PostScRipt – PrimaRy Care

February 2007

ANTIBIOTIC PRESCRIBING: For a review of use of antibiotics in common infections, see the MeReC bulletin of December 2006. For more information on managing infections and which patients to offer antibiotics, see http://www.npc.nhs.uk/MeReC_Bulletins/MeReC_Bulletin_Vol17_No3_Intro.htm. Some of the main points are summarised below. For all these common infections watchful waiting and delayed scripts may be an appropriate strategy in many patients.

Common cold

- This is a mild, self-limiting viral illness. Symptoms typically resolve within seven to ten days but can last for three weeks.
- Analgesics or anti-inflammatory drugs will relieve pain or fever. There is little or no evidence to support the use of other symptomatic treatments.

Acute sinusitis

- Signs and symptoms that increase the likelihood of acute sinusitis include maxillary toothache, poor response to nasal decongestants, history of coloured discharge and purulent nasal secretion.
- Antibiotics should not be prescribed routinely. Over two thirds experience improvement or resolution of symptoms without antibiotic treatment.
- Antibiotics should be reserved for patients with systemic illness, or several severe signs and symptoms which have lasted longer than seven to ten days, or worsened after five to seven days.
- There is insufficient evidence to support the use of antihistamines, decongestants and topical intranasal steroids. Analgesics may be used to relieve pain and fever.
- Symptoms tend to resolve slowly and may persist for two to three weeks, whether antibiotics are taken or not.

Sore throat

- This is a self-limiting condition, which resolves by one week in 85% of people.
- Serious complications are rare.
- Those given antibiotics are more likely to re-attend with another similar infection.

Acute otitis media

- 80% of children recover in around three days without antibiotics. Complications are rare.
- Antibiotics reduce pain to a small degree but this should be balanced against the risk of causing adverse effects such as vomiting, diarrhoea or rashes and should not be used routinely.
- Antibiotics may be beneficial in children under two years old with bilateral infection, or with discharge from the ear, or who are systemically unwell, or have recurrent infections.
- Paracetamol or ibuprofen reduce earache.

Acute bronchitis

- Acute bronchitis is mild and self-limiting, often follows an upper respiratory tract infection and can last for three weeks.
- It is difficult to distinguish acute bronchitis from community-acquired pneumonia. An otherwise healthy, non-elderly adult who presents with cough as the main symptom is unlikely to have pneumonia if there are no new focal chest signs on auscultation and all vital signs are normal.
- Antibiotic treatment is not indicated for the majority of previously well patients.
- Patients should be reassured and offered a patient information leaflet explaining the nature of the illness, and the risks and limited efficacy of antibiotic treatment.
- Analgesics and antipyretics may be used where appropriate. There is insufficient evidence to support the use of cough medicines. The simplest and cheapest treatment for a cough may be a home remedy such as honey and lemon.

VARENICLINE (CHAMPIX®): This has been accepted for use by SMC. It will be considered by the ADTC and Smoking Planning Group to determine the place in therapy. Prescribers should wait for this advice before initiating treatment.

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Penicillin Allergy

In TRUE penicillin allergy*
ALL penicillins, cephalosporins and other beta-lactam antibiotics should be avoided

CONTRA-INDICATED

Antibiotics to be avoided in penicillin allergy

- Amoxicillin (in Co-amoxiclav / Augmentin®, Heliclear®)
- Ampicillin (in Co-fluampicil / Magnapen®)
- Benzylpenicillin / Penicillin G
- Flucloxacillin (in Co-fluampicil / Magnapen®)
- Phenoxymethylpenicillin / Penicillin V
- Piperacillin (in Tazocin)
- Pivmecillinam
- Ticarcillin (in Timentin)

CAUTION

Avoid if serious penicillin allergy (e.g. anaphylaxis/ angioedema)
Use with caution if non-severe allergy (e.g. minor rash only)

Antibiotics to be avoided or used with caution in penicillin allergy

Cephalosporins:
Cefaclor, Cefadroxil, Cefalexin, Cefixime, Cefotaxime, Cefpirome, Cefpodoxime, Cefprozil, Cefradine, Ceftazidime, Ceftriaxone, Cefuroxime

Other beta-lactam antibiotics:
Aztreonam, Imipenem, Meropenem, Ertapenem

CONSIDERED SAFE

Antibiotics safe in penicillin allergy (not a complete list)

Amikacin	Metronidazole
Ciprofloxacin	Nitrofurantoin
Clarithromycin	Minocycline
Clindamycin	Rifampicin
Colistin	Sodium Fusidate
Co-trimoxazole	Teicoplanin
Doxycycline	Tetracycline
Erythromycin	Tobramycin
Gentamicin	Trimethoprim
Linezolid	Vancomycin

*TRUE penicillin allergy includes anaphylaxis, urticaria or rash immediately after penicillin administration
In cases of INTOLERANCE to penicillin (e.g. gastrointestinal upset) or a rash occurring >72 hours after administration, penicillins / related antibiotics should not be withheld unnecessarily in severe infection but the patient must be monitored closely after administration

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