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1.0 Action for AWMSG

AWMSG members are asked to consider the recent updates to the *Primary care antimicrobial guidelines* document (originally published in March 2022, latest update published in October 2026), which is provided here for information. The updates have been highlighted and were focused on the following sections:

- Catheter associate urinary tract infection
- Cellulitis Perichondritis
- Scabies
- Vaginal candidiasis

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Infection	Formulary Choice	Adult Dose (unless otherwise specified)	Duration of Treatment
Catheter-associated UTI NICE NG113 (2018)	Antibiotics will not eradicate asymptomatic bacteriuria; only treat if systemically unwell or pyelonephritis likely. Do not use prophylactic antibiotics for catheter changes unless history of catheter-change-associated UTI or trauma (NICE [CG139] *Healthcare-associated infections: prevention and control in primary and community care*). Ensure all patients with an indwelling catheter have a catheter passport completed. **If signs and symptoms of pyelonephritis (upper UTI), treat as per pyelonephritis.** Ensure catheter is correctly positioned, drains correctly and is not blocked. Consider removing or changing the catheter if it has been in place for more than 7 days. Do not perform urine dipsticks. Most people with a urinary catheter will have bacteria present in the bladder/urine without an infection. **Treat according to sensitivities on recent (0-6 months) MSU/catheter specimen of urine (CSU) results if available, otherwise treat empirically.** Resistance to many agents is increasing, particularly in the elderly (≥ 65 years old). **NB: Susceptibilities are only released if clinical details that indicate systemic or specific clinical signs of infection are included on the request form. If sensitivities are suppressed and the patient has signs of infection, contact microbiology for discussion.**		
	Non-pregnant women and men, no upper UTI symptoms, first line:		
	Nitrofurantoin (if eGFR ≥ 45 ml/minute) MHRA Guidance on Nitrofurantoin risks.	100 mg m/r BD	7 days
	OR		
	Trimethoprim (if susceptible)	200 mg BD	7 days
	OR		
	Amoxicillin (if susceptible)	500 mg TDS	7 days
	Non-pregnant women and men, no upper UTI symptoms, second line:		
	Pivmecillinam (Warning: β-lactam, do not use if allergic to penicillin).	400 mg TDS (N.B. High dose recommended due to increased risk of resistance)	7 days
	Pregnant women, no upper UTI symptoms (consider hospital referral/seeking specialist advice):		
	Cefalexin	1 g TDS	7–10 days

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Vaginal candidiasis BASHH (2019) NICE CKS (2023)	All topical and oral azoles give 80% cure. **Pregnancy**: Avoid oral azoles and use intravaginal treatment for 7 days. When inserting the pessary, the use of the applicator should be avoided due to the risk of mechanical trauma. **Breastfeeding:** Avoid oral azoles and use intravaginal treatment. **Recurrent infection:** • At least four episodes per 12 months with two episodes confirmed by microscopy or culture when symptomatic (at least one must be culture). • When sending a sample, ensure that the clinical details specify that this is a recurrent infection to ensure sensitivities are assessed. • If failure of initial treatment, patient should be assessed and have a clinical examination to rule out other causes.		
	Acute infection First line:		
	Fluconazole	150 mg orally	stat
	Acute infection Second line (if oral imidazole contraindicated e.g. breastfeeding):		
	Clotrimazole	500 mg pessary	stat
	Acute infection Alternative regimen:		
	Clotrimazole	10% cream 5 g intravaginally *or* 200 mg pessary at night	stat 3 nights
	Acute infection Pregnant First Line:		
	Clotrimazole	500 mg pessary intravaginally nocte	7 nights
	Acute infection Pregnant Second Line:		
	Clotrimazole	10% cream 5 g intravaginally nocte	7 nights
	Recurrent infection First Line (a high vaginal sample may be useful to confirm diagnosis and assess for antifungal resistance prior to commencing treatment):		
	Fluconazole (induction/maintenance)	150 mg every 72 hours THEN 150 mg once a week	3 doses 6 months
			Section continued overleaf.

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Vaginal candidiasis (continued) BASHH (2019) NICE CKS (2023)	**Recurrent infection Second Line or treatment failure (for alternative regimens see BASHH guidance):**		
	Clotrimazole (induction/maintenance)	500 mg pessary intravaginally nocte THEN 500 mg pessary intravaginally weekly	10 – 14 days 6 months
	Recurrent infection Third Line or treatment failure (for alternative regimens see BASHH guidance):		
	Nystatin (Off-label) (**NB:** May not be readily available in the community and require ordering)	100,000 units pessary intravaginally nocte	14 nights per month for 6 months
	Recurrent infection in pregnancy or breastfeeding:		
	Clotrimazole (induction/maintenance)	500 mg pessary intravaginally nocte THEN 500 mg pessary intravaginally weekly	10 – 14 days 6 months
Trichomoniasis BASHH (2014) NICE CKS (2021)	Treat partners and refer to Sexual Health service. **Pregnancy or breastfeeding***:* Avoid 2 g single dose metronidazole. Consider clotrimazole for symptom relief (not cure) if metronidazole declined. When inserting the pessary the use of the applicator should be avoided due to the risk of mechanical trauma.		
	Metronidazole	400 mg BD *or* 2 g	5–7 days stat
	Pregnant or breastfeeding:		
	Metronidazole	400 mg BD	5–7 days
	OR		
	Clotrimazole (see note above)	100 mg pessary at night	6 nights
Pelvic inflammatory disease BASHH (2019) NICE CKS (2024)	Refer patient and contacts to Sexual Health service. Always culture for gonorrhoea and chlamydia and test for *Mycoplasma genitalium*. 28% of gonorrhoea isolates are now resistant to quinolones, therefore if gonorrhoea likely (partner has it, severe symptoms, sex abroad) use ceftriaxone regimen or refer to Sexual Health service. Use of an oral cephalosporin instead of IM preparations is **not** recommended due to increasing resistance. **Exclude**: ectopic, appendicitis, endometriosis, UTI, irritable bowel, complicated ovarian cyst, functional pain.		
			Section continued overleaf.

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Panton-Valentine Leukocidin (PVL)	• Panton-Valentine Leukocidin (PVL) is a toxin produced by 2% of *Staphylococcus aureus* strains. It can rarely cause severe invasive infections in healthy people. • Send swabs if recurrent boils/abscesses. • At risk: close contact in communities or sport; poor hygiene – for details see British Association of Dermatologists patient information leaflet. • To prevent transmission of PVL: change towels every day and do not share them; change bed sheets frequently; keep house very clean especially sink and bath; do not visit gym or swimming pool until infections have healed; cover infected areas with dressings; wash hands frequently with liquid soap. • Once primary infection has resolved, PVL eradication can be achieved in line with local MRSA decolonisation guidelines. • Discuss with Consultant Microbiologist to ensure adequate treatment and eradication.		
Cellulitis and Erysipelas NICE CKS (2024) NICE NG141 (2019)	• If patient afebrile and healthy other than cellulitis, use oral flucloxacillin alone. • **If exposed to bodies of water e.g. river, lake, sea, discuss with Consultant Microbiologist.** • If febrile and ill, admit for IV treatment. • **Erysipelas**: often facial and unilateral. Use flucloxacillin for non-facial erysipelas. • Infection around the eyes or the nose (the triangle from the bridge of the nose to the corners of the mouth, or immediately around the eyes including periorbital cellulitis) is of more concern because of risk of a serious intracranial complication. For active **MRSA infection**: use antibiotic sensitivities to guide treatment; if severe infection or no response to monotherapy after 24–48 hours, seek advice from Consultant Microbiologist on combination therapy.		
	Flucloxacillin	500 mg–1 g QDS Use higher dose in obesity (BMI > 30 kg/m^2) or depending on severity.	5–7 days – If slow response continue for a further 7 days.
	Penicillin allergy		
	Clarithromycin	500 mg BD	5–7 days If slow response continue for a further 7 days.
	OR		
	Doxycycline	200 mg stat, then 100 mg OD	
	OR		
	Erythromycin (if pregnant)	500 mg QDS	
			Section continued overleaf.

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Cellulitis and Erysipelas (continued) NICE CKS (2024) NICE NG141 (2019)	**MRSA known or suspected (check recent cultures and adapt therapy as needed):**		
	Doxycycline	200 mg stat, then 100 mg BD	5–7 days If slow response continue for a further 7 days.
	OR		
	Co-trimoxazole	960 mg BD	
	Facial (inside the triangle treat as below – if outside of the triangle treat as above):		
	Co-amoxiclav	625 mg TDS	7 days
	OR (if penicillin allergic)		
	Clarithromycin	500 mg BD	
	PLUS		
	Metronidazole	400 mg TDS	
Pinna chondritis/ Perichondritis	• **NB: infection of the ear lobe is not classified as Pinna chondritis/Perichondritis as it does not involve the cartilage – see cellulitis guidance.** • **Refer to ear, nose and throat team (ENT) if no response / severe cases / complications** • Refer to exclude alternative causes e.g. **Malignant otitis externa** which is a potentially **life-threatening progressive infection of the external ear canal** causing osteomyelitis of the temporal bone and adjacent structures and **requires urgent referral.** • Assess for **presence of abscess and/or necrosis,** if present then surgical intervention may be required • If discharge present – consider swab for microscopy, culture, and sensitivity (MC &S) • **REMOVE ANY PIERCINGS** • If failure of treatment or infection due to ear trauma/piercing or abscess present consider possibility of Pseudomonal infection, **discuss with Consultant Microbiologist.**		
	Flucloxacillin	500 mg–1 g QDS Use higher dose in obesity (BMI > 30 kg/m^2) or depending on severity.	5–7 days – If slow response continue for a further 7 days.
			Section continued overleaf.

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Pinna chondritis/ Perichondritis (contd).	**Penicillin allergy**		
	Clarithromycin	500 mg BD	5–7 days If slow response continue for a further 7 days.
	OR		
	Doxycycline	200 mg stat, then 100 mg OD	
	OR		
	Erythromycin (if pregnant)	500 mg QDS	

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Bites (human/cat/ dog) NICE CKS (2020) NICE NG184 (2020)	**Prophylaxis or treatment:**		3 days (prophylaxis). 5 days (treatment). Course length can be increased to 7 days (with review) based on clinical assessment of the wound, for example, if there is significant tissue destruction or it has penetrated bone, joint, tendon or vascular structures.
	Co-amoxiclav	625 mg TDS	
	Penicillin allergy:		
	Metronidazole **PLUS** Doxycycline (cat/dog/human) (N.B. Not suitable for children < 12 years)	400 mg TDS 200 mg stat followed by 100 mg OD–BD	
	If child < 12 years		
	Co-trimoxazole	Dose as per BNFc	
Scabies NICE CKS (2025) UKHSA (2026) BAD (2023) BASHH (2025)	• Treat affected individual(s), all household members, sexual contacts (within the past month) and any other close personal contacts at the same time. • Itching may continue for up to six weeks after successful treatment of scabies, however, if itching is not improving or symptoms are getting worse 4–6 weeks after the last treatment application, or if new mites or burrows are seen, advise the person to seek follow-up and assess for treatment failure. • If under 2 months of age, or crusted scabies suspected seek dermatology specialist advice. • NHS 111 Wales has produced information on scabies, including its clinical features and additional advice on washing of bedding and clothing to prevent it spreading, which should be shared with the patient. • Consult UKHSA guidelines for the management of scabies cases and outbreaks in communal residential settings. **Topical treatment** • Treat **ALL** areas of the skin, including all of the body, neck, scalp and face (only avoiding areas around the eyes). The product advice may suggest not treating the scalp and face, but it is best that all these areas are treated. • In infants avoid the area around the mouth where the cream could be licked off. Mittens can be used to prevent infants putting treated hands in their mouths. • The treatment should be applied to clean, cool dry skin (not after a hot bath) and allowed to dry before the person dresses in clean clothes. • Permethrin should be washed off after 8 to 12 hours, and malathion after 24 hours. Body areas that are washed within 8 hours of permethrin application or 24 hours of malathion application should be treated again. • A second application is required one week after the first. • **Note:** pregnancy and breastfeeding are not contraindications to the use of permethrin or malathion. • Permethrin is not suitable in patients with an allergy to chrysanthemum. • Additional resources available at the British Association for Sexual Health and HIV (2025)		

Glossary

AWMSG	All Wales Medicines Strategy Group
BASHH	British Association for Sexual Health and HIV
BD	Twice-daily
BNF	British National Formulary
BNFc	British National Formulary for children
BP	Blood pressure
BTS	British Thoracic Society
BMI	Body Mass Index
CEPP	Clinical Effectiveness Prescribing Programme
CKS	Clinical Knowledge Summaries
COPD	Chronic obstructive pulmonary disease
CRP	C-Reactive Protein
CSU	**Catheter Specimen of Urine**
DH&SC	Department of Health and Social Care (UK Government)
EAU	European Association of Urology
ESCMID	European Society for Clinical Microbiology and Infectious Diseases
eGFR	Estimated glomerular filtration rate
GOLD	Global Initiative for Chronic Obstructive Lung Disease
GUM	Genito-urinary medicine
IM	Intramuscular
IV	Intravenous
MC&S	Microscopy, culture and sensitivities
MHRA	Medicines and Healthcare products Regulatory Agency
M/R	Modified-release
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSU	Mid-stream sample of urine
NICE	National Institute for Health and Care Excellence
NNT	Number Needed to Treat
OD	Once-daily
PVL	Panton-Valentine Leukocidin
PO	By mouth (per os)
PHE	Public Health England
PIL	Patient Information Leaflet
PHW	Public Health Wales
QDS	Four times daily
RCGP	Royal College of General Practitioners
RHIG	Respiratory Health Implementation Group
SIGN	Scottish Intercollegiate Guidelines Network
SPC	Summary of Product Characteristics
SPIRA	Server for Prescribing Information Reporting and Analysis
TDS	Three times daily
TARGET	Treat Antibiotics Responsibly, Guidance, Education and Tools
UKTIS	United Kingdom Teratology Information Service
UKHSA	United Kingdom Health Security Agency
UTI	Urinary tract infection
WFI	Water for injection

Date of update publication	Details of update
	Scabies • Updated to align with updated UKHSA, British Association for Sexual Health and HIV (BASHH) and NICE CKS guidance. • Ivermectin added as a treatment option. • Restructuring of guidance to provide clarity on advice for topical and oral agents.
October 2026	Cellulitis and Perichondritis • Very minor amendment to the wording on dosage of Flucloxacillin in obesity on clinician advice. Catheter-associated urinary tract infection • Minor amendment to wording on use of catheter passport • Time frame added to define 'recent' sample and minor amendment to wording • Additional wording provided to prescribers on release of susceptibility results • Trimethoprim – 'if susceptible' added – NICE states 'if low risk of resistance', however due to high Trimethoprim resistance rates especially in this cohort, decision made to state if susceptible to avoid risk of treatment failure • Pregnant women – wording on referral/seeking specialist advice added as per NICE and removal of dose range for Cefalexin to avoid confusion Vaginal Candidiasis • Minor amendment in structure of wording on use in pregnancy and breastfeeding • Additional information on recurrent disease added on clinician request – discussions had with a group of GP colleagues • Rationalisation of treatment choices with removal of Miconazole cream which is discontinued • Additional treatment options for recurrent infection added on clinical request. • Discussion had with clinicians on availability of certain preparations in Primary Care. Request to add an option as patients have usually been suffering for a longtime prior to presentation. Scabies • Additional patient information regarding things that can be done during treatment to stop scabies from spreading was added on request.