Primary Care Paediatric Empiric Infection Management Guidelines

NHS Greater Glasgow and Clyde

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 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 is__ 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 Under 12 years: 50mg/kg 12 years and above: 1g	STAT dose And Urgent transfer	For suspected meningococcal disease i.e. fever plus purpuric rash **TRANSFER TO HOSPITAL** **Withhold antibiotic only if clear history of anaphylaxis after previous dose. A history of rash after previous dose is not a contraindication**
Acute Otitis Media	**Routine antibiotics not required** If antibiotic required: **Amoxicillin** Penicillin allergy: **Clarithromycin***	 5 days 5 days	Consider delayed antibiotic treatment. Children with otorrhea, 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: **Phenoxymethypenicillin** Penicillin allergy: **Clarithromycin***	 10 days 5-7 days	Treatment if systemically unwell with high fever, lymphadenopathy and enlarged tonsils with exudates. 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 suppurative complications.
Scarlet Fever	**Phenoxymethylpenicillin** Penicillin allergy: **Clarithromycin***	10 days 7 days	Signs and symptoms include fever, tonsillitis, sand paper like rash, red lips and strawberry tongue.
Community Acquired Pneumonia	**Amoxicillin** Penicillin allergy: **Clarithromycin***	5 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, a viral infection or mycoplasma in which case clarithromycin* might be indicated.
Bronchiolitis	**Antibiotics not required**		Antibiotic therapy is not recommended in the treatment of acute bronchiolitis in infants.
Urinary Tract Infection (lower)	**Trimethoprim**	3 days	**Refer to hospital if child under 6 months of age and/or significantly unwell.** Consider if patient has had previous trimethoprim resistance or is currently on trimethoprim prophylaxis. If yes to either use **Co-amoxiclav** or if penicillin allergy: **Nitrofuantion** (over 3months)
Skin infection	**Topical fusidic acid** **Flucloxacillin** Penicillin allergy: **Clarithromycin***	7 days 7 days 7 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
Infected Animal/Human bites	**Co-amoxiclav** Penicillin allergy human bite: **Metronidazole and clarithromycin** Penicillin allergy animal bite: **Metronidazole and co-trimoxazole**	7 days 7 days 7 days	Give 3 days prophylactic antibiotics to all moderate/ severe bites especially if oedema or crush and in puncture wounds to hand, face, genitals, foot, joint or tendon and in asplenic or immunocompromised hosts. Consider tetanus prophylaxis and for human bites, blood borne virus. Consider rabes if animal bite acquired in endemic area.

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CLINICAL GUIDELINE

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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:

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