

Antibiotic prescribing in primary care: Therapeutic Guidelines summary table 2022

This table summarises information in *Therapeutic Guidelines* about the management of common conditions in primary care. For detailed and up-to-date information, including **second-line treatment options** and management of **special patient groups** (eg penicillin hypersensitivity, renal impairment), see *Therapeutic Guidelines*.

This table should be used in conjunction with **clinical judgement**. Prescribers should consider the **harm–benefit profile** of a drug in each patient (eg consider potential drug interactions).

Antibiotics that are **overused** in primary care include **amoxicillin+clavulanate, cefalexin, cefaclor, roxithromycin** and **erythromycin**.

Indication	First-line therapy	Notes
acute rhinosinusitis	symptomatic treatment	Antibiotic treatment is required rarely—most cases are viral. See <i>Therapeutic Guidelines</i> for more information and resources to support discussion with the patient or carer.
acute otitis media	symptomatic treatment for most cases	80% of cases spontaneously resolve without antibiotic treatment. Advise the carer to return if symptoms do not improve within 72 hours. Consider a delayed prescription for antibiotic therapy. Treat the following groups: infants younger than 6 months; children younger than 2 years with bilateral infection; children who are systemically unwell (eg lethargic, pale; fever alone is not sufficient); children who have otorrhoea; Aboriginal or Torres Strait Islander children; children at risk of complications (eg immunocompromised children). See <i>Therapeutic Guidelines</i> for the dose of amoxicillin . See <i>Therapeutic Guidelines</i> for resources to support discussion with the patient or carer.
acute pharyngitis/tonsillitis	patients <i>not</i> at high risk of acute rheumatic fever: symptomatic treatment for most cases patients at high risk of acute rheumatic fever: phenoxymethylpenicillin 500 mg (child: 15 mg/kg up to 500 mg) orally, 12-hourly for 10 days	Most cases are viral. In patients <i>not</i> at high risk of acute rheumatic fever, even if infection is bacterial, antibiotic treatment is of limited benefit. See <i>Therapeutic Guidelines</i> for resources to support discussion with the patient or carer. In patients at high risk of acute rheumatic fever, antibiotic treatment is recommended for all patients because the increased risk of acute rheumatic fever and resultant rheumatic heart disease outweighs the risk of harms from potentially unnecessary antibiotic treatment. See <i>Therapeutic Guidelines</i> for assessment of risk of acute rheumatic fever.
acute bronchitis	symptomatic treatment	Antibiotic treatment is not indicated—over 90% of cases are viral. See <i>Therapeutic Guidelines</i> for resources to support discussion with the patient or carer.
mild infective exacerbation of COPD	amoxicillin 500 mg orally, 8-hourly for 5 days	Antibiotic treatment has little benefit for patients managed in the community with less severe COPD: for every 100 patients treated with antibiotics, only 8 patients will be better by 4 weeks because they took antibiotics. Consider a delayed prescription for antibiotic therapy. See <i>Therapeutic Guidelines</i> for more information and resources to support discussion with the patient or carer.
community-acquired pneumonia in adults: low-severity (mild)	amoxicillin 1 g orally, 8-hourly. If the patient has significantly improved after 2 to 3 days, treat for 5 days. If the clinical response is slow, treat for 7 days	Assess the patient's pneumonia severity, comorbidities and social circumstances to decide whether to admit the patient to hospital; see <i>Therapeutic Guidelines</i> . See <i>Therapeutic Guidelines</i> for risk factors for infection caused by atypical bacteria. Patient review within 48 hours is essential. If patient follow-up within 48 hours may not occur, consider using initial combination therapy with doxycycline instead; see <i>Therapeutic Guidelines</i> . If the patient is not improving after 48 hours of monotherapy, see <i>Therapeutic Guidelines</i> .
pneumonia in residents of aged-care facilities: oral therapy	amoxicillin 1 g orally, 8-hourly. If the patient has significantly improved after 2 to 3 days, treat for 5 days. If the clinical response is slow, treat for 7 days	Consider whether a viral infection could be the cause of symptoms. See <i>Therapeutic Guidelines</i> for indications for parenteral therapy. If infection caused by atypical bacteria (eg <i>Legionella</i> species) is suspected, see <i>Therapeutic Guidelines</i> . Patient review within 48 hours is essential; see <i>Therapeutic Guidelines</i> if the patient is not improving.

Indication	First-line therapy	Notes
localised odontogenic infection	dental treatment	Prescribe analgesia and refer the patient to the dentist. Explain that antibiotic treatment without dental intervention will not be effective. If dental treatment will be delayed or the infection is spreading, see <i>Therapeutic Guidelines</i> .
acute cystitis in nonpregnant women	trimethoprim 300 mg orally, daily for 3 days	Half of cases in nonpregnant women younger than 65 years resolve within 7 days without antibiotic treatment. See <i>Therapeutic Guidelines</i> if the patient is a resident of an aged-care facility or has risk factors for multidrug resistant bacteria. Take a urine sample for culture and susceptibility testing if empirical therapy is not effective. Do not use ciprofloxacin, norfloxacin or fosfomycin unless susceptibility testing rules out all alternative antibiotics—see <i>Therapeutic Guidelines</i> .
acute cystitis in pregnancy	nitrofurantoin 100 mg orally, 6-hourly for 5 days	Take a urine sample for culture and susceptibility testing before starting treatment, and repeat 1 to 2 weeks after treatment is completed. Avoid using nitrofurantoin close to delivery—see <i>Therapeutic Guidelines</i> .
bites and other wounds caused by teeth	amoxicillin+clavulanate 875+125 mg (child 2 months or older: 22.5+3.2 mg/kg up to 875+125 mg) orally, 12-hourly for 5 days	Check the patient's tetanus immunisation status. Treatment may not be required if the wound is not infected—see <i>Therapeutic Guidelines</i> .
erysipelas without systemic symptoms	phenoxymethylpenicillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 5 days	Initial intravenous therapy is needed if the patient has 2 or more systemic symptoms—see <i>Therapeutic Guidelines</i> .
cellulitis without systemic symptoms	phenoxymethylpenicillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 5 days OR (if penetrating injury or associated ulcer or abscess) flucloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 5 days	<i>Streptococcus</i> species are the most common cause of nonpurulent, recurrent cellulitis and spontaneous, rapidly spreading cellulitis. If the wound was exposed to fresh or salt water or there is a risk of MRSA, see <i>Therapeutic Guidelines</i> . Initial intravenous therapy is needed if the patient has 2 or more systemic symptoms—see <i>Therapeutic Guidelines</i> . See <i>Therapeutic Guidelines</i> for periorbital, orbital and peritonsillar cellulitis.
impetigo: localised sores (nonendemic settings)	mupirocin 2% ointment or cream topically to crusted areas, 8-hourly for 5 days	Use soap and water topically three times a day to soften crusts. For management of impetigo in endemic settings, see <i>Therapeutic Guidelines</i> .
impetigo: multiple or recurrent sores (nonendemic settings)	flucloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 7 days	Stop therapy earlier if the infection has resolved. If treatment is unsuccessful, see <i>Therapeutic Guidelines</i> . Eradication of staphylococcal carriage may be indicated; see <i>Therapeutic Guidelines</i> . For management of impetigo in endemic settings, see <i>Therapeutic Guidelines</i> .
acute mild diabetic foot infection	flucloxacillin 500 mg orally, 6-hourly	See <i>Therapeutic Guidelines</i> if the patient has systemic symptoms, chronic diabetic foot infection, has recently received antibiotics, or has risk factors for MRSA infection.
lactation-associated mastitis	flucloxacillin 500 mg orally, 6-hourly. If symptoms and signs resolve rapidly, 5 days of therapy may be sufficient; otherwise continue treatment for 10 days	For patients without systemic symptoms, increased breastfeeding and gentle expression of milk from the affected breast for 24 to 48 hours may resolve symptoms without antibiotic treatment. If this fails to resolve symptoms, and in all patients with systemic symptoms, antibiotic treatment is recommended to minimise the risk of abscess. Advise the patient to continue with breastfeeding and gentle milk expression. Consider lactation support.

COPD = chronic obstructive pulmonary disease; MRSA = methicillin-resistant *Staphylococcus aureus*