



CLINICAL GUIDELINE

Empiric infection management, Primary Care, Paediatric

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Principles of Treatment:

1. This guidance is based on the best available evidence but its application may be modified by professional judgement.
2. Where a 'best guess' therapy has failed or special circumstances exist, microbiological advice can be obtained via the Microbiology Department at your local hospital, the Infectious Diseases service, or the Paediatric Antimicrobial Pharmacist at the Royal Hospital for Children in Glasgow.
3. Prescribe an antibiotic only when there is likely to be a clear clinical benefit.
4. Do NOT prescribe an antibiotic for viral sore throat, non-productive coughs or cold.
5. Use simple, narrow-spectrum, generic antibiotics whenever possible.
6. Prolonged antibiotic therapy also increases risk of adverse events.
7. Avoid widespread use of topical antibiotics (especially those agents also available as systemic preparations).
8. Refer to BNF for Children for dosing advice.

*Clarithromycin and Azithromycin are known to have serious drug interactions and may prolong the QTc interval. Avoid in patients with other risk factors for QTc prolongation. See BNF (appendix 1).

Condition	Treatment	Duration	Comments
Suspected Meningococcal Disease	Benzylpenicillin Give IV or IM Under 1 year: 300mg Age 1-9 years: 600mg 10 years and over:1200mg Or Cefotaxime Give IV or IM All ages: 50mg/kg (max 2g)	STAT dose <u>and</u> Urgent transfer	For suspected meningococcal disease i.e. fever plus purpuric rash TRANSFER TO HOSPITAL Administer stat dose while awaiting transfer UNLESS there is a known definite history of ANAPHYLAXIS to penicillin antibiotics. History of rash without anaphylaxis is NOT a contraindication. Allergic cross-sensitivity reactions can occur between penicillin and cephalosporin antibiotics. Contact Public Health for advice on prevention of secondary cases/contacts.
Acute Otitis Media	Routine antibiotics not required If antibiotic required: Amoxicillin Penicillin allergy: Clarithromycin*	5 days 5 days	Consider delayed antibiotic treatment. Children with otorrhoea, or those under 2 years of age with bilateral otitis media, have greater benefit but are still eligible for delayed prescribing.
Tonsillitis	Routine antibiotics not required If antibiotic required: Phenoxymethylpenicillin Penicillin allergy: Clarithromycin*	5 days 5 days	Treatment if systemically unwell with high fever, lymphadenopathy and enlarged tonsils with exudates. For children >3years use FeverPAIN to assess symptoms. Antibiotics should not be routinely used for symptom relief, to prevent development of rheumatic fever or acute glomerulonephritis, or to prevent cross infection in the general population or to prevent complications. Course length 10 days for relapse/recurrence within 2 weeks, or where there are signs/symptoms of Scarlet Fever.
Scarlet Fever	Phenoxymethylpenicillin Penicillin allergy: Clarithromycin* or Azithromycin*	10 days 10 days 5 days	Signs and symptoms include fever, tonsillitis, sand paper like rash, red lips and strawberry tongue. Prompt treatment with antibiotics significantly reduces risk of complications. If systemically unwell OR no improvement in symptoms after 24-48 hours of antibiotics refer to hospital for further review and management.
Community Acquired Pneumonia (non-severe)	Amoxicillin Penicillin allergy: Azithromycin*	5 days 3 days	Cough symptoms can persist for up to 21 days. If patient remains unwell after treatment then consider whether ongoing symptoms are due to a residual cough, viral infection or mycoplasma/chlamydia in which case azithromycin is indicated.
Bronchiolitis	Antibiotics not required		Antibiotic therapy is not recommended in the treatment of acute bronchiolitis in infants.
Urinary Tract Infection (upper)	Refer to hospital if child <3months, or suspected UPPER tract infection including fever >38° and/or systemically unwell. In this instance antibiotics should NOT be given pre-admission UNLESS clinically severely unwell or anticipated long delay in transfer.		
Urinary Tract Infection (lower)	Take a urine sample Cefalexin Penicillin allergy: Nitrofurantoin (over 3 months)	3 days 3 days	If clinically well, take a urine sample and consider holding antibiotics until cultures known. Empirical antibiotics can be started where clinically indicated. If true penicillin allergy and under 3 months of age, microbiology or ID should be consulted for advice If a patient is known to the renal service or has had previous UTIs then please check previous urine culture results as this may influence empiric prescribing.
Skin infection	Topical fusidic acid Flucloxacillin Penicillin allergy: Clarithromycin*	7 days 5 days 5 days	Use topical treatment only for localised small lesions in a well child Use oral treatment for more extensive or multiple lesions or if systemic upset or concern. Review after 7 days may be warranted if lesions are near the eyes or nose.
Infected Animal/Human bites	Co-amoxiclav Penicillin allergy <12 years Co-trimoxazole Penicillin allergy 12-17years Doxycycline and Metronidazole	Prophylaxis 3 days Treatment 5 days BUT review at 24 & 48 hrs	Assess tetanus, rabies risk, and if human, blood borne virus transmission. Antibiotic prophylaxis advised for – all human and cat bites and for dog bites if puncture wound; bite involving hand, foot, face, joint, tendon, ligament; immunocompromised; cirrhotic; asplenic or presence of prosthetic valve/joint. Seek specialist advice from microbiology for bites from a wild or exotic animal because the spectrum of bacteria involved may be different and may be risk of other serious non-bacterial infections.