Antibiotic treatment length Guidelines - work for Barnsley Healthcare Federation

evidenced from CKS Clinical Knowledge Summaries and the BNF – British National Formulary

Notes- please see Adult and children BNF for further details

Note that clarithromycin tablets are not licensed for use in children under 12 years

Avoid Clarithromycin in pregnancy – erythromycin is preferred in pregnancy

Avoid Doxycycline in pregnant/breast-feeding women and in young children under 12 years

This is a piece of work carried out for Barnsley Health care Federation for auditing antibiotic lengths of treatment in clinical practice.
oral thrush has been included – despite being antifungal

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All references from CKS, NICE and BNF guidelines.
Each clinician must do their own checks to confirm accuracy.
BHF is not liable for any complications through prescribing

	Treatment Length	Evidence from CKS NICE Guidelines - BNF
EYES		
Conjunctivitis	Until 48 hrs after infection cleared 7-10 days max	Scenario: Management in primary care | Management | Conjunctivitis - infective | CKS | NICE **Acute bacterial conjunctivitis** Advise the person that most cases of bacterial conjunctivitis are self-limiting and resolve within 5–7 days without treatment. Treat with topical antibiotics if severe or circumstances require rapid resolution. A delayed treatment strategy may be appropriate — advise the person to initiate topical antibiotics if symptoms have not resolved within 3 days. **Options for topical antibiotics include:** Chloramphenicol 0.5% drops — apply 1 drop 2 hourly for 2 days, then reduce frequency depending on the severity of infection (3-4 times daily is usually sufficient for less severe infection). Continue use until 48 hours after infection has cleared. Chloramphenicol 1% ointment — apply 3-4 times daily. Continue use until 48 hours after infection has cleared. Fusidic acid 1% eye drops — apply 1 drop twice daily. Continue use until 48 hours after infection has cleared. **If the person re-attends with ongoing symptoms of conjunctivitis,** consider sending swabs for viral PCR (for adenovirus and *Herpes simplex*) and bacterial culture, and consider offering empirical topical antibiotics if these have not already been tried. For further information, see the section on Prescribing. Consider referral to ophthalmology if symptoms persist for more than 7 to 10 days after initiating treatment.
ENT		
Otitis externa	7 days	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 day
	7-14 days	**Consider prescribing a topical antibiotic preparation with or without a topical corticosteroid for 7–14 days,** depending on clinical judgement and symptom response. Treatment should be for no longer than 2 weeks. Topical ear preparations | Prescribing information | Otitis externa | CKS | NICE **Consider prescribing an oral antibiotic if the person is immunocompromised, there is severe infection, or there is spread beyond the external ear canal to adjacent tissues,** depending on clinical judgement. See the CKS topic on Cellulitis - acute for more information on how to diagnose cellulitis. Treatment Failure of Otitis Externa Specialist Advice or Referral for Acute Otitis Externa
Otitis media OM	5-7 days	Scenario: Acute otitis media - initial presentation | Management | Otitis media - acute | CKS | NICE **If an antibiotic is required:** Prescribe a 5–7day course of amoxicillin. For people who are allergic to, or intolerant of, penicillin, prescribe a 5–7 day course of clarithromycin or erythromycin (erythromycin is preferred in pregnant women). The second-choice oral antibiotic is to prescribe a 5-7 day course of co-amoxiclav where there are worsening symptoms on the first choice antibiotic taken for at least 2-3 days.
Sinusitis	5 days	Scenario: Acute sinusitis | Management | Sinusitis | CKS | NICE **If an antibiotic is indicated for acute sinusitis:** **In adults aged 18 years and over:** if there are no life-threatening symptoms, prescribe phenoxymethylpenicillin 500 mg four times daily for 5 days. If the person is systemically very unwell, has symptoms or signs of a more serious illness or condition, or is at high risk of complications (and immediate referral is not indicated), prescribe co-amoxiclav 500/125 mg three times daily for 5 days. If the person is allergic or intolerant to penicillin, prescribe: Doxycycline 200 mg on the first day, then 100 mg once daily for 4 days (5-day course in total) *or* Clarithromycin 500 mg twice daily for 5 days. If the person is pregnant and allergic or intolerant to penicillin, prescribe: Erythromycin 250–500 mg four times daily for 5 days *or* Erythromycin 500–1000 mg twice daily for 5 days.

Tonsillitis	Penicillin V 5-10 days 5 days symptomatic cure 10 days microbiological cure	Phenoxymethylpenicillin | Prescribing information | Sore throat - acute | CKS | NICE In adults, prescribe 500 mg four times daily, or 1000 mg twice daily (increased, if necessary, up to 1000 mg four times daily) for 5 to 10 days. In children aged: 1-11 months, prescribe 62.5 mg 4 times daily, or 125 mg twice daily for 5 to 10 days. 1-5 years, prescribe 125 mg 4 times daily, or 250 mg twice daily for 5 to 10 days. 6-11 years, prescribe 250 mg 4 times daily, or 500 mg twice daily for 5 to 10 days. 12-17 years, prescribe 500 mg 4 times daily, or 1000 mg twice daily for 5 to 10 days. A 5-day course may be enough for symptomatic cure; but a 10-day course may increase the chance of microbiological cure. [BNF, 2023; BNFC, 2023; NICE, 2023]
	Clarithromycin / erythromycin 5 days	Clarithromycin and erythromycin | Prescribing information | Sore throat - acute | CKS | NICE **Clarithromycin** In adults, prescribe 250 to 500 mg twice daily for 5 days. In children aged 1 month to 11 years weighing: Up to 8 kg, prescribe 7.5 mg/kg twice daily for 5 days. 8-11 kg, prescribe 62.5 mg twice daily for 5 days. 12-19 kg, prescribe 125 mg twice daily for 5 days. 20-29 kg, prescribe 187.5 mg twice daily for 5 days. 30-40 kg, prescribe 250 mg twice daily for 5 days. In children aged 12-17 years, prescribe 250-500 mg twice daily for 5 days. [BNF, 2023; BNFC, 2023; NICE, 2023] **Erythromycin** For women who are pregnant, prescribe 250 mg to 500 mg four times daily or 500 mg to 1,000 mg twice daily for 5 days. [PHE, 2017; BNF, 2023; NICE, 2023]
Scarlet fever	10 days	**If the person does not need hospital admission, prescribe appropriate antibiotics promptly.** Offer a 10-day course of phenoxymethylpenicillin (penicillin V) first line. Second-line options for people with penicillin allergy are: Birth to 6 months — clarithromycin for 10 days. Non-pregnant adults and children aged 6 months to 17 years — azithromycin for 5 days, or clarithromycin for 10 days. Pregnant or postpartum (within 28 days of childbirth) — erythromycin for 10 days.
Oral Thrush - Children	miconazole - 7 days after lesions healed nystatin 7 days / 48 hrs after lesions have resolved	**Scenario: Children (not immunocompromised) | Management | Candida - oral | CKS | NICE** **Prescribe topical antifungal treatment.** Offer miconazole oral gel first-line for children aged 4 months and over (unlicensed for use in a child aged younger than 4 months, or 5–6 months for an infant born pre-term). Treatment should be for at least 7 days after lesions have healed, or symptoms have cleared. If miconazole oral gel is unsuitable, offer oral nystatin suspension (unlicensed for use in neonates). See the prescribing information sections on miconazole oral gel and nystatin suspension for information on prescribing these treatments, including contraindications, cautions, adverse effects, and possible drug interactions
Oral Thrush Adults	miconazole - 7 days after lesions healed nystatin -7 days / 48 hrs after lesions have resolved	**Scenario: Adults and young people (not immunocompromised) | Management | Candida - oral | CKS | NICE** **Prescribe antifungal treatment.** **If the infection is mild and localized,** prescribe topical antifungal treatment. Offer miconazole oral gel first-line. Treatment should be continued for at least 7 days after lesions have healed, or symptoms have cleared. If miconazole is unsuitable, offer nystatin suspension. Nystatin treatment is recommended for 7 days and continued for 48 hours after lesions have resolved. **If the infection is extensive or severe infection,** consider one of the following: Prescribe fluconazole 200–400 mg on day one, followed by 100–200 mg once daily for 7–21 days. See the prescribing information section on oral fluconazole for information on prescribing this treatment. Seek specialist advice or refer to an oral surgeon.

Nystatin	7 days / 48 hrs after lesions have resolved	Nystatin suspension | Prescribing information | Candida - oral | CKS | NICE **Nystatin suspension (100,000 units/mL) is indicated for the prevention and treatment of candidal infections of the oral cavity, oesophagus, and intestinal tract.** **The licensed dose for oral candidiasis is** 1ml (100,000 units) dropped into the mouth four times a day, usually for 7 days. **Advise that:** Nystatin should be taken after food or drink. The suspension should be kept in contact with the affected areas for as long as possible. The treatment should be continued for 48 hours after lesions have resolved. [ABPI, 2017; BNF, 2022] **What are the contraindications and cautions?** **Do not prescribe nystatin suspension to:** People with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption, or sucrase-isomaltose insufficiency — nystatin suspension contains sucrose. **Prescribe nystatin suspension with caution to:** People on a controlled sodium diet — nystatin suspension contains 0.3 mmol (or 1.3 mg) sodium per 1 mL dose. People with diabetes mellitus — nystatin suspension contains sucrose. Pregnant women. Absorption of nystatin from the gastrointestinal tract is negligible. However, the manufacturer advises that it should be prescribed during pregnancy only if the potential benefits to be derived outweigh the possible risks involved, as it is not known whether nystatin can cause foetal harm when administered to a pregnant woman or can affect reproductive capacity [ABPI, 2017]. Breastfeeding women. The manufacturer advises that caution should be exercised when nystatin is prescribed for a breastfeeding woman, as it is not known whether nystatin is excreted in human milk.
Miconazole	7 days after symptoms resolved	Miconazole oral gel | Prescribing information | Candida - oral | CKS | NICE **Miconazole oral gel (24 mg/mL)** is indicated for the treatment of fungal infections of the oropharynx and gastrointestinal tract (unlicensed for use in a child aged younger than 4 months, or 5–6 months for an infant born pre-term). **The licensed doses for oral candidiasis are:** Children aged 4–24 months — 1.25 mL (1/4 measuring spoon) of gel applied four times a day after meals. Each dose should be divided into smaller portions, and the gel should be applied to the affected area(s) with a clean finger. The gel should not be applied to the back of the throat due to possible choking. Adults and children 2 years of age and older — 2.5 mL (1/2 measuring spoon) of gel applied four times a day after meals. **Also advise that:** The gel should not be swallowed immediately but kept in the mouth as long as possible. The treatment should be continued for at least 7 days after the symptoms have disappeared. Dental prostheses should be removed at night and brushed with the gel.

RTI- Respiratory tract Infection		
Acute bronchitis	5 days	**Scenario: Acute bronchitis | Management | Chest infections - adult | CKS | NICE** **If antibiotics are indicated, for adults 18 years of age and older:** First-line choice is oral doxycycline: 200 mg on the first day, then 100 mg once a day for 4 days (5-day course in total). Note doxycycline is not the first-choice antibiotic for pregnant women. Alternative first choices are oral: Amoxicillin (preferred in pregnant women) 500 mg three times a day for 5 days. Clarithromycin 250 mg to 500 mg twice a day for 5 days. Erythromycin (preferred in pregnant women) 250 mg to 500 mg four times a day or 500 mg to 1000 mg twice a day for 5 days. **If antibiotics are indicated, for young people aged 12–17 years:** First-line choice is oral amoxicillin (preferred in young women who are pregnant): 500 mg three times a day for 5 days. Alternative first choices are oral: Clarithromycin 250 mg to 500 mg twice a day for 5 days. Erythromycin (preferred in young women who are pregnant) 250 mg to 500 mg four times a day or 500 mg to 1000 mg twice a day for 5 days. Doxycycline 200 mg on first day, then 100 mg once a day for 4 days (5-day course in total). Note doxycycline should *not* be given to women who are pregnant.
Community acquired Pneumonia	5 days	Scenario: Community-acquired pneumonia | Management | Chest infections - adult | CKS | NICE adults: First choice oral antibiotic is amoxicillin 500 mg three times a day for 5 days (higher doses can be used — see the BNF). Alternatively, if there is a penicillin allergy, or amoxicillin is unsuitable (for example atypical pathogens are suspected) options are oral doxycycline 200 mg on the first day then 100 mg once a day for 4 days (total course of 5 days), *or* oral clarithromycin 500 mg twice a day for 5 days, *or* oral erythromycin (in pregnancy) 500 mg four times a day for 5 days. **Explain to the person that after starting antibiotic treatment**, symptoms should improve, although the speed of improvement will depend on the severity of illness. It is usually expected that by: 1 week — fever should have resolved. 4 weeks — chest pain and sputum production should have substantially reduced. 6 weeks — cough and breathlessness should have substantially reduced. 3 months — most symptoms should have resolved but fatigue might still be present. 6 months — symptoms should have fully resolved.

SKIN		
Cellulitis in adults	5-7 days	**For adults with cellulitis:** Prescribe flucloxacillin 500–1000 mg four times daily for 5–7 days. If this is unsuitable, or the person has a penicillin allergy, prescribe either: Clarithromycin 500 mg twice daily for 5–7 days. Doxycycline 200 mg on the first day then 100 mg once daily, for a total of 5–7 days. Erythromycin (in pregnancy) 500 mg four times daily for 5–7 days.
Cellulitis adults infection near eyes/nose	7 days	**For adults with an infection near the eyes or nose,** consider seeking specialist advice and prescribe co-amoxiclav 500/125 mg three times daily for 7 days. If this is unsuitable, or the person has a penicillin allergy, prescribe clarithromycin 500 mg twice daily for 7 days plus metronidazole 400 mg three times daily for 7 days.
Cellulitis with lymphedema	14 days	**For adults with known lymphoedema who develop cellulitis but do not require admission or referral:** Prescribe flucloxacillin 500-1000 mg four times daily for 14 days. If this cannot be tolerated, prescribe: Amoxicillin 500 mg three times daily for 14 days. f the person has a penicillin allergy, prescribe doxycycline 100 mg twice daily. If this is unsuitable, prescribe clarithromycin 500 mg twice daily for 14 days. Note: skin changes (such as discolouration) may persist for months or longer following severe cellulitis and do not necessarily require ongoing antibiotics.
Mastitis Lactating women	10-14 days	Scenario: Management - lactating women | Management | Mastitis and breast abscess | CKS | NICE If breast milk culture results are not available: Treat empirically with flucloxacillin 500 mg four times a day for 10–14 days. If the woman is allergic to penicillin, prescribe either erythromycin 250 mg to 500 mg four times a day, or clarithromycin 500 mg twice a day for 10–14 days.
Mastitis - NON lactating women	10-14 days	**Scenario: Management - non-lactating women | Management | Mastitis and breast abscess | CKS | NICE** **Prescribe an oral antibiotic for *all* women with non-lactational mastitis:** Prescribe co-amoxiclav 500/125 mg three times a day for 10–14 days. If the woman is allergic to penicillin, prescribe a combination of erythromycin (250 mg to 500 mg four times a day) or clarithromycin (500 mg twice a day) *plus,* metronidazole (400 mg three times a day) for 10–14 days.

UTI & Genito-Urinary		
LUTI- cystitis	3 days	**Scenario: Acute UTI (no visible haematuria, not pregnant or catheterized) | Management | Urinary tract infection (lower) - women | CKS | NICE** **If prescribing an immediate antibiotic,** First-line, consider prescribing either of the following: Nitrofurantoin 100 mg modified release twice a day for 3 days. Trimethoprim 200 mg twice a day for 3 days (if low risk of antimicrobial resistance). Second-line, if there is no improvement in symptoms after at least 48 hours of first-line treatment, or first-line options are contraindicated or not tolerated, consider prescribing one of the following: Nitrofurantoin 100 mg modified-release twice a day for 3 days (if not used first-line). Pivmecillinam 400 mg initial dose, then 200 mg three times a day for a total of 3 days. Fosfomycin 3 g single dose sachet.
UTI pregnant women	7 days	**Scenario: UTI in pregnancy (no visible haematuria) | Management | Urinary tract infection (lower) - women | CKS | NICE** **Prescribe an immediate antibiotic,** Ensure that a mid-stream urine (MSU) sample for culture and sensitivities has been sent before starting antibiotic treatment. Consider prescribing antibiotics according to culture and sensitivity as follows: First choice is nitrofurantoin 100 mg modified release twice daily for 7 days (avoid in third trimester). Second choice is either cefalexin 500 mg twice a day for 7 days or amoxicillin 500 mg 3 times a day for 7 days.
UTI in Males		Oral First line Nitrofurantoin Immediate release: 50 mg 4 times a day for 7 days MR: 100 mg twice daily for 7 days Trimethoprim 200mg twice daily for 7 days Oral second line: Amoxicillin/ Pivmecillinam if no improvement after at least 48 hours, **or** first line not suitable https://cks.nice.org.uk/topics/urinary-tract-infection-lower-men/prescribing-information/ https://bnf.nice.org.uk/treatment-summaries/urinary-tract-infections/#drug-treatment
Pyelonephritis	Cefalexin Cocmaoxiclav 7-10 days Trimethoprim 14 days Ciprofloxacin 7 days	**Scenario: Management | Management | Pyelonephritis - acute | CKS | NICE** **For women who are not pregnant, men, and people with indwelling catheters, take account of local antimicrobial resistance data,** Cefalexin 500 mg twice or three times a day (up to 1– 1.5 g three or four times a day for severe infections) for 7-10 days. Co-amoxiclav (only if appropriate in line with culture and sensitivity results) 500/125 mg three times a day for 7-10 days. Trimethoprim (only if appropriate in line with culture and sensitivity results) 200 mg twice a day for 14 days. Ciprofloxacin 500 mg twice a day for 7 days. Note that systemic fluoroquinolones must now only be prescribed when other commonly recommended antibiotics are inappropriate
	7-10 days	**For pregnant women who do *not* require admission, prescribe**: Cefalexin 500 mg twice or three times a day (up to 1– 1.5 g three or four times a day for severe infections) for 7-10 days.

Prostatitis	14 days	**Scenario: Management | Management | Prostatitis - acute | CKS | NICE** **Offer oral antibiotic treatment to people with acute prostatitis** Offer ciprofloxacin 500 mg twice daily or ofloxacin 200 mg twice daily for 14 days first line, or if a fluoroquinolone is not appropriate, offer trimethoprim 200 mg twice daily for 14 days. Offer levofloxacin 500 mg once daily, or co-trimoxazole 960 mg twice daily for 14 days second line after taking specialist advice. Co-trimoxazole should only be considered when there is bacteriological evidence of sensitivity and good reasons to prefer this combination to a single antibiotic.
Balanitis-children	14 days Topical clotrimazole 1% OR 7-10 days Topical mupirocin ointment 14 days Topical steroids if required 7 days Oral antibiotics If severe	Scenario: Balanitis - children | Management | Balanitis | CKS | NICE **Advise on the importance of good daily hygiene.** Advise to wash daily with lukewarm water and to keep the foreskin retracted until the glans penis is dry, where possible. Do not attempt to retract the foreskin to clean under it, if it is still fixed. Avoid irritants such as soap, bubble bath, or baby wipes. Consider use of an emollient as a soap substitute. For infants and toddlers, advise to change nappies frequently. **Advise on management options depending on the likely underlying cause:** If there is suspected ***non-specific dermatitis***: *Prescribe topical hydrocortisone 1% cream or ointment once a day*, until symptoms settle or for up to 14 days. *Prescribe an imidazole cream*, the frequency depending on the preparation used, until symptoms settle or for up to 14 days Topical clotrimazole 1% is licensed for the treatment of balanitis. Advise the person to apply topical clotrimazole to the affected area 2 to 3 times daily for at least two weeks. If there is suspected ***irritant or allergic contact dermatitis***: Avoid any suspected triggers (such as soap, bubble bath, or creams). *Prescribe topical hydrocortisone 1% cream or ointment* once a day until symptoms settle, or for up to 14 days. Advise on the use of a regular emollient to moisturise and use as a soap substitute. **Bacterial Balanitis** Mild infection: Topical Mupirocin 2% ointment 2–3 times a day for 7–10 days. Severe infection: PO Phenoxymethylpenicillin for 10 days while awaiting swab results If Penicillin allergy PO Clarithromycin for 7 days If inflammation is causing discomfort: consider topical hydrocortisone 1% cream or ointment for up to 14 days in addition
Balanitis - Adults		Scenario: Balanitis - adults | Management | Balanitis | CKS | NICE Quite complex - with multiple possible diagnosis and treatment plans depending on cause of infection
Epididymo-orchitis	14 days	**Scenario: Epididymo-orchitis | Management | Scrotal pain and swelling | CKS | NICE** **if urgent referral to a local specialist sexual health clinic is not possible, start empirical antibiotic treatment in primary care. Advise the person to abstain from sexual contact until they and any partner(s) have completed treatment and follow up if there is a confirmed or suspected sexually transmitted infection (STI). Ideally follow up and contact tracing should be arranged by a local specialist sexual health clinic [Chirwa, 2021].** **If epididymo-orchitis is most likely due to *any* STI:** Treat empirically with ceftriaxone 1 g intramuscular (IM) injection as a single dose, depending on local prescribing protocols, *plus* oral doxycycline 100 mg twice daily for 10–14 days [Chirwa, 2021]. If a cephalosporin and/or tetracycline antibiotic is contraindicated, treat with oral ofloxacin 200 mg twice daily for 14 days. **If epididymo-orchitis is most likely due to chlamydia or other non-gonococcal organisms (if no risk factors for gonorrhoea):** Treat empirically with oral doxycycline 100 mg twice daily for 10–14 days, *or* oral ofloxacin 200 mg twice daily for 14 days [Chirwa, 2021].If a quinolone antibiotic is contraindicated, treat with oral co-amoxiclav 500/125 mg three times a day for 10 days. **If epididymitis is most likely due to an STI *and/or* enteric organism (for example men who have insertive anal sex):**Consider treating empirically with ceftriaxone 1 g IM, depending on local prescribing protocols, *plus* oral ofloxacin 200 mg twice daily for 14 days [Chirwa, 2021]. If a quinolone antibiotic is contraindicated, treat with oral co-amoxiclav 500/125 mg three times a day for 10 days.

Pelvic Inflammatory Disease	14 days	Scenario: Management | Management | Pelvic inflammatory disease | CKS | NICE **Advise the woman to attend a local specialist sexual health service for sexually transmitted infection (STI) screening, treatment, and contact tracing of current and recent sexual partners. If the woman is unable or unwilling to attend, consider prescribing antibiotic treatment in primary care.** • **If the risk of gonococcal infection is high:** Prescribe ceftriaxone 1 g as a single intramuscular (IM) dose, followed by oral doxycycline 100 mg twice daily *plus* oral metronidazole 400 mg twice daily for 14 days. • **If the risk of gonococcal infection is low, prescribe one of the following antibiotic regimens,** First-line, prescribe ceftriaxone 1 g as a single IM dose, followed by oral doxycycline 100 mg twice daily *plus* oral metronidazole 400 mg twice daily for 14 days. Second-line, consider prescribing one of the following antibiotic regimens: Oral ofloxacin 400 mg twice daily *plus* oral metronidazole 400 mg twice daily for 14 days, *or* Oral levofloxacin 500 mg once daily *plus* oral metronidazole 400 mg twice daily for 14 days, *or* Oral moxifloxacin 400mg once daily for 14 days. **Consider arranging a further review 2–4 weeks after completion of antibiotic treatment.**
GUT		
Diverticulitis	5 days	Scenario: Acute diverticulitis | Management | Diverticular disease | CKS | NICE **Offer an oral antibiotic if the person with acute diverticulitis is systemically unwell but does not meet the criteria for referral for suspected complicated acute diverticulitis.** Prescribe co-amoxiclav 500/125 mg three times daily for 5 days if the person is allergic to penicillin, or this is unsuitable, alternatives include cefalexin (500 mg twice or three times daily for 5 days [up to 1 to 1.5 g three or four times daily for severe infection]) plus, metronidazole (400 mg three times daily for 5 days), or trimethoprim (200 mg twice daily for 5 days) plus metronidazole (400 mg three times daily for 5 days).
Cholecystitis		Scenario: Management | Management | Cholecystitis - acute | CKS | NICE If acute cholecystitis is suspected, admit the person to hospital for: Confirmation of the diagnosis, including abdominal ultrasound and blood tests (such as a white blood cell count, C-reactive protein, and serum amylase). Monitoring (for example blood pressure, pulse, and urinary output). Treatment (may include intravenous fluids, antibiotics, and analgesia). Surgical assessment for cholecystectomy.