

## Primary Care Paediatric Empiric Infection Management Guidelines

### 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 in 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 and Azithromycin** are 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
<b>Suspected Meningococcal Disease</b>	<b>Benzylpenicillin</b> Give IV or IM Under 1 year: 300mg Age 1-9 years: 600mg 10 years and over: 1200mg <b>Or</b> <b>Cefotaxime</b> Give IV or IM Under 12 years: 50mg/kg 12 years and above: 1g	STAT dose <u>and</u> Urgent transfer	For suspected meningococcal disease i.e. fever plus purpuric rash  <b>TRANSFER TO HOSPITAL</b>  Administer stat dose while awaiting transfer UNLESS there is a known definite history of ANAPHYLAXIS to penicillin antibiotics. History of rash without anaphylaxis is NOT a contraindication. Allergic cross-sensitivity reactions can occur between penicillin and cephalosporin antibiotics. Contact Public Health for advice on prevention of secondary cases/contacts.
<b>Acute Otitis Media</b>	<b>Routine antibiotics not required</b>  If antibiotic required: <b>Amoxicillin</b>  <b>Penicillin allergy:</b> <b>Clarithromycin*</b>	5 days  5 days	Consider delayed antibiotic treatment.  Children with otorrhoea, or those under 2 years of age with bilateral otitis media, have greater benefit but are still eligible for delayed prescribing.
<b>Tonsillitis</b>	<b>Routine antibiotics not required</b>  If antibiotic required: <b>Phenoxymethylpenicillin</b>  <b>Penicillin allergy:</b> <b>Clarithromycin*</b>	5 days  5 days	Treatment if systemically unwell with high fever, lymphadenopathy and enlarged tonsils with exudates. For children > 3 years use FeverPAIN to assess symptoms  Antibiotics should <b>not</b> 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 complications.  Course length 10 days for relapse/recurrence within 2 weeks, or where there are signs/symptoms of Scarlet Fever.
<b>Scarlet Fever</b>	<b>Phenoxymethylpenicillin</b>  <b>Penicillin allergy:</b> <b>Clarithromycin*</b>	10 days  10 days	Signs and symptoms include fever, tonsillitis, sand paper like rash, red lips and strawberry tongue. Prompt treatment with antibiotics significantly reduces risk of complications. <b>If systemically unwell OR no improvement in symptoms after 24-48 hours of antibiotics refer to hospital for further review and management.</b>
<b>Community Acquired Pneumonia (non-severe)</b>	<b>Amoxicillin</b>  <b>Penicillin allergy:</b> <b>Azithromycin*</b>	5 days  3 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, viral infection or mycoplasma/chlamydia in which case azithromycin is indicated.
<b>Bronchiolitis</b>	<b>Antibiotics not required</b>		Antibiotic therapy is not recommended in the treatment of acute bronchiolitis in Infants.
<b>Urinary Tract Infection (upper)</b>	<b>Refer to hospital if child &lt;3months, or suspected UPPER tract infection including fever &gt;38° and/or systemically unwell</b> In this instance antibiotics should NOT be given pre-admission UNLESS clinically severely unwell or anticipated long delay in transfer		
<b>Urinary Tract Infection (lower)</b>	<b>Take a urine sample</b> <b>Cefalexin</b>  <b>Penicillin allergy:</b> <b>Nitrofurantoin (over 3 months)</b>	3 days  3 days	If clinically well, take a urine sample and consider holding antibiotics until cultures known. Empirical antibiotics can be started where clinically indicated. If true penicillin allergy and under 3 months of age microbiology or ID should be consulted for advice. If a patient is known to the renal service or has had previous UTIs then please check previous urine culture results as this may influence empiric prescribing.
<b>Skin infection</b>	<b>Topical fusidic acid</b>  <b>Flucloxacillin</b>  <b>Penicillin allergy:</b> <b>Clarithromycin*</b>	7 days  5 days 5 days	Use topical treatment <b>only</b> for localised small lesions in a well child  Use oral treatment for more extensive or multiple lesions or if systemic upset or concern. Review after 7 days may be warranted if lesions are near the eyes or nose.
<b>Infected Animal/Human bites</b>	<b>Co-amoxiclav</b>  <b>Penicillin allergy human bite:</b> <b>Metronidazole and clarithromycin</b>  <b>Penicillin allergy animal bite:</b> <b>Metronidazole and co-trimoxazole</b>	5 days  5 days 5 days	Give 3 days prophylactic antibiotics to all moderate/ severe bites especially if oedema, crush, puncture wounds, facial, genital, joint, tendon, hand or foot bites or in immunocompromised hosts.  Consider tetanus prophylaxis and for human bites, blood borne virus transmission. Consider rabies if animal bite acquired in endemic area.



## CLINICAL GUIDELINE

# Primary Care Paediatric Empiric Infection Management Guidelines

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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<b>Lead Author:</b>	Susan Kafka, Antimicrobial Pharmacist / Natalie Donald, Paediatric Pharmacist
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### Important Note:

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