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Agenda item No:	12. Primary care antimicrobial guidelines – Minor updates
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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 April 2026), which is provided here for information. The updates have been highlighted and were focused on the following sections:

- Cellulitis and Erysipelas
- Community acquired pneumonia in adults – treatment in the community
- Community acquired pneumonia in children and young people 17 years and under – treatment in the community
- Pinna chondritis/Perichondritis

Contents

Resources to help manage antibiotic prescribing 4

Aims 5

Principles of treatment..... 5

Upper Respiratory Tract Infections 7

 Treatment of influenza (adults)..... 7

 Prophylaxis of influenza 7

 Treatment of COVID-19 8

 Prophylaxis of COVID-19 9

 Scarlet fever (Group A *Streptococcus*) 10

 Acute sore throat 11

 Acute otitis media (in children) 12

 Acute otitis externa 13

 Acute rhinosinusitis..... 14

 Acute rhinosinusitis..... 15

Lower Respiratory Tract Infections 16

 Acute cough, bronchitis..... 16

 Acute infective exacerbation of chronic obstructive pulmonary disease (COPD)
 17

 Community-acquired pneumonia in adults – Treatment in the community 18

 Community-acquired pneumonia in children and young people 17 years and
 under – Treatment in the community 19

 Meningitis 21

 Suspected meningococcal disease..... 21

 Out of Hospital Sepsis..... 22

Urinary Tract Infection (UTI) 23

 Lower UTI in adults..... 23

 Patient < 65 years and no risk factors for resistance..... 24

 Patient ≥ 65 years or risk factors for resistance 24

 Acute pyelonephritis (upper UTI)..... 25

 Acute pyelonephritis in pregnancy 25

 Catheter-associated UTI 26

 Lower UTI in pregnancy 27

 Acute prostatitis 28

 Recurrent UTI 29

All Wales Medicines Strategy Group

Lower UTI in children	31
Upper UTI in children	31
Gastro-intestinal Tract Infections	32
Oral candidiasis (immuno-competent adults)	32
Oral candidiasis (immuno-competent children)	33
Infectious diarrhoea	33
Travellers' diarrhoea	33
Threadworm	33
Threadworm (continued)	34
Acute diverticulitis	35
Biliary infection (cholecystitis/choolangitis)	35
Eradication of <i>Helicobacter pylori</i>	36
<i>Clostridioides difficile</i> infection (CDI)	37
Antibiotic Prophylaxis in Asplenia	38
Antibiotic prophylaxis in asplenia	38
Genital Tract Infections	39
Uncomplicated chlamydia trachomatis/urethritis	39
Non-specific / non-gonococcal urethritis – first episode	39
Epididymo-orchitis	40
Bacterial vaginosis	40
Vaginal candidiasis	41
Trichomoniasis	42
Pelvic inflammatory disease	42
Genital herpes	43
Skin Infections	44
Impetigo	44
Rosacea	45
Acne vulgaris	47
Eczema	48
Panton-Valentine Leukocidin (PVL)	49
Cellulitis and Erysipelas	49
Cellulitis in patients with lymphoedema	52
Prophylaxis for recurrent cellulitis in lymphoedema	52
Leg ulcer	53
Insect bites and stings	54

Primary Care Antimicrobial Guidelines

Bites (human/cat/dog)	55
Scabies.....	56
Tick bites (Lyme disease).....	57
Mastitis	57
Dermatophyte infection – skin	58
Cold sores	59
Herpes zoster (Shingles).....	61
Dermatophyte infection – nail.....	63
Eye Infections	64
Conjunctivitis	64
Ophthalmia neonatorum.....	64
Blepharitis.....	65
Ophthalmic shingles.....	65
Dental Infections.....	66
Mucosal ulceration and inflammation (simple gingivitis)	66
Acute necrotising ulcerative gingivitis	67
Pericoronitis (inflammation around partially erupted teeth).....	67
Dental abscess	68
Glossary	69
Updates	70

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
<p>Community-acquired pneumonia in adults – Treatment in the community NICE NG250 (2025) RHIG (2021) BTS (2009)</p>	<p>Use CRB65 score to help guide mortality risk, place of care and antibiotics. Each feature scores 1:</p> <ul style="list-style-type: none"> • Confusion (Abbreviated Mental Test score 8 or less – Age, time, address for recall at end of test, year, place, identification of 2 persons, DOB, year of World War 1, present monarch, count backwards 20–1), or new disorientation in person, place or time • Respiratory rate ≥ 30/min • BP systolic < 90 mmHg or diastolic ≤ 60 mmHg (if below their normal baseline BP) • Age ≥ 65 years old <p>Use clinical judgement together with the CRB65 score (bearing in mind this can be affected by other factors, for example, comorbidities or pregnancy) to inform shared decisions about place of care.</p> <ul style="list-style-type: none"> ○ CRB65 Score 0: usually suitable for home treatment ○ CRB65 Score 1 – 2: consider hospital assessment or admission ○ CRB65 Score 3 – 4: urgent hospital admission usually required <p>Refer adults to hospital if they have any symptoms or signs suggesting a more serious illness or condition (for example, cardiorespiratory failure or sepsis).</p> <ul style="list-style-type: none"> • Prescribers should advise patients to start antibiotic treatment as soon as possible after establishing a diagnosis of community-acquired pneumonia. • Clinically assess need for dual therapy to cover atypical infections if high CRB65 score. However, <i>Mycoplasma</i> infection is rare in over 65s. • Give safety net advice and likely duration of different symptoms, such as cough 6 weeks. • If recent influenza infection, consider need for anti-staphylococcal cover e.g. doxycycline monotherapy or addition of flucloxacillin to standard treatment. • If failure of first-line agents, patients should be reassessed for on-going signs of infection before further treatment is prescribed. • Consider testing for HIV in adult patients presenting with community acquired pneumonia as recommended by the British HIV Association. HIV testing may be particularly useful in patients with unexplained recurrent pneumonia or other infections. 		
	<p>Low severity disease:</p>		
	<p>First line</p> <p>Second line (failure first line treatment/penicillin allergy/atypical pathogen suspected)</p>	<p>Amoxicillin</p> <p>Doxycycline</p> <p>OR</p> <p>Clarithromycin</p> <p>OR if pregnant</p> <p>Erythromycin</p>	<p>500 mg TDS</p> <p>200 mg stat then 100 mg OD</p> <p>500 mg BD</p> <p>500mg QDS</p>
<p>Section continued overleaf.</p>			

Infection	Formulary choice		Adult dose (unless otherwise specified)	Duration of treatment	
Community-acquired pneumonia in adults – Treatment in the community (contd.)	Third line (treatment failure)	Co-trimoxazole	960 mg BD	5 days. Stop antibiotic treatment after 5 days unless microbiological results suggest a longer course length is needed or the person is not clinically stable.	
	Moderate-severity disease:				
	First line	Amoxicillin PLUS Clarithromycin OR if pregnant	500 mg TDS (higher doses can be used; see the BNF)	500 mg BD	5 days. Stop antibiotic treatment after 5 days unless microbiological results suggest a longer course length is needed or the person is not clinically stable.
		Amoxicillin PLUS Erythromycin	500 mg TDS (higher doses can be used; see the BNF)	500mg QDS	
		Second line (penicillin allergy or if underlying lung disease)	Doxycycline	200 mg stat then 100 mg OD	
Third line (underlying lung disease and failed second line treatment)	Co-trimoxazole	960 mg BD			
Community-acquired pneumonia in children and young people 17 years and under – Treatment in the community BTS (2011) NICE CKS (2024) NICE NG250 (2025)	<p>Consider referring children and young people with community-acquired pneumonia to hospital or seek specialist paediatric advice on further investigation and management.</p> <p>All children with a clear clinical diagnosis of pneumonia should receive antibiotics, as bacterial and viral pneumonia cannot reliably be distinguished from each other.</p> <p>Prescribers should advise patients/parents/carers to start antibiotic treatment as soon as possible after establishing a diagnosis of community-acquired pneumonia.</p> <p>Children aged < 2 years presenting with mild symptoms of lower respiratory tract infection do not usually have pneumonia and do NOT need to be treated with antibiotics, but should be reviewed if symptoms persist. A history of conjugate <i>Pneumococcal</i> vaccination gives greater confidence in this decision.</p> <p>Give safety net advice and likely duration of different symptoms. Consider using the ‘When Should I Worry?’ booklet or a ‘TARGET Treating your Infection’ leaflet (RCGP), available in multiple languages.</p>				

Section continued overleaf.

Infection	Formulary choice		Adult dose (unless otherwise specified)	Duration of treatment
<p>Community-acquired pneumonia in children and young people 17 years and under – Treatment in the community (contd). BTS (2011) NICE CKS (2024) NICE NG 250 (2025)</p>	Non-severe symptoms or signs			
	First line:	Amoxicillin	See BNFc	<p>Babies and children aged 3 months (corrected gestational age) to 11 years – 3 days (Consider extending use of antibiotics beyond 3 days if they are not clinically stable)</p> <p>Children 12-17 years – 5 days</p> <p>For all children and young people, stop antibiotic treatment after 5 days unless microbiological results suggest a longer course is needed or the child or young person is not clinically stable</p>
	Second line (penicillin allergy/atypical pathogens suspected):	Clarithromycin	See BNFc	<p>Babies and children aged 3 months (corrected gestational age) to 11 years – 3 days (Consider extending use of antibiotics beyond 3 days if they are not clinically stable)</p> <p>Children 12-17 years – 5 days</p> <p>For all children and young people, stop antibiotic treatment after 5 days unless microbiological results suggest a longer course is needed or the child or young person is not clinically stable</p>
Post-influenza:	Co-amoxiclav	See BNFc	<p>Babies and children aged 3 months (corrected gestational age) to 11 years – 3 days (Consider extending use of antibiotics beyond 3 days if they are not clinically stable)</p> <p>Children 12-17 years – 5 days</p> <p>For all children and young people, stop antibiotic treatment after 5 days unless microbiological results suggest a longer course is needed or the child or young person is not clinically stable</p>	

Infection	Formulary choice	Adult dose (unless otherwise specified)	Duration of treatment
Panton-Valentine Leukocidin (PVL)	<ul style="list-style-type: none"> • Panton-Valentine Leukocidin (PVL) is a toxin produced by 2% of <i>Staphylococcus aureus</i> 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)	<ul style="list-style-type: none"> • If patient afebrile and healthy other than cellulitis, use oral flucloxacillin alone. • If river or sea water exposure, 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. <p>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.</p>		
Flucloxacillin		500 mg–1 g QDS Use higher dose in obesity (BMI > 30 kg/m ²) or severe infections.	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.			

All Wales Medicines Strategy Group

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	<ul style="list-style-type: none"> • 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 severe infections.	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	
	OR		
	Doxycycline	200 mg stat, then 100 mg OD	5–7 days
	OR		If slow response continue for a further 7 days.
	Erythromycin (if pregnant)	500 mg QDS	

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
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 <i>Staphylococcus aureus</i>
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

Updates

Date of update publication	Details of update
March 2022	Original guidelines document published.
June 2022	Updated the following sections: <ul style="list-style-type: none"> • Acute otitis media (in children) • Varicella zoster (Chicken pox)
September 2022	Updated link to Lymphoedema Wales guidance in the following sections: <ul style="list-style-type: none"> • Cellulitis in patients with lymphoedema • Prophylaxis for recurrent cellulitis in lymphoedema.
December 2022	Updated the following sections: <ul style="list-style-type: none"> • Blepharitis • Community-acquired pneumonia in children - Treatment in the community • Vaginal candidiasis in pregnancy
February 2023	Updated the 'Lower UTI in children' section to note that nitrofurantoin tablets should not be crushed.
April 2023	Updated layout of 'Acute rhinosinusitis' section and included additional guidance from NICE NG79.
May 2023	Updated paediatric doses for Cefotaxime in 'Suspected meningococcal disease' to reflect BNFC changes.
July 2023	Updated to add extra treatment options to Scarlet fever section for treatment in cases of penicillin allergy, as per updated NICE CKS. Miconazole vaginal cream treatment footnote added due to discontinuation of preparation.
September 2023	Updated paediatric doses for Cefotaxime in 'Out of hospital sepsis' to reflect BNFC changes.
January 2024	Updated quinolone statements in light of MHRA advice to 'Consider updated (January 2024) prescribing restrictions and safety issues – see MHRA advice'.
March 2024	Updated the following sections following the MHRA warning on quinolone use (January 2024): <ul style="list-style-type: none"> • Principles of treatment (page 5) – meningitis prophylaxis • Acute pyelonephritis (upper UTI) • Acute prostatitis • Eradication of <i>Helicobacter pylori</i> • Non-specific / non-gonococcal urethritis – first episode • Epididymo-orchitis • Pelvic inflammatory disease <p>Further updates also made to the following sections</p> <ul style="list-style-type: none"> • Conjunctivitis (amended duration of treatment to align with NICE CKS)

Date of update publication	Details of update
	<ul style="list-style-type: none"> • Threadworms (added clarity around the use of mebendazole in pregnancy and breastfeeding) • MHRA reminder of the risk of pulmonary and hepatic adverse drug reactions added where nitrofurantoin is mentioned as a treatment option.
August 2024	<ul style="list-style-type: none"> • Acute cough, bronchitis updated to align with NICE guidance. • Ophthalmic shingles, updated to include optometrist and ophthalmology following feedback from Optometry Wales. • Acute sore throat updated to align with NICE guidance. • Travellers' diarrhoea updated to reflect changes to NICE CKS. • Infectious diarrhoea updated as tinidazole no longer available in the UK.
January 2025	<ul style="list-style-type: none"> • Oral Candidiasis section has been updated to correct inconsistencies in the guidance and to reflect the latest NICE Clinical Knowledge Summary.
April 2025	<ul style="list-style-type: none"> • Lower UTI in adults section has been updated to align with recently published guidance from NICE and SIGN on the use of ibuprofen for mild symptoms. • Threadworm section has been updated to reflect hygiene measures are not always practical for women who are breastfeeding and therefore medical options have been added. • Acute rhinosinusitis sections have been updated to align with NICE guidance.
July 2025	<p>New 'Treatment of COVID-19' and 'Prophylaxis of COVID-19' sections added to the document.</p> <p>Varicella zoster (Chicken pox)</p> <ul style="list-style-type: none"> • Additional information added to enforce the need to engage with specialists for advice on the management of pregnant women • Added clarification of the definition of an immune naïve pregnant woman • Valaciclovir removed as treatment option to simplify guidance • Immunoglobulin removed as treatment option to align with UKHSA guidance <p>Herpes zoster (Shingles)</p> <ul style="list-style-type: none"> • Minor restructuring of guidance and alignment of wording to NICE guidance <p>Suspected meningococcal disease</p>

Date of update publication	Details of update
	<ul style="list-style-type: none"> • Reworded introductory section to align with NICE and added a link for further information on ‘strongly suspected’ cases • Agent of choice switched to Ceftriaxone as per NICE <p>Out of Hospital Sepsis</p> <ul style="list-style-type: none"> • Link provided for further information on ‘high risk’ patients • Agent of choice switched to Ceftriaxone to have one single agent for the management of Out of Hospital Meningitis and Sepsis
December 2025	<p>Influenza</p> <ul style="list-style-type: none"> • Updated to align with updated United Kingdom Health Security Agency (UKHSA) guidance. • Updated links to United Kingdom Teratology Information Service (UKTIS) information on antiviral use in pregnancy. • Added link to UK Drugs in Lactation Advisory Service (UKDILAS) information on antiviral use in breast feeding. <p>Treatment of COVID-19</p> <ul style="list-style-type: none"> • A footnote has been added throughout the monograph to communicate that sotrovimab is being discontinued from late February 2026, and therefore will be unavailable after stocks have expired in February 2026. <p>Oral candidiasis</p> <ul style="list-style-type: none"> • Fluconazole dosing and duration updated to align with updated NICE CKS, Summary of Product Characteristics (SmPC) and British National Formulary (BNF). • Minor amendments to align with updated NICE CKS. <p>Dermatophyte infection</p> <ul style="list-style-type: none"> • Updated to align with updated NICE Clinical Knowledge Summary and British Association of Dermatologists (BAD) guidance. • More information on oral treatment options added. <p>Dental abscess</p> <ul style="list-style-type: none"> • Metronidazole agent of choice for those with penicillin allergy as per Scottish Dental Clinical Effectiveness Programme (SDCEP) guidance. • Wording amended slightly to align with updated SDCEP guidance. • Updated to align with updated SDCEP guidance providing phenoxymethylpenicillin as a treatment option, amoxicillin retained for those with compliance issues.

Date of update publication	Details of update
March 2026	<p>Treatment of COVID-19</p> <ul style="list-style-type: none"> • Sotrovimab has been removed as an option after being discontinued, and stocks having expired in February 2026.
April 2026	<p>Cellulitis and Erysipelas</p> <ul style="list-style-type: none"> • References updated. <p>Pinna chondritis/Perichondritis</p> <ul style="list-style-type: none"> • New section added following user feedback. <p>Community acquired pneumonia in adults – treatment in the community</p> <ul style="list-style-type: none"> • Minor amendments to wording to align with updated NICE guidance • Severity assessment amended to align with updated NICE guidance (CRB-65 and clinical judgement) • Option for higher dose Amoxicillin added as per NICE guidance • Treatment option for use in pregnancy added as per NICE guidance <p>Community acquired pneumonia in children and young people 17 years and under – treatment in the community.</p> <ul style="list-style-type: none"> • Title amended to align with the definition of children as per updated NICE guidance • Minor amendments to wording to align with updated NICE guidance • Link to patient information leaflets with safety netting advice added as per other sections of this document • Severity definitions aligned to updated NICE guidance • Duration of antibiotic treatment aligned with updated NICE guidance.