Lanarkshire Adult Antibiotics Guidelines for the Department of ENT

Condition	Comments	First Line Antibiotic	Alternative Antibiotic	Duration of Treatment
Acute Sore Throat / Tonsillitis (mild –patient managing oral intake)	The majority of sore throats are viral and most patients do not benefit from antibiotics. Use FeverPAIN scoring. Score 1 for each: - **Fever** in last 24 h - **P**urulence - **A**ttend rapidly under 3 days - severely **I**nflamed tonsils - **N**o cough or coryza. **0-1**: 13-18% streptococci, use NO antibiotic strategy; **2-3**: 34-40% streptococci, offer a delayed antibiotic prescription; **>4**: 62-65% streptococci, use immediate antibiotic if severe or offer delayed antibiotic prescription.	Penicillin V 500mg – 1g ORAL 6 hourly	Clarithromycin 500 mg ORAL 12 hourly	10 days Stop antibiotics if Glandular Fever diagnosed and no positive cultures
Acute Sore Throat / Tonsillitis (moderate / severe)		Benzylpenicillin 1.2g IV 6 hourly **Plus** Metronidazole IV 500mg 8 hourly ***Oral step down if no positive cultures:*** Penicillin V ORAL 500mg 6 hourly **Plus** metronidazole ORAL 400mg 8 hourly	Clindamycin IV 900mg 8 hourly ***Oral step down if no positive cultures:*** Clindamycin ORAL 450mg 6 hourly	10 days IV to oral switch when clinically stable (24-48 hours) Stop antibiotics if IM diagnosed and no positive cultures
Tonsillitis / Pharyngitis (severe sepsis, including hypotension or erythroderma)		Benzylpenicillin 2.4g IV 6 hourly **Plus** Clindamycin 600mg IV 6 hourly ***Oral step down if no cultures:*** Penicillin V ORAL 500mg 6 hourly **Plus** Clindamycin 450mg ORAL 6 hourly	Vancomycin as per dose calculator **Plus** Clindamycin 600mg IV 6 hourly ***Oral step down if no cultures:*** Clindamycin 450mg ORAL 6 hourly	10 days IV to oral switch when clinically stable (24-48 hours) Stop antibiotics if IM diagnosed and no positive cultures

Prepared by; I Khan, S Irvine

Approved by AMT: Sept 2017
Approved by ADTC: Sept 2017
Review Date: Sept 2019

Condition	Comments	First Line Antibiotic	Alternative Antibiotic	Duration of Treatment
Peri-tonsillar Abscess (Quinsy)	Usually polymicrobial Abscesses should be drained promptly and pus sent for microscopy and culture	Benzylpenicillin 1.2g IV 6 hourly **Plus** Metronidazole 500mg IV 8 hourly ***Oral step down:*** Penicillin V ORAL 500mg 6 hourly **Plus** metronidazole 400mg 8 hourly Above regimen may be insufficient for polymicrobial infection. ***If lack of clinical response:*** Co-Amoxiclav IV 1.2g 8 hourly (Oral step down: Co-Amoxiclav ORAL 625mg 8 hourly)	Clindamycin IV 900mg 8 hourly ***Oral step down*:** Clindamycin ORAL 450mg 6 hourly	10 days IV to oral switch when clinically stable (24-48 hours)
Acute Epiglottitis	**PROTECT AIRWAY**	Ceftriaxone 2g IV once daily ***Oral step down*:** Co-Amoxiclav 625mg ORAL 8 hourly	Clindamycin IV 900mg 8 hourly **Plus** Ciprofloxacin 400mg IV 12 hourly ***Oral step down:*** Clindamycin ORAL 450mg 6 hourly **Plus** ciprofloxacin ORAL 500mg 12 hourly	7 – 10 days IV to oral switch when clinically stable (24-48 hours) Review culture and sensitivity results
Acute Otitis Media	**Optimise analgesia** **Avoid antibiotics** as 60% improve within 24 hours without antibiotics.	**1st line** Amoxicillin 500mg to 1g ORAL 8 hourly **2nd line** Co-Amoxiclav 625mg ORAL 8 hourly **Severe Infection** (requiring admission) Co-Amoxiclav IV 1.2g 8 hourly ***Oral step down:*** Co-Amoxiclav 625mg ORAL 8 hourly	**1st line** Clarithromycin 500 mg ORAL 12 hourly **2nd line** Doxycycline 100mg ORAL 12 hourly **Plus** metronidazole 400mg ORAL 8 hourly **Severe Infection** (requiring admission) Clindamycin IV 900mg 8 hourly ***Oral step down:*** Clindamycin 450mg ORAL 6 hourly	5 days (Mild infection) 5-10 days if severe (depending on response) IV to oral switch when clinically stable (24-48 hours)

Condition	Comments	First Line Antibiotic	Alternative Antibiotic	Duration of Treatment
Suppurative Parotitis **(Salivary Gland Infection)**	Drain any collections promptly Consider other causes e.g. Mumps	Co-Amoxiclav IV 1.2g 8 hourly ***Oral step down:*** Co-Amoxiclav ORAL 625mg 8 hourly	Clindamycin IV 900mg 8 hourly ***Oral step down:*** Clindamycin 450mg ORAL 6 hourly	10 – 14 days Review culture and sensitivity results.
Otitis Externa	Aural Toilet Ear swab for C&S for persistent infection	Acetic acid 2% 1 spray 8 hourly **Or** Neomycin Sulphate with Corticosteroid 3 drops 8 hourly **Or** Canesten 2-3 drops 2-3 times a day if suspecting fungal infection	If additional oral treatment required; Flucloxacillin 500mg ORAL 6 hourly ***Penicillin Allergy*** Clarithromycin 500 mg ORAL 12 hourly	7 days
Malignant Otitis Externa	Ensure swabs are taken prior to starting antibiotic therapy. Please refer to sampling notes below Malignant external otitis is caused by *P. aeruginosa* in > 95% of cases Other potential pathogens include *Staphylococcus aureus*, *Aspergillus* spp., enteric Gram negative rods and *Candida* spp.	Piperacillin/Tazobactam 4.5g IV 8 hourly (Alert form required) **Plus** Ciprofloxacin 500mg - 750mg ORAL 12 hourly +/- topical Ciprofloxacin drops	***Severe Penicillin allergy:*** Ciprofloxacin 500mg - 750mg ORAL 12 hourly **Plus** Gentamicin IV as per NHSL dose calculator +/- topical ciprofloxacin drops ***Penicillin intolerance:*** Ciprofloxacin 500mg - 750mg ORAL 12 hourly **Plus** Ceftazidime IV 1g to 2g 8 hourly +/- topical ciprofloxacin drops	Treatment needed for 6 weeks (May be suitable for OPAT) Switch to oral based on clinical assessment and microbiological results Assess for any bone and intracranial extension *See additional notes
Acute Mastoiditis	Need to ascertain severity of infection +/- presence of osteomyelitis or CNS involvement (will require longer duration)	Co-Amoxiclav 1.2 g IV 8 hourly ***Oral step down:*** Co-Amoxiclav 625mg ORAL 8 hourly	Clindamycin IV 900mg 8 hourly **Plus** Ciprofloxacin 500mg ORAL 12 hourly ***Oral step down:*** Clindamycin 300-450mg ORAL 6 hourly +/- Ciprofloxacin 500mg ORAL 12 hourly	10 – 14 days (if no bone or intracranial extension) IV to oral switch when clinically suitable.
Preseptal / Orbital Cellulitis	Need to assess for intracranial extension as coverage needs to include anaerobes Discuss with ID/micro if any debate	Ceftriaxone 2g IV once daily (or 12 hourly if intracranial extension) **Plus** Flucloxicillin 1-2g IV 6 hourly	***Penicillin Allergy:*** Vancomycin as per NHSL calculator **Plus** Ciprofloxacin 400mg IV 12 hourly **Or** Levofloxacin 500mg to 750mg IV once daily	IV to oral switch when clinically suitable

Condition	Comments	First Line Antibiotic	Alternative Antibiotic	Duration of Treatment
Deep Neck Abscess/Retro-pharyngeal Abscess	Abscesses should be drained promptly	Ceftriaxone IV 2g once daily **plus** Metronidazole IV 500mg 8 hourly ***Oral step down:*** Co-Amoxiclav ORAL 625mg 8 hourly	Clindamycin 900mg IV 8 hourly **plus** Ciprofloxacin ORAL 500mg 12 hourly ***Oral step down:*** Clindamycin ORAL 450mg 6 hourly **plus** ciprofloxacin 500mg ORAL 12 hourly	10 – 14 days Review at 7 days (depending on whether or not abscess drained) IV to oral switch when clinically suitable
Facial Cellulitis (requiring admission)		Flucloxacillin 1-2 G IV 6 hourly **Plus** Consider Clindamycin 600mg IV 6 hourly ***Oral step down:*** Flucloxacillin 1g ORAL 6 hourly **Plus** Clindamycin 450mg ORAL 6 hourly	Vancomycin as per NHSL dose calculator **Plus** Clindamycin 600mg IV 6 hourly ***Oral step down:*** Clindamycin 450mg ORAL 6 hourly	7 days
Acute Sinusitis	Exclude any intracranial spread	Amoxicillin 500mg to 1g 8 hourly orally **Severe infection:** IV Co-Amoxiclav 1.2g 8 hourly ***Oral step down:*** Co-Amoxiclav ORAL 625mg 8 hourly	Doxycycline 200mg stat/100mg once daily	7 days IV to oral switch when clinically suitable

Sampling notes

In order to maximise diagnostic yield from clinical samples:

- Send samples for culture before starting antibiotics, including blood cultures if septic
- Where pus is present, collect pus, not a swab of pus in a sterile leak-proof container and transport to Microbiology promptly

Please note that specimens taken from the external auditory canal may be contaminated with colonising flora, including *Pseudomonas aeruginosa.*

NB: Doses assume normal renal/liver function. Consult BNF/pharmacy for dosing if this is not the case.

Antibiotic advice

- Doxycycline should never be used in pregnancy or breast feeding.
- Please check all drug interactions in the BNF.
- All antibiotics are associated with an increased risk of C. difficile. Patients must be aware of the risk, especially with the use of:
    - Co-Amoxiclav
    - Clindamycin
    - Ceftriaxone
    - Ciprofloxacin

Out Patient IV Antibiotic Therapy (OPAT) Referral

- Patients with confirmed or suspected malignant otitis externa or any complicated infections with associated osteomyelitis can be referred to OPAT if they are clinically stable and could receive antibiotic therapy on an out-patient basis.
- The OPAT nurses can arrange for a mid line to be inserted in ward 2 at Monklands once they have been accepted onto OPAT rather than waiting for a PICC line to be inserted.
- Please make an early referral if you feel the patient is suitable via the OPAT referral form on FirstPort.