nitrofurantoin or pivmecillinam are not suitable: fosfomycin	3-gram single dose sachet	-	Single dose
Pregnant women first choice: nitrofurantoin (avoid at term) – if eGFR ≥ 45 ml/minute	100mg m/r BD (or if unavailable 50mg QDS)	-	7 days
Pregnant women second choice: amoxicillin (can be used at term, only if culture results available and susceptible)	500mg TDS	-	7 days
Pregnant women second choice alternative: cefalexin (can be used at term)	500mg BD	-	7 days

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Treatment of asymptomatic bacteriuria in pregnant women: choose from nitrofurantoin (avoid at term), amoxicillin or cefalexin based on recent culture and susceptibility results.	See above	-	See above
Men first choice: trimethoprim	200mg BD	-	7 days
Men first choice alternative: nitrofurantoin (if eGFR $\geq$ 45 ml/minute)	100mg m/r BD (or if unavailable 50mg QDS)	-	7 days
Men second choice: consider alternative diagnoses basing antibiotic choice on recent culture and susceptibility results.	-	-	-
Children and young people (3 months and over) first choice: trimethoprim (if low risk of resistance) or nitrofurantoin (if eGFR $\geq$ 45 ml/minute)	-	See visual summary	-
Children and young people (3 months and over) second choice: nitrofurantoin (if eGFR $\geq$ 45 ml/minute and not used as first choice) or amoxicillin (only if culture results available and susceptible) or cefalexin	-	See visual summary	-

Acute pyelonephritis (Upper Urinary Tract)

(NICE/CKS last updated May 2023)

- Advise paracetamol (+/- low-dose weak opioid) for pain for people over 12.
- Offer an antibiotic.
- When prescribing antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data.
- Avoid antibiotics that don't achieve adequate levels in renal tissue, such as nitrofurantoin.
- *For detailed information see [visual summary](#). See also the [NICE guideline on urinary tract infection in under 16s: diagnosis and management](#) and the UK Health Security Agency [urinary tract infection: diagnostic tools for primary care](#).*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Non-pregnant women and men first choice: cefalexin	500mg BD or TDS (up to 1gram to 1.5gram TDS or QDS for severe infections)	-	7 to 10 days
Non-pregnant women and men first choice alternative: co-amoxiclav (only if culture results available and susceptible)	500/125mg TDS	-	7 to 10 days
Non-pregnant women and men first choice alternative: trimethoprim (only if culture results available and susceptible)	200mg BD	-	14 days
Non-pregnant women and men first choice alternative: ciprofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available). Only to be prescribed as last resort if this is the only alternative based on susceptibility results.	500mg BD	-	7 days
Pregnant women first choice: cefalexin	500mg BD or TDS (up to 1gram to 1.5gram TDS or QDS for severe infections)	-	7 to 10 days
Children and young people (3 months and over) first choice: cefalexin or co-amoxiclav (only if culture results available and susceptible)	-	See visual summary	-

Acute Prostatitis

(NICE/CKS last updated August 2021)

- Advise paracetamol (+/- low-dose weak opioid) for pain, or ibuprofen if preferred and suitable.
- Offer antibiotic.
- Review antibiotic treatment after 14 days and either stop antibiotics or continue for a further 14 days if needed (based on assessment of history, symptoms, clinical examination, urine and blood tests).
- For detailed information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice (guided by susceptibilities when available): ciprofloxacin (Please access the MHRA January 2024 Alert for more information, download the patient information leaflet and counsel your patient).	500mg BD	-	14 days then review
First choice alternative (guided by susceptibilities when available): ofloxacin (Please access the MHRA January 2024 Alert for more information, download the patient information leaflet and counsel your patient).	200mg BD	-	14 days then review
First choice alternative (guided by susceptibilities when available): trimethoprim (if fluoroquinolone not appropriate; seek specialist advice)	200mg BD	-	14 days then review
Second choice discuss with specialist	-	-	14 days then review

Recurrent urinary tract infection (rUTI)
(NICE/CKS last updated August 2023)

Please also refer to our local [Management of Recurrent Urinary Tract Infections in Adults](#) guidance.

- First advise about behavioural and personal hygiene measures, and self-care (with D-mannose or cranberry products) to reduce the risk of UTI.
- **Treat** each episode as acute lower UTI, and ensure urine culture is arranged on each occasion.
- For postmenopausal women, if no improvement, consider vaginal oestrogen (review within 12 months).
- D-mannose and cranberry products should not be taken in pregnancy. No evidence of benefit for cranberry products in older women.
- For non-pregnant women, if no improvement, consider single-dose antibiotic prophylaxis for exposure to a trigger (review within 6 months).
- For non-pregnant women (if no improvement or no identifiable trigger) or with specialist advice for pregnant women, men, children or young people, consider a trial of daily antibiotic prophylaxis (review within 6 months).
- *For detailed information see [visual summary](#). See also the [NICE guideline on urinary tract infection in under 16s: diagnosis and management](#) and the UK Health Security Agency [urinary tract infection: diagnostic tools for primary care](#).*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice antibiotic prophylaxis: trimethoprim (avoid in pregnancy)	200mg single dose when exposed to a trigger or 100mg at night	See visual summary	Return for review within three months
First choice antibiotic prophylaxis alternative: nitrofurantoin (avoid at term) - if eGFR ≥45 ml/minute	100mg single dose when exposed to a trigger or 50 to 100mg at night	See visual summary	Return for review within three months
Second choice antibiotic prophylaxis: amoxicillin <i>High resistance so only use where susceptible strains are isolated</i>	500mg single dose when exposed to a trigger or 250mg at night	See visual summary	Return for review within three months
Second choice antibiotic prophylaxis alternative: cefalexin	500mg single dose when exposed to a trigger or 125mg at night	See visual summary	Return for review within three months

Catheter-associated urinary tract infections (CAUTIs)

(NICE/CKS last updated August 2023)

- DO NOT give antibiotics routinely in the absence of symptomatic infection.
- Consider removing or, if not possible, changing the catheter if it has been in place for more than 7 days. But do not delay antibiotic treatment.
- Advise paracetamol for pain.
- Advise drinking enough fluids to avoid dehydration.
- When prescribing antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data.
- DO NOT routinely offer antibiotic prophylaxis to people with a short-term or long-term catheter.
- For detailed information see [visual summary](#). See also the [UK Health Security Agency urinary tract infection: diagnostic tools for primary care](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Non-pregnant women and men first choice if no upper UTI symptoms: nitrofurantoin (if eGFR $\geq$ 45 ml/minute)	100mg m/r BD (or if unavailable 50mg QDS)	-	7 days
Non-pregnant women and men first choice if no upper UTI symptoms alternative: trimethoprim (if low risk of resistance)	200mg BD	-	7 days
Non-pregnant women and men first choice if no upper UTI symptoms alternative: amoxicillin (only if culture results available and susceptible)	500mg TDS	-	7 days
Non-pregnant women and men second choice if no upper UTI symptoms: pivmecillinam (a penicillin)	400mg initial dose, then 200mg TDS	-	7 days
Non-pregnant women and men first choice if upper UTI symptoms: cefalexin	500mg BD or TDS (up to 1gram to 1.5gram TDS or QDS for severe infections)	-	7 to 10 days
Non-pregnant women and men first choice if upper UTI symptoms alternative: co-amoxiclav (only if culture results available and susceptible)	500/125mg TDS	-	7 to 10 days

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Non-pregnant women and men first choice if upper UTI symptoms alternative: trimethoprim (only if culture results available and susceptible)	200mg BD	-	14 days
Non-pregnant women and men first choice if upper UTI symptoms alternative: ciprofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	500mg BD	-	7 days
Pregnant women first choice: cefalexin	500mg BD or TDS (up to 1gram to 1.5gram TDS or QDS for severe infections)	-	7 to 10 days
Children and young people (3 months and over) first choice: trimethoprim (if low risk of resistance) or amoxicillin (only if culture results available and susceptible) or cefalexin or co-amoxiclav (only if culture results available and susceptible)	-	See visual summary	-

Meningitis

Suspected meningococcal disease

(NICE/CKS last updated July 2020)

- Rapid admission to hospital is the highest priority when invasive meningococcal disease is suspected for all patients.
- Children and young people with suspected bacterial meningitis without non-blanching rash should be transferred directly to secondary care without giving parenteral antibiotics. If urgent transfer to hospital is not possible, for example, in remote locations or adverse weather conditions, antibiotics should be administered to children and young people with suspected bacterial meningitis.
- For suspected meningococcal disease (meningitis with non-blanching rash or meningococcal septicaemia) parenteral antibiotics (intramuscular or intravenous benzylpenicillin) should be given at the earliest opportunity, either in primary or secondary care, but urgent transfer to hospital should not be delayed in order to give the parenteral antibiotics.
- The administration of benzylpenicillin in children and young people should only be withheld if they have a clear history of anaphylaxis after a previous dose; a history of a rash following penicillin is not a contraindication.

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
IV or IM benzylpenicillin	1.2 gram	Child under 1 year: 300mg Child 1 to 9 years: 600mg Child 10+ years: 1.2 gram	Stat dose; give IM, if vein cannot be accessed

Prevention of secondary case of meningitis

(NICE/CKS last updated July 2020)

- Only prescribe following advice from your local health protection specialist/consultant: Telephone 0300 303 8537.
- Out of hours: contact on-call doctor: Telephone 01603 481 221.
- Expert advice is available for managing clusters of meningitis. Please alert the appropriate organisation to any cluster situation.
- UKHSA, Colindale (telephone: 0208 200 4400).
- AWARe (all Wales Acute Response team) (telephone: 0300 003 0032).
- For management guidance please refer to [Meningococcal disease: guidance on public health management - GOV.UK \(www.gov.uk\)](https://www.gov.uk/guidance/meningococcal-disease-guidance-on-public-health-management)

Gastrointestinal tract infections

Oral candidiasis

(NICE/CKS last updated May 2022)

- **Topical azoles** are more effective than topical nystatin.
- Miconazole, including the topical gel formulation, can enhance the anticoagulant effect of warfarin - if miconazole and warfarin are used concurrently, the anticoagulant effect should be carefully monitored and, if necessary, the dose of warfarin reduced. Please see MHRA alert on [Topical miconazole, including oral gel: reminder of potential for serious interactions with warfarin](#)
- Oral candidiasis is rare in immunocompetent adults; consider undiagnosed risk factors, including HIV.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Candida - oral](#)

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Miconazole oral gel	2.5mL of 24mg/mL QDS (hold in mouth after food)	See BNF for children	7 days; continue for 7 days after resolved
If not tolerated: nystatin suspension	1mL; 100,000 units/mL QDS (half in each side)	See BNF for children	7 days; continue for 2 days after resolved
Fluconazole capsules	See NICE CKS	See BNF for children	

Infectious diarrhoea

(NICE/CKS last updated November 2023)

- **Antibiotic treatment is not usually needed for people with mild symptoms, as infection is usually self-limiting.**
- In Campylobacteriosis, if symptoms are severe (high fever, bloody and/or high-output diarrhoea) or the patient is immunocompromised, consider early prescribing with clarithromycin 250–500 mg BD for 5 to 7 days, within 3 days of onset of illness.
- Otherwise consult microbiology.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Gastroenteritis](#)

Traveller's diarrhoea

(NICE/CKS last updated September 2023)

- Do not routinely offer prophylactic treatment for prevention of travellers' diarrhoea.
- Do not routinely prescribe 'stand-by' (to be used if affected) treatments for travellers' diarrhoea.
- Seek specialist advice if considering prophylactic antibiotic treatment or a 'stand-by antibiotic'.
- The National Travel Health Network and Centre (NaTHNaC) provides a telephone advice line for health professionals advising travellers with complex itineraries or specialist health needs. For more information, see the NaTHNaC website (www.nathnac.net)
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Diarrhoea - prevention and advice for travellers](#)

Threadworm

(NICE/CKS last updated February 2023)

- Treat ALL household contacts (unless contraindicated) as threadworms are highly transmissible.
- Advise rigorous hygiene measures for 2 weeks if treated with mebendazole hand hygiene; cut fingernails regularly; morning shower, including perianal area). Wash sleepwear, bed linen, and dust and vacuum.
- See [UKTIS advice](#) for use of mebendazole in pregnancy.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Threadworm](#)

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Adult/Child over 6 months: mebendazole (Unlicensed use for children <2 years of age but BNF still advises to use)	100mg stat	See BNF for Children	1 dose; repeat in 2 weeks if persistent

- **Child under 6 months of age and pregnant or breastfeeding women** (at least in first trimester): only hygiene measure for 6 weeks.

Clostridioides difficile infection (CDI)
(NICE/CKS last updated June 2023)

- For suspected or confirmed *C. difficile* infection, see [UK Health Security Agency'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).
- **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 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 see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First-line for first episode of mild, moderate or severe: vancomycin	125mg QDS	See BNF for children	10 days
Second-line for first episode of mild, moderate or severe if vancomycin ineffective: fidaxomicin*	200mg BD	See BNF for children	10 days
For further episode within 12 weeks of symptom resolution (relapse): fidaxomicin*	200mg BD	See BNF for children	10 days
For further episode more than 12 weeks after symptom resolution (recurrence): vancomycin*	125mg QDS	See BNF for children	10 days

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
For further episode more than 12 weeks after symptom resolution (recurrence) alternative: fidaxomicin*	200mg BD	See BNF for children	10 days
For alternative antibiotics if first-line and second-line antibiotics are ineffective or for life-threatening infection seek specialist advice* (see visual summary)	-	-	-

*Additional microbiology support can be sought for recurrent and difficult to manage CDI cases.

Helicobacter pylori

(NICE last updated October 2019)

- For management guidance please refer to NICE/BNF treatment summaries: [Helicobacter pylori infection](#)
- Always test for *H. Pylori* before giving antibiotics ('test and treat' strategy).
- Treat all positives, if known duodenal ulcer (DU), gastric ulcer (GU), or low-grade MALToma. Number needed to treat in non-ulcer dyspepsia: 14.
- Do not offer eradication for gastro-oesophageal reflux disease.
- Do not use clarithromycin, metronidazole or quinolone if used in the past year for any infection.
- **Penicillin allergy:** use PPI **PLUS** clarithromycin **PLUS** metronidazole. If previous clarithromycin, use PPI **PLUS** bismuth salt **PLUS** metronidazole **PLUS** tetracycline hydrochloride.
- **Relapse and no penicillin allergy** use PPI **PLUS** amoxicillin **PLUS** clarithromycin or metronidazole (whichever was not used first line).
- **Relapse and previous metronidazole and clarithromycin:** use PPI **PLUS** amoxicillin **PLUS** either tetracycline **OR** levofloxacin (if tetracycline not tolerated).
- **Relapse and penicillin allergy (no exposure to quinolone):** use PPI **PLUS** metronidazole **PLUS** levofloxacin.
- **Relapse and penicillin allergy (with exposure to quinolone):** use PPI **PLUS** bismuth salt **PLUS** metronidazole **PLUS** tetracycline.
- **Retest for *H. Pylori*:** post DU/GU, or relapse after second-line therapy, using the urea (13C) breath test or Stool Helicobacter Antigen Test, consider referral for endoscopy and culture.

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Always use PPI First line and first relapse and no penicillin allergy PPI PLUS 2 antibiotics	-	See BNF for children	7 days MALToma 14 days
amoxicillin PLUS	1000mg BD	See BNF for children	7 days MALToma 14 days
clarithromycin or	500mg BD	See BNF for children	7 days MALToma 14 days

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
metronidazole	400mg BD	See BNF for children	7 days MALToma 14 days
Penicillin allergy and previous clarithromycin: PPI with bismuth subsalicylate PLUS 2 antibiotics	-	-	7 days MALToma 14 days
bismuth subsalicylate PLUS	525mg QDS	-	7 days MALToma 14 days
metronidazole PLUS	400mg BD	See BNF for children	7 days MALToma 14 days
tetracycline	500mg QDS	-	7 days MALToma 14 days
Relapse and previous metronidazole and clarithromycin: PPI PLUS 2 antibiotics	-	-	7 days MALToma 14 days
amoxicillin PLUS	1000mg BD	See BNF for children	7 days MALToma 14 days
tetracycline or	500mg QDS	-	7 days MALToma 14 days
levofloxacin (if tetracycline cannot be used)	250mg BD	-	7 days MALToma 14 days
Consult Specialist for advice:	-	-	10 days

Acute diverticulitis

(NICE/CKS last updated July 2023)

- **Acute diverticulitis and systemically well:** Consider no antibiotics, offer simple analgesia (for example paracetamol), advise to re-present if symptoms persist or worsen.
- **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.
- If CT-confirmed uncomplicated acute diverticulitis, review the need for antibiotics.
- For further information see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First-choice (uncomplicated acute diverticulitis): co-amoxiclav	500/125mg TDS	-	5 days*
Penicillin allergy or co-amoxiclav unsuitable: cefalexin (caution in penicillin allergy) and metronidazole	cefalexin: 500mg BD or TDS (up to 1 to 1.5gram TDS or QDS for severe infections) metronidazole: 400mg TDS	-	5 days*
Penicillin allergy or co-amoxiclav unsuitable, alternative: trimethoprim and metronidazole	trimethoprim: 200mg BD metronidazole: 400mg TDS	-	5 days*

*A longer course may be needed based on clinical assessment

Genital Tract Infections

Epididymitis

(BASHH guideline last updated 2020)

- Patients should be advised to abstain from sexual intercourse until they and their partner have completed treatment and follow-up in those with confirmed and suspected sexually transmitted infection.
- All patients with probable sexually transmitted infection (STI) should be advised to attend an appropriate sexual health (GUM) clinic for STI testing.
- For management guidance please refer to the BASHH United Kingdom [guideline for the management of epididymo-orchitis](#).

Recommended Regimes

- For epididymo-orchitis most probably due to any sexually transmitted pathogen (e.g. younger patient, a new sexual partner or more than one sexual partner in the past year, lack of consistent condom use and a contact of a sexually transmitted infection):

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Ceftriaxone PLUS Doxycycline	1 gram IM single dose 100mg BD	-	10 to 14 days

- If most probably due to chlamydia or other non-gonococcal organisms (e.g. where gonorrhoea has been ruled out by Gram stain and no risk factors for gonorrhoea identified):

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Doxycycline or	100mg BD	-	10 to 14 days
Ofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	200mg BD	-	14 days

- For epididymo-orchitis most probably due to an enteric pathogen (e.g. older patient, not sexually active, recent instrumentation (such as prostatic biopsy, vasectomy or catheterisation), men who practice insertive anal intercourse, men with known abnormalities of the urinary tract or positive urine dipstick for leucocytes and nitrites):

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Ofloxacin or (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	200mg BD	-	14 days
Levofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	500mg OD	-	10 days
If quinolones are contraindicated: Co-amoxiclav	500/125mg TDS	-	10 days

For acute epididymitis most likely caused by sexually transmitted chlamydia and gonorrhoea and/or enteric organisms (men who practice insertive anal sex), consider:

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Ceftriaxone PLUS Ofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	1g IM in a single dose 200mg BD	-	10 days

Where *Mycoplasma genitalium* has been tested and identified, see British Association of Sexual Health and HIV national guideline for the management of infection with *Mycoplasma genitalium*, 2025.

Chlamydia trachomatis/urethritis

(BASHH Guideline last updated September 2018)

- The National Chlamydia Screening Programme recommends annual screening for all sexually active people younger than 25 years of age, or more frequently if they change their partner.
- If positive, treat index case, refer to GUM and initiate partner notification, testing and treatment.
- Advise patient with chlamydia to abstain from sexual intercourse until doxycycline is completed or for 7 days after treatment with azithromycin.
- Offer repeat testing to all people under the age of 25 years diagnosed with chlamydia 3–6 months after completion of treatment to check for re-infection; or consider offering repeat testing to people over the age of 25 years who are at high risk of re-infection.
- Test of cure is recommended in pregnancy, where poor compliance is suspected and where symptoms persist.
- For management guidance please refer to the BASHH United Kingdom [guideline for the management of Chlamydia](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line: Doxycycline	100mg BD	-	7 days
Second line/ pregnant/breastfeeding/ allergy/intolerance: Azithromycin	1 gram then 500mg OD	-	Stat 2 days (total 3 days)
If Doxycycline or Azithromycin is contra-indicated: Erythromycin OR	500mg BD		10 to 14 days
Ofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available)	200mg BD or 400mg OD		7 days

Vaginal candidiasis

(BASHH Guideline last updated 2019)

- All topical and oral azoles give over 80% cure in acute vulvovaginal candidiasis.
- **Pregnant and breastfeeding:** avoid oral azoles
- **Recurrent (>4 episodes per year):** 150mg oral fluconazole every 72 hours for 3 doses induction, followed by 1 dose once a week for 6 months maintenance.
- For management guidance please refer to the BASHH United Kingdom [guideline for the management of vulvovaginal candidiasis](#).

Acute vaginal candidiasis – Recommended regimen

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line: Oral fluconazole	150mg	-	Stat
If oral fluconazole contra-indicated: Clotrimazole	500mg pessary	-	Stat
If recurrent: fluconazole (induction/maintenance)	150mg every 72 hours then 150mg once a week	-	3 doses 6 months

Alternative topical regimens (if oral therapy contraindicated):

- Clotrimazole vaginal cream (10%) 5 g as a single dose, intravaginally**
- Clotrimazole pessary 200 mg intravaginally at night for three consecutive nights**
- Econazole pessary 150 mg intravaginally as a single dose or 150 mg intravaginally at night for three consecutive nights**
- Fenticonazole capsule intravaginally as a single dose 600 mg or 200 mg intravaginally at night for three consecutive nights**
- Itraconazole 200 mg orally twice daily for one day PO*
- Miconazole capsule 1200 mg intravaginally as a single dose or 400 mg intravaginally at night for three consecutive nights**
- Miconazole vaginal cream (2%) 5 g intravaginally at night for seven consecutive nights**

Severe vaginal candidiasis – Recommended regimen

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line: Oral fluconazole	150mg	-	Stat on day 1 and 4 (2 doses)_
If oral fluconazole contra-indicated: Clotrimazole	500mg pessary	-	Stat on day 1 and 4 (2 doses)_

Recurrent (>4 episodes per year) vaginal candidiasis – Recommended regimen

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Induction: Oral fluconazole	150mg every 72 hours	-	3 doses
Maintenance: Oral fluconazole	150mg once a week	-	6 months

Alternative regimens (if oral fluconazole contraindicated):

Induction: topical imidazole therapy can be increased to 7-14 days according to symptomatic response

Maintenance for six months: Clotrimazole pessary 500mg intravaginally once a week or Itraconazole 50-100mg orally daily*

*Oral therapies must be avoided in pregnancy, risk of pregnancy and breastfeeding; topical imidazoles are a safe and effective alternative in these situations.

**Intravaginal and topical treatments can also damage latex condoms and diaphragms with case reports of unplanned pregnancies; women must be appropriately counselled about this risk

Bacterial vaginosis

(BASHH Guideline last updated 2012)

- Oral [metronidazole](#) is as effective as topical treatment, and is cheaper.
- Single dose therapies (metronidazole 2 gram single dose) are less effective than prolonged treatment.
- **Pregnant/breastfeeding:** avoid 2 gram dose.
- For management guidance please refer to the BASHH United Kingdom [guideline for the management of bacterial vaginosis](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Oral metronidazole or	400mg BD or 2 gram	-	5 to 7 days or Stat
Metronidazole 0.75% vaginal gel or	5 gram applicator at night	-	5 nights
Clindamycin 2% cream	5 gram applicator at night	-	7 nights

Genital herpes

(BASHH Guideline last updated 2024)

- **Advise:** saline bathing, analgesia, or topical lidocaine for pain, and discuss transmission.
- **First episode:** treat within 5 days if new lesions or systemic symptoms and refer to GUM.
- **Recurrent:** self-care if mild, or immediate short course antiviral treatment, or suppressive therapy if more than 6 episodes per year.
- For management guidance please refer to the BASHH United Kingdom [guideline for the management of anogenital herpes](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First episode genital herpes:			
First line: Aciclovir or	400mg TDS	-	5 days
First line: Valaciclovir or	500mg BD	-	5 days
Second line: Aciclovir or	200mg five times a day	-	5 days
Second line: Famciclovir	250mg TDS	-	5 days
Recurrent genital herpes:			
Short course therapies			
Aciclovir or	800mg TDS (if recurrent)	-	2 days
Famciclovir or	1 gram BD (if recurrent)	-	1 day
Valaciclovir	500mg BD	-	3 days
Alternative 5-day treatment regimens			
Aciclovir or	200mg five times a day or 400mg TDS	-	5 days 3-5 days
Valaciclovir or	500mg BD		5 days
Famciclovir	125mg BD		5 days

Suppressive antiviral therapy and recommended regimens can be found in the BASHH United Kingdom [guideline for the management of anogenital herpes](#).

Gonorrhoea

(BASHH Guideline last updated 2025)

- The prevalence of ciprofloxacin resistance in the UK is high.
- Use IM ceftriaxone if susceptibility not known prior to treatment.
- Use Ciprofloxacin **only** if susceptibility is known prior to treatment and the isolate is sensitive to ciprofloxacin at all sites of infection.
- Refer to GUM. Test of cure is essential.
- Patients should be advised to abstain from sexual intercourse until seven days after they and their partner(s) have completed treatment.
- For further management guidance please refer to the BASHH United Kingdom [Guideline for the Management of Gonorrhoea](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Ceftriaxone	1 gram IM	-	Stat
Alternative regimens if allergy, needle phobia or other contraindications:			
Cefixime PLUS Azithromycin OR	Cefixime: 400mg orally followed by 400mg dose 6-12 hours later Azithromycin: 2 gram orally (which may be divided as two 1 gram doses 6-12 hours apart)		Cefixime: 2 doses Azithromycin: Stat
Gentamicin PLUS Azithromycin OR	Gentamicin: 240mg IM Azithromycin: 2 gram orally		Cefixime: Stat Azithromycin: Stat
Azithromycin OR	2 gram orally		Stat
Ciprofloxacin (only if known to be sensitive and only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	500mg orally	-	Stat

Gonococcal ocular infection:

Ceftriaxone 1 gram IM Stat

Adjunctive cefuroxime 5% eye drops hourly day and night for 48 hours then hourly daytime only for 5 days. Maintain QDS until complete resolution OR

Topical azithromycin hourly day and night for 48 hours then hourly daytime only for 5 days. Maintain QDS until complete resolution.

Trichomoniasis

(BASHH Guideline last updated 2021)

- Oral treatment needed as extravaginal infection common.
- Treat partners and refer to GUM for other STIs.
- Patients should be advised to avoid sexual intercourse for at least 1 week and until they and their partner(s) have completed treatment and follow-up
- **Pregnant/breastfeeding:** avoid 2gram single dose [metronidazole](#); [clotrimazole](#) for symptom relief (not cure) if metronidazole declined.
- For management guidance please refer to the BASHH United Kingdom [Guideline on the Management of *Trichomonas vaginalis*](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Metronidazole	400mg to 500mg BD	-	7 days
Metronidazole	2 gram (more adverse effects)	-	Stat
Pregnancy to treat symptoms: clotrimazole	100mg pessary at night	-	6 nights

Pelvic Inflammatory Disease

(BASHH Guideline last updated 2019)

- Initiation in Primary Care is not expected, diagnosing service to provide full course.
- **Refer** women and sexual contacts to GUM.
- **Elevated ESR or C-reactive protein** supports the diagnosis but is non-specific.
- The absence of endocervical or vaginal pus cells has a good negative predictive value (95%) for a diagnosis of pelvic inflammatory disease but their presence is non-specific (poor positive predictive value – 17%).
- **Exclude:** ectopic pregnancy, acute appendicitis, endometriosis, ovarian cyst torsion or rupture, UTI, functional pain.
- Advise: resting if severe disease and analgesia
- Intravenous therapy is recommended in more severe clinical disease e.g. pyrexia > 38°C, signs of tubo-ovarian abscess or pelvic peritonitis.
- Avoid unprotected intercourse until patient and partner(s) have completed treatment and follow-up.
- Give a detailed explanation with clear and accurate written information. A [patient information leaflet](#) is available.
- Admission for parenteral therapy, observation and possible surgical intervention should be considered in clinically severe disease, if a surgical emergency cannot be excluded, if no response to oral therapy and in those with a tubo-ovarian abscess or who are pregnant.
- All the recommended regimens below are of similar efficacy.
- For further management guidance please refer to the BASHH United Kingdom national [guideline on the management of pelvic inflammatory disease](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line therapy: ceftriaxone plus metronidazole plus doxycycline	ceftriaxone: 1000mg IM metronidazole: 400mg BD doxycycline: 100mg BD	-	ceftriaxone: Stat metronidazole: 14 days doxycycline: 14 days
Second line therapy: metronidazole plus ofloxacin (only to be prescribed if no other alternatives are available: MHRA January 2024 Alert and patient information leaflet available).	metronidazole: 400mg BD ofloxacin: 400mg BD	-	metronidazole: 14 days ofloxacin: 14 days
First line for <i>M. genitalium</i> associated PID: moxifloxacin alone (only to be prescribed if no other alternatives are available: MHRA January	400mg OD	-	14 days

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
2024 Alert and patient information leaflet available).			

Alternative outpatient regimens listed:

Ceftriaxone 1 gram IM stat plus Azithromycin orally 1 gram per week for 2 weeks

Inpatient regimens can be found in the BASHH United Kingdom national [guideline on the management of pelvic inflammatory disease](#).

Skin and soft tissue infections

Cold sores

(NICE/CKS last updated January 2023)

- For patients with primary or recurrent herpes labialis or gingivostomatitis infection, advise the use of paracetamol and/or ibuprofen to treat symptoms of pain and fever, if needed, and there are no contraindications.
- Do not routinely prescribe topical antiviral preparations, such as aciclovir. These medicines are available over-the-counter, and may be used by some people if they find them helpful, from the time of onset of prodromal symptoms before vesicles appear, if possible, until lesions have healed.
- Consider prescribing oral antivirals for healthy patients with an episode of primary oral herpes simplex infection; recurrent herpes labialis if lesions are severe, frequent, or persistent; and recurrent gingivostomatitis (rare), depending on clinical judgement.
- Consider prescribing oral antivirals for people who are immunocompromised with an episode of primary or recurrent oral herpes simplex infection, depending on clinical judgement.
- If there is concern or uncertainty in the treatment of oral herpes simplex infection, long-term oral antiviral prophylaxis may be needed for some patients, following specialist advice.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Herpes simplex - oral](#).

PVL-SA

(UKHSA (PHE) Guidance last updated November 2008)

- Panton-Valentine leukocidin (PVL) is a toxin that destroys white blood cells and is a virulence factor in some strains of *Staphylococcus aureus*.
- **Suppression therapy** should only be started after primary infection has resolved, as ineffective if lesions are still leaking.
- For management guidance please refer to UKHSA (PHE) [PVL-Staphylococcus aureus infections: diagnosis and management](#).

Eczema (bacterial infection)

(NICE Guidance last updated March 2021)

- Manage underlying eczema and flares with treatments such as emollients and topical corticosteroids, whether antibiotics are given or not.
- Symptoms and signs of secondary bacterial infection can include weeping, pustules, crusts, no response to treatment, rapidly worsening eczema, fever, and malaise.
- Not all flares are caused by a bacterial infection, so will not respond to antibiotics.
- Eczema is often colonised with bacteria but may not be clinically infected.
- Do not routinely take a skin swab.
- **Not systemically unwell:**
 - **Do not routinely offer either a topical or oral antibiotic.**
 - If an antibiotic is offered, when choosing between a topical or oral antibiotic, take account of patient preferences, extent and severity of symptoms or signs, possible adverse effects, and previous use of topical antibiotics because antimicrobial resistance can develop rapidly with extended or repeated use.
- **Systemically unwell:**
 - Offer an oral antibiotic.
 - If there are symptoms or signs of cellulitis, see [cellulitis and erysipelas](#).
- For detailed information, see [visual summary](#).
- *If MRSA suspected or confirmed, consult local microbiologist.*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Topical antibiotic (if a topical is appropriate). For localised infections only: First choice: fusidic acid 2%	TDS	See visual summary	5 to 7 days
Oral antibiotic first choice: flucloxacillin	500mg QDS	See visual summary	5 to 7 days
Penicillin allergy or flucloxacillin unsuitable: clarithromycin	250mg BD (can be increased to 500mg BD for severe infections)	See visual summary	5 to 7 days
Penicillin allergy or flucloxacillin unsuitable, alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	250mg to 500mg QDS	See visual summary	5 to 7 days

Impetigo

(NICE/CKS last updated August 2023)

- **Localised non-bullous impetigo:**
 - Hydrogen peroxide 1% cream (other topical antiseptics are available but no evidence for impetigo).
 - If hydrogen peroxide unsuitable or ineffective, short-course topical antibiotic.
- **Widespread non-bullous impetigo:**
 - Short-course topical or oral antibiotic.
 - Take account of person's preferences, practicalities of administration, previous use of topical antibiotics because antimicrobial resistance can develop rapidly with extended or repeated use, and local antimicrobial resistance data.
- **Bullous impetigo, systemically unwell, or high risk of complications:**
 - Short-course oral antibiotic.
 - Do not offer combination treatment with a topical and oral antibiotic to treat impetigo.
- *For detailed information, see [visual summary](#).*
- *If MRSA suspected or confirmed, consult local microbiologist.*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Topical antiseptic: hydrogen peroxide 1%	BD or TDS	See visual summary	5 days*
Topical antibiotic: first choice: fusidic acid 2%	TDS	See visual summary	5 days*
Topical antibiotic: fusidic acid resistance suspected or confirmed: mupirocin 2%	TDS	See visual summary	5 days*
Oral antibiotic: first choice: flucloxacillin	500mg QDS	See visual summary	5 days*
Oral antibiotic: penicillin allergy or flucloxacillin unsuitable: clarithromycin	250mg BD	See visual summary	5 days*
Oral antibiotic: penicillin allergy or flucloxacillin unsuitable, alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	250 to 500mg QDS	See visual summary	5 days*

*Note: 5 days is appropriate for most, can be increased to 7 days based on clinical judgement.

Mastitis

(NICE/CKS last updated September 2023)

- *S. aureus* is the most common infecting pathogen. Suspect if woman has: a painful breast; fever and/or general malaise; a tender, red, swollen and hard area of the breast, usually in a wedge-shaped distribution.
- **Breastfeeding:** oral antibiotics are appropriate, where indicated (see table below). Women should continue feeding, including from the affected breast.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Mastitis and breast abscess](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Flucloxacillin	500mg QDS	-	10 to 14 days
Penicillin allergy: erythromycin	250mg to 500mg QDS	-	10 to 14 days
Penicillin allergy alternative: clarithromycin	500mg BD	-	10 to 14 days

Tick bites (Lyme disease)

(NICE Guidance last updated October 2018)

- **Treatment:** Treat erythema migrans **empirically**; serology is often negative early in infection.
- For other suspected Lyme disease such as neuroborreliosis (CN palsy, radiculopathy) seek advice.
- For management guidance please refer to [NICE NG95: Lyme disease](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Treatment: doxycycline	100mg BD	See BNF for children	21 days
Alternative: amoxicillin	1000mg TDS	See BNF for children	21 days
Alternative if doxycycline and amoxicillin are not suitable: Azithromycin	500 mg daily	See BNF for children	17 days

Scabies

(BASHH Guidelines last updated 2016)

- **First choice permethrin:** Treat whole body from ear/chin downwards, and under nails.
- **If using permethrin** and patient is under 2 years, elderly or immunosuppressed, or **if treating with malathion:** also treat face and scalp.
- **Home/sexual contacts:** treat within 24 hours.
- For management guidance please refer to the BASHH United Kingdom national [Guideline on the Management of Scabies](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Permethrin	5% cream	See BNF for children	2 applications, 1 week apart
Permethrin allergy: malathion	0.5% aqueous liquid	See BNF for children	2 applications, 1 week apart

Insect bites and stings

(NICE/CKS last updated September 2020)

- *Most insect bites or stings will not need antibiotics.*
- *Do not offer an antibiotic if there are no symptoms or signs of infection.*
- *If there are symptoms or signs of infection, see [cellulitis and erysipelas](#).*
- *For detailed information see [visual summary](#).*

Leg ulcer infection

(NICE Guidance last updated February 2020)

- Manage any underlying conditions to promote ulcer healing.
- Only offer an antibiotic when there are symptoms or signs of infection (such as redness or swelling spreading beyond the ulcer, localised warmth, increased pain or fever). Few leg ulcers are clinically infected, but most are colonised by bacteria.
- When prescribing antibiotics, take account of severity, risk of complications and previous antibiotic use.
- For detailed information, see [visual summary](#).
- For antibiotic choices if severely unwell or MRSA suspected or confirmed, usually treated in hospital, see [visual summary](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First-choice: flucloxacillin	500mg to 1gram QDS (please note off label dose)	-	7 days
Penicillin allergy or if flucloxacillin unsuitable: doxycycline	200mg on day 1, then 100mg OD (can be increased to 200mg daily)	-	7 days
Penicillin allergy or if flucloxacillin unsuitable, alternative: clarithromycin	500mg BD	-	7 days
Penicillin allergy or if flucloxacillin unsuitable, alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg QDS	-	7 days
Second choice (if infection worsening or not improving and guided by microbiological results): co-amoxiclav	500/125mg TDS	-	7 days
Second choice in penicillin allergy (if infection worsening or not improving and guided by microbiological results): co-trimoxazole (please note off-label use)	960mg BD	-	7 days

Cellulitis and erysipelas

(NICE Guidance last updated September 2019)

- Exclude other causes of skin redness (inflammatory reactions or non-infectious causes).
- Consider marking extent of infection with a single-use surgical marker pen.
- Offer an antibiotic. Take account of severity, site of infection, risk of uncommon pathogens, any microbiological results and MRSA status.
- Infection around eyes or nose is more concerning because of serious intracranial complications.
- Do not routinely offer antibiotics to prevent recurrent cellulitis or erysipelas.
- *For detailed information, including referral criteria to hospital, see [visual summary](#).*
- *For alternative choice antibiotics for severe infection, suspected or confirmed MRSA infection and IV antibiotics, via ambulatory care, see [visual summary](#). Please note, if suitable for ambulatory care only treat in line with agreed protocols. Oral linezolid is Hospital Only.*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice: flucloxacillin	500mg to 1gram* QDS <i>*Please note off label dose</i>	See visual summary	5 to 7 days*
Penicillin allergy or if flucloxacillin unsuitable: clarithromycin	500mg BD	See visual summary	5 to 7 days*
Penicillin allergy or if flucloxacillin unsuitable, alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg QDS	See visual summary	5 to 7 days*
Penicillin allergy or if flucloxacillin unsuitable, alternative: doxycycline (adults only)	200mg on day 1, then 100mg OD	-	5 to 7 days*
For children if flucloxacillin unsuitable, alternative: co-amoxiclav (not in penicillin allergy)	-	See visual summary	5 to 7 days*
If infection near eyes or nose: co-amoxiclav	500/125mg TDS	See visual summary	7 days*
If infection near eyes or nose (penicillin allergy): clarithromycin and metronidazole (only add in children if anaerobes suspected)	Clarithromycin: 500mg BD Metronidazole: 400mg TDS	See visual summary	7 days*

**Note: A longer course (up to 14 days in total) may be needed but skin takes time to return to normal, and full resolution at 5 to 7 days is not expected.*

Diabetic foot infection

(NICE guidance last updated October 2019)

- In diabetes, all foot wounds are likely to be colonised with bacteria. Diabetic foot infection has at least 2 of: local swelling or induration; erythema; local tenderness or pain; local warmth; purulent discharge.
- Severity is classified as:
 - **Mild:** local infection with 0.5 to less than 2cm erythema.
 - **Moderate:** local infection with more than 2cm erythema or involving deeper structures (such as abscess, osteomyelitis, septic arthritis or fasciitis).
 - **Severe:** local infection with signs of a systemic inflammatory response.
- Start antibiotic treatment as soon as possible.
- Take samples for microbiological testing before, or as close as possible to, the start of treatment.
- When choosing an antibiotic, take account of severity, risk of complications, previous microbiological results and antibiotic use, and patient preference.
- Do not offer antibiotics to prevent diabetic foot infection.
- *For detailed information, see [visual summary](#).*
- *For antibiotic choices for moderate or severe infection, infections where *Pseudomonas aeruginosa* or MRSA is suspected or confirmed, and IV antibiotics via ambulatory care, review the [visual summary](#) - usually treated in Secondary Care or on the recommendation of microbiology. Please note if suitable for ambulatory care - only treat in line with agreed protocols.*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Mild infection: first choice: flucloxacillin	500mg to 1gram* QDS <i>*Please note off label dose</i>	-	7 days*
Mild infection (penicillin allergy): clarithromycin	500mg BD	-	7 days*
Mild infection (penicillin allergy) alternative: erythromycin (if macrolide needed in pregnancy; consider benefit/harm)	500mg QDS	-	7 days*
Mild infection (penicillin allergy) alternative: doxycycline	200mg on day 1, then 100mg OD (can be increased to 200mg daily)	-	7 days*

**Note: A longer course (up to a further 7 days) may be needed based on clinical assessment. However, skin does take time to return to normal, and full resolution at 7 days is not expected.*

Dermatophyte infection: skin

(NICE/CKS last updated July 2023)

- Advise treatment with a topical antifungal cream if there is mild, non-extensive disease in children and adults.
- If an adult has severe or extensive disease, consider prescribing oral terbinafine first line and oral itraconazole if terbinafine is not tolerated or is contra-indicated.
 - Consider prescribing oral antifungal treatment if there is a positive skin sample fungal microscopy or culture result, a strong clinical suspicion of fungal skin infection before mycology results are back, depending on clinical judgement, a negative mycology result, but clinical features are very suggestive of infection.
 - Arrange for repeat skin sampling, and start oral antifungal treatment.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Fungal skin infection - body and groin](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line: topical terbinafine	1% OD to BD	See BNF for children	1 to 4 weeks
Alternative: topical imidazole	1% OD to BD	See BNF for children	4 to 6 weeks

Dermatophyte infection: nail

(NICE/CKS last updated August 2023)

- **Take nail clippings**; start therapy only if **dermatophyte nail infection** is confirmed. Use oral terbinafine first line and oral itraconazole second line.
- **If candida or non-dermatophyte infection** is confirmed, use oral itraconazole first line and oral terbinafine second line.
- **To prevent recurrence**: apply weekly 1% topical antifungal cream to entire toe area.
- **Children**: seek specialist advice.
- Please note topical antifungal nail paints not recommended on FP10.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Fungal nail infection](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line: terbinafine	250mg OD	See BNF for children	Fingers: 6 weeks Toes: 12-24 weeks Stop treatment when continual, new, healthy, proximal nail growth.
Second line: itraconazole	200mg BD	See BNF for children	Pulsed therapy for 1 week, with subsequent courses repeated after 21 days Fingers: 2 courses Toes: 3 courses Stop treatment when continual, new, healthy, proximal nail growth.

Human and animal bites

(NICE/CKS last updated August 2023)

- Offer an antibiotic for a human or animal bite if there are symptoms or signs of infection, such as increased pain, inflammation, fever, discharge or an unpleasant smell. Take a swab for microbiological testing if there is discharge (purulent or non-purulent) from the wound.
- Do not offer antibiotic prophylaxis if a human or animal bite has not broken the skin.
- **Human bite:**
 - Offer antibiotic prophylaxis if the human bite has broken the skin and drawn blood.
 - Consider antibiotic prophylaxis if the human bite has broken the skin but not drawn blood if it is in a high-risk area or person at high risk.
- **Cat bite:**
 - Offer antibiotic prophylaxis if the cat bite has broken the skin and drawn blood.
 - Consider antibiotic prophylaxis if the cat bite has broken the skin but not drawn blood if the wound could be deep.
- **Dog or other traditional pet bite (excluding cat bite)**
 - Do not offer antibiotic prophylaxis if the bite has broken the skin but not drawn blood.
 - Offer antibiotic prophylaxis if the bite has broken the skin and drawn blood if it has caused considerable, deep tissue damage or is visibly contaminated (for example, with dirt or a tooth).
 - Consider antibiotic prophylaxis if the bite has broken the skin and drawn blood if it is in a high-risk area or person at high risk.
- *Seek specialist advice in pregnancy and for children under 12 years of age.*
- *For detailed information see [visual summary](#).*

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First choice: co-amoxiclav	250/125mg or 500/125mg TDS	See visual summary	3 days for prophylaxis 5 days for treatment*
Penicillin allergy or co-amoxiclav unsuitable: doxycycline (not in under 12s) and metronidazole	Doxycycline: 200mg on day 1, then 100mg or 200mg daily Metronidazole: 400mg TDS	See visual summary	Doxycycline: 3 days for prophylaxis Metronidazole: 5 days for treatment*

*Note: course length can be increased to 7 days (with review) based on clinical assessment of the wound. View [visual summary](#) for advice when to refer to Hospital/microbiology.

Varicella zoster/ chickenpox and Herpes zoster/shingles

(NICE/CKS last updated November 2023)

- **Pregnant/immunocompromised/neonate:** seek urgent specialist advice.
- **Chickenpox:**
 - Consider aciclovir for an immunocompetent, non-pregnant adult or adolescent (aged 14 years or older) with chickenpox who presents within 24 hours of rash onset, particularly for people with severe chickenpox or those at increased risk of complications, such as smokers.
 - Give paracetamol for pain relief.
- **Shingles:**
 - Prescribe an oral antiviral treatment within 72 hours of rash onset for people with any of the following criteria:
 - Immunocompromise (if the level of immunocompromise is not severe, the rash is localized, the person is not systemically unwell, and they can be closely followed up).
 - Non-truncal involvement (such as shingles affecting the neck, limbs, or perineum).
 - Moderate or severe pain.
 - Moderate or severe rash.
 - Consider prescribing oral antiviral treatment within 72 hours of rash onset for all people aged over 50 years to reduce the incidence of post-herpetic neuralgia, which is most common in this age group.
 - If it is not possible to initiate treatment within 72 hours, consider starting antiviral treatment up to one week after rash onset, especially if the person is at higher risk of severe shingles or complications (for example continued vesicle formation, older age, immunocompromised, or in severe pain).
 - Ophthalmology review/referral needed if shingles affects the ophthalmic branch of the facial nerve.
- For management guidance please refer to NICE/Clinical Knowledge Summaries - [Chickenpox](#)
- Or
- NICE/Clinical Knowledge Summaries - [Shingles](#)

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
First line for chicken pox and shingles: aciclovir	800mg 5 times daily	See BNF for children	7 days
Second line for shingles if poor compliance: <i>not for children:</i> famciclovir	500mg TDS or 750mg 1-2 times a day	-	7 days
Second line for shingles if poor compliance, alternative: <i>not for children:</i> valaciclovir	1 gram TDS	See BNF for children	7 days

Eye infections

Conjunctivitis

(NICE/CKS last updated October 2022)

- **First line:** bath/clean eyelids with cotton wool dipped in sterile saline or boiled (cooled) water, to remove any discharge.
- **Treat only if severe**, as most cases are viral or self-limiting.
- **Bacterial conjunctivitis:** usually self-limiting and resolve within 5-7 days without treatment. It is characterised by red eye with mucopurulent, not watery discharge. **Third line:** fusidic acid as it has no Gram-negative activity.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Conjunctivitis - infective](#).

Medicine where clinically appropriate	Dose (Adult)	Dose (Child)	Length
Second line: chloramphenicol 0.5% eye drop or 1% ointment	Eye drops: 2 hourly for 2 days, then reduce frequency to 3 to 4 times daily. Eye ointment: 3 to 4 times daily	See BNF for children	48 hours after resolution
Third line: fusidic acid 1% gel	BD	See BNF for children	48 hours after resolution

Blepharitis

(NICE/CKS last updated April 2023)

- Only consider oral antibiotics after 2 weeks of topical and hygiene measure.
- **First line:** lid hygiene for symptom control, including: warm compresses; lid massage and scrubs; gentle washing; avoiding cosmetics.
- **Second line:** topical antibiotics if hygiene measures are ineffective after 2 weeks.
- **Signs of meibomian gland dysfunction**, or acne rosacea: consider oral antibiotics.
- For management guidance please refer to NICE/Clinical Knowledge Summaries: [Blepharitis](#).

Suspected dental infections in primary care

- Refer to dentist for treatment. GP prescribing in Primary Care is **not recommended**.

References

- British Society for Sexual Health and HIV (BASHH) UK national guidance for the management of infection with *Neisseria gonorrhoea*. Available here: [Microsoft Word - GC 2019.docx \(bashhguidelines.org\)](#)
- British Association for Sexual Health and HIV (BASHH) UK national guidance on the management of *Trichomonas vaginalis* 2021. Available here: [British Association for Sexual Health and HIV \(BASHH\) United Kingdom national guideline on the management of Trichomonas vaginalis 2021 \(bashhguidelines.org\)](#)
- Clinical Knowledge Summaries (CKS) Available here: [CKS | NICE](#)
- RCGP. Summary of antimicrobial prescribing guidance- managing common infections. Available here: [Antibiotic and diagnostic quick reference tools: Summary of antimicrobial prescribing guidance - managing common infections \(rcgp.org.uk\)](#)
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