PHE Summary tables: RTIs in primary care

ILLNESS	COMMENTS	DRUG	ADULT DOSE Click on ☺ for child doses	DURATION OF TREATMENT
UPPER RESPIRATORY TRACT INFECTIONS[1]				
Acute sore throat CKS FeverPAIN	**Avoid antibiotics** as 90% resolve in 7 days[1A+] without, and pain only reduced by 16 hours.[2A+] Use **FeverPAIN Score:** Fever in last 24h, Purulence, Attend rapidly under 3d, severely Inflamed tonsils, No cough or coryza).[3B+,4B+] **Score 0-1**: 13-18% streptococci, use NO antibiotic strategy; **2-3:** 34-40% streptococci, use 3 day back-up antibiotic; **>4:** 62-65% streptococci, use immediate antibiotic if severe, or 48hr short back-up prescription.[5A-] Always share self-care advice & safety net. Antibiotics to prevent Quinsy NNT >4000.[4B-] Antibiotics to prevent Otitis media NNT 200.[2A+] 10d penicillin lower relapse *vs* 7d in <18yrs.[8]	Phenoxymethylpenicillin[5B-] *Penicillin Allergy:* clarithromycin	500mg QDS ☺ or 1G BD[6A+] (QDS when severe[7D]) 250-500mg BD ☺	10 days[8A-] 5 days[9A+]
Acute Otitis Media *(child doses)* CKS OM NICE feverish children	**Optimise analgesia and target antibiotics**[2,3B-] AOM resolves in 60% in 24hrs without antibiotics, which only reduce pain at 2 days (NNT15) **and does not prevent deafness.**[4A+] Consider 2 or 3-day delayed[1A+] or immediate antibiotics for pain relief if: **<2 years** AND bilateral AOM (NNT4) or bulging membrane and ≥ 4 marked symptoms.[5-7+] **All ages** with otorrhoea NNT3.[8A+] Abx to prevent Mastoiditis NNT >4000.[9B-]	Amoxicillin[10A+] *Penicillin Allergy:* erythromycin[11D]	**Child doses** Neonate 7-28 days 30mg/kg TDS 1 month-1 yr: 125mg TDS 1-5 years: 250mg TDS 5-18 years: 500mg TDS <2 years 125mg QDS 2-8 years 250mg QDS 8-18 years 250-500mg QDS	5 days[13A+] 5 days[13A+]
Acute Otitis Externa CKS OE	First use analgesia. Cure rates similar at 7 days for topical acetic acid or antibiotic +/- steroid.[1A+] If cellulitis/disease extending outside ear canal, start oral antibiotics & refer to exclude malignant OE[2A+]	*First Line:* acetic acid 2% *Second Line:* neomycin sulphate with corticosteroid[3A-,4D]	1 spray TDS 3 drops TDS	7 days 7 days min to 14 days max[1A+]
Acute Rhinosinusitis[5C] CKS RS	**Avoid antibiotics as** 80% resolve in 14 days without; they only offer marginal benefit after 7days NNT15.[2,3A+] **Use adequate analgesia.**[4B+] Consider 7-day delayed or immediate antibiotic when purulent nasal discharge NNT8.[1,2A+] In persistent infection use an agent with anti-anaerobic activity eg. co-amoxiclav.[6B+]	Amoxicillin[4A+,7A] *or* doxycycline *or* phenoxymethylpenicillin[8B] *For persistent symptoms:* co-amoxiclav[6B+]	500mg TDS ☺ 1g if severe[11D] 200mg stat then100mg OD 500mg QDS ☺ 625mg TDS	7 days[9A+] 7 days 7 days 7 days 7 days
LOWER RESPIRATORY TRACT INFECTIONS				
Note: *Low doses of penicillins are more likely to select out resistance[1], we recommend 500mg of amoxicillin. Do* ***not*** *use quinolone (ciprofloxacin, ofloxacin) first line due to poor pneumococcal activity.[2B-] Reserve all quinolones (including levofloxacin) for proven resistant organisms.*				
Acute cough bronchitis CKS[6] NICE 69	Antibiotic little benefit if no co-morbidity.[1-4A+] Consider 7d delayed antibiotic with advice.[1,5A] Symptom resolution can take 3 weeks. Consider immediate antibiotics if > 80yr and ONE of: hospitalisation in past year, oral steroids, diabetic, congestive heart failure **OR** > 65yrs with 2 of above. Consider CRP test[1A,4] if antibiotic being considered. If CRP<20mg/L no antibiotics, 20-100mg/L delayed, CRP >100mg immediate antibiotics.	Amoxicillin *or* doxycycline	500mg TDS ☺ 200mg stat then100mg OD	5 days[4A+] 5 days[4A+]
Acute exacerbation of COPD NICE 12 GOLD	Treat exacerbations promptly with antibiotics if purulent sputum **and** increased shortness of breath **and/or** increased sputum volume.[1-3B+] Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations, antibiotics in last 3 months.[2]	Amoxicillin *or* doxycycline *or* clarithromycin *If resistance:* co-amoxiclav	500mg TDS 200mg stat/100mg OD 500mg BD 625mg TDS	5 days[4C] 5 days[4C] 5 days[4A] 5 days[4A]
Community acquired pneumonia-treatment in the community[2,3] BTS 2009 NICE 191	Use CRB65 score to guide mortality risk, place of care & antibiotics[1] Each CRB65 parameter scores 1: **C**onfusion (AMT<8); **R**espiratory rate >30/min; **B**P systolic <90 or diastolic ≤60; Age >**65**; **Score 3-4 urgent hospital admission; Score 1-2** intermediate risk consider hospital assessment; **Score 0** low risk: consider home based care. **Always give safety-net advice** and likely duration of symptoms. Mycoplasma infection is rare in >65s.[1]	**IF CRB65=0:** amoxicillin[A+] *or* clarithromycin[A-] *or* doxycycline[D] **If CRB65=1,2** & AT HOME, **clinically assess need for dual therapy for atypicals**: amoxicillin[A+] AND clarithromycin[A-] *or* doxycycline alone	500mg TDS ☺ 500mg BD ☺ 200mg stat/100mg OD 500mg TDS ☺ 500mg BD ☺ 200mg stat/100mg OD	CRB65=0: use 5 days. Review at 3 days & extend to 7-10 days if poor response. 7-10 days