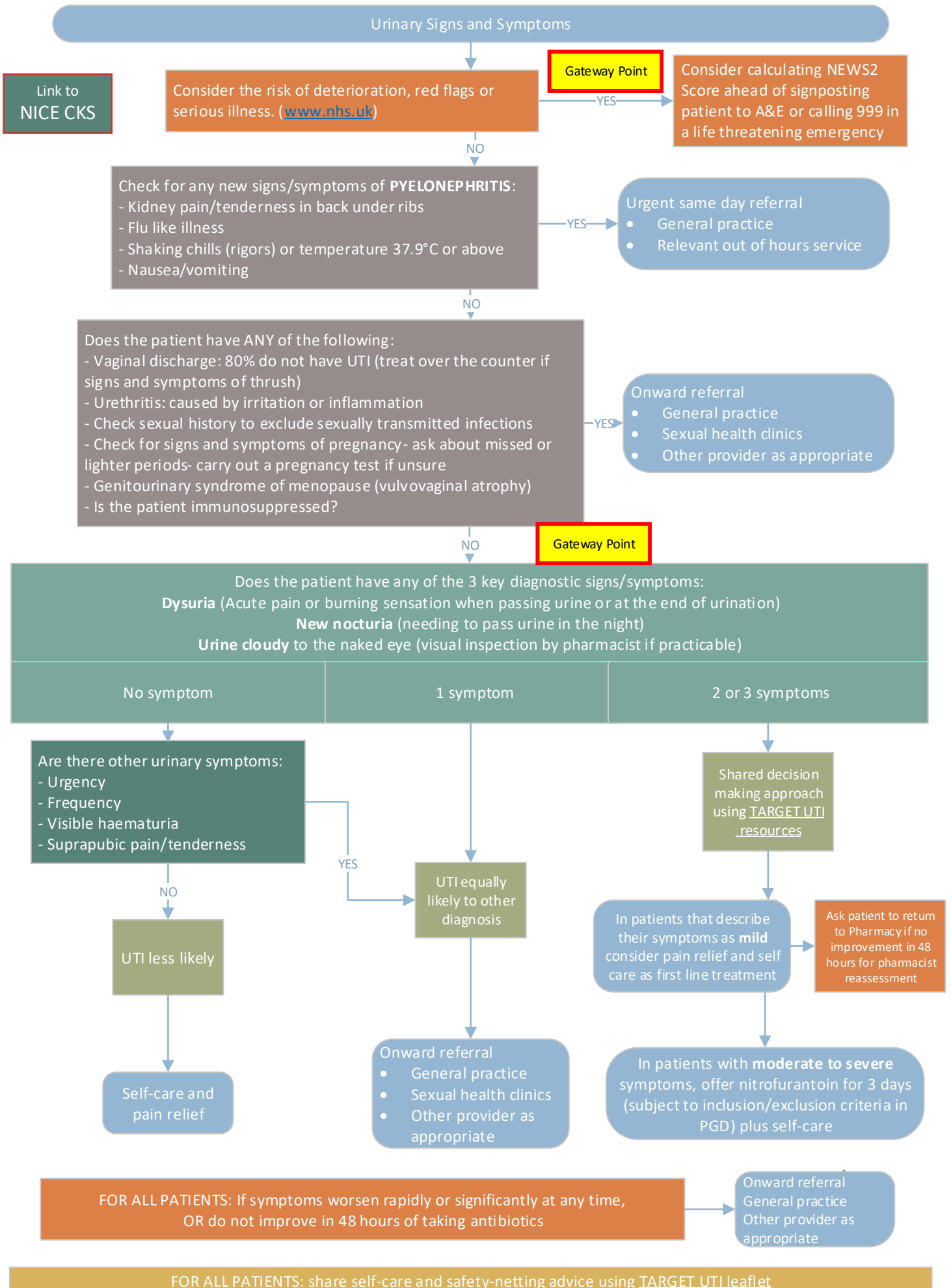


Uncomplicated Urinary Tract Infection

(For **women aged 16 to under 65 years** who **do not have diabetes** with suspected lower UTIs)

Exclude: pregnant individuals, urinary catheter, recurrent UTI (2 episodes in last 6 months, or 3 episodes in last 12 months)



Impetigo

(Non-bullous impetigo, for **adults and children aged 1 year and over**)

Exclude: bullous impetigo, recurrent impetigo (defined as 2 or more episodes in the same year), pregnant individuals under 16 years

Confirm likely presentation of impetigo through visual examination in a consultation room

Consider the risk of deterioration, red flags or serious illness (www.nhs.uk)

Patient is immunosuppressed and infection is widespread

Severe complications suspected (such as deeper soft tissue infection)

Gateway Point

YES

Consider calculating NEWS2 Score ahead of signposting patient to A&E or calling 999 in a life threatening emergency

Gateway Point

NO

Does the patient follow typical progression of impetigo clinical features:

- The initial lesion is a very thin-walled vesicle on an erythematous base, which ruptures easily and is seldom observed
- The exudate dries to form golden yellow or yellow-brown crusts, which gradually thickens
- Lesions can develop anywhere on the body but are most common on exposed skin on the face (the peri-oral and peri-nasal areas), limbs and flexures (such as the axillae)
- Satellite lesions may develop following autoinoculation
- Usually asymptomatic but may be mildly itchy
- Refer to [NHS.UK website](http://NHS.UK) for images of impetigo

Impetigo more likely

YES

Impetigo less likely

NO

Consider alternative diagnosis and proceed appropriately

Does the patient have ≤ 3 lesions/clusters present?

NO

Does the patient have ≥ 4 lesions/clusters present?

YES

YES

Localised non-bullous impetigo

Widespread non-bullous impetigo

Offer hydrogen peroxide 1% cream for 5 days (subject to inclusion/exclusion criteria in protocol) plus self care

Offer flucloxacillin (if no allergy) for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

or if unsuitable or ineffective

Offer fusidic acid cream for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

Reported penicillin allergy (via National Care Record or Patient/Carer)

YES

Offer clarithromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

If pregnant

Offer erythromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

If symptoms worsen rapidly or significantly at any time, OR do not improve after completion of treatment course

Onward referral

- General practice
- Other provider as appropriate

FOR ALL PATIENTS:

- Offer advice on importance of good hygiene to reduce spread of impetigo
- Offer advice on how to take their medicines to encourage adherence

Fusidic acid cream can be offered 2nd line if:

- Hydrogen peroxide unsuitable, for example if impetigo is around eyes
- Hydrogen peroxide treatment has been ineffective and impetigo still remains localised

Infected Insect Bites (For adults and children aged 1 year and over)

Exclude: pregnant individuals under 16 years

Do not offer an antibiotic if there are no signs or symptoms of infection. Be aware that a rapid-onset skin reaction to insect bite is likely to be an inflammatory or allergic reaction rather than an infection. Most insect bites and stings are not serious and will get better within a few hours or days, and do not need treatment with antibiotics.

Consider likelihood of Lyme disease (Tick bites – painless and can go unnoticed). Erythema Migrans rash may be indistinguishable from other insect bites.
[nise-lyme-disease-rash-images](#)

Patient presenting with signs and symptoms of infected insect bite

Consider the risk of deterioration, red flags or serious illness (consider Lyme disease, cellulitis, etc) (www.nhs.uk)

Signs of systemic hypersensitivity reaction or anaphylaxis
- Administer adrenaline

Severely immunosuppressed and have signs or symptoms of an infection

Stings where there is risk of airway obstruction (e.g. in the mouth or throat) or concerns of orbital cellulitis from bite or sting around the eyes

Gateway Point

Consider calculating NEWS2 Score ahead of signposting patient to A&E or calling 999 in a life threatening emergency

YES

NO

Does the patient meet ANY of the following criteria:

- Bite or scratch caused by animal(s)
- Bite caused by human(s)
- Bite caused by tick in the UK and signs of Lyme disease such as erythema migrans (bullseye) rash
- Bite or sting that occurred while travelling outside of UK with concern of insect borne diseases e.g. malaria, tick borne encephalitis
- Bite or sting caused by an unusual or exotic insect

Onward referral

- General practice
- Other provider as appropriate

YES

NO

Has it been at least 48 hours after the initial insect bite or sting?

NO

Recommend self care, oral antihistamine and/or topical steroids over the counter and safety netting advice

YES

Is itch the principal symptom?
(In the absence of other signs or symptoms of infection)

YES

NO

Does the patient have acute onset of ≥3 of the following symptoms of an infected insect bite?

- Redness of skin
- Pain or tenderness to the area
- Swelling of skin
- Skin surrounding the bite feels hot to touch

Gateway Point

YES

Infected Insect bite more likely

Infected insect bite less likely

NO

Does the patient meet ANY of the following criteria:

- Redness and swelling of skin surrounding the bite is spreading
- There is evidence of pustular discharge at site of bite/sting

YES

Recommend self care, oral antihistamine and/or topical steroids over the counter and safety netting advice

NO

- Clearly demarcate the area and ask patient to monitor
- Ask patient to return to pharmacy if symptoms worsen at any time OR do not improve after 3 days of over the counter treatment for pharmacist reassessment

Recommend self care, oral antihistamine and/or topical steroids over the counter and safety netting advice

Does the patient meet ANY of the following criteria:

- Patient systemically unwell
- Known comorbidity which may complicate or delay resolution of infection: for example peripheral arterial disease, chronic venous insufficiency, lymphoedema or morbid obesity
- Severe pain out of proportion to the wound (may indicate the presence of toxin-producing bacteria)
- Patient has significant collection of fluid or pus at site of infection (for incision and drainage where appropriate)

YES

Onward referral

- Other provider as appropriate
- General practice

NO

Offer flucloxacillin (if no allergy) for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

Reported penicillin allergy (via National Care Record or Patient/Carer)

YES

Offer clarithromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

If pregnant

Offer erythromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

If symptoms worsen rapidly or significantly at any time, OR do not improve after completion of 5 days treatment course

Onward referral

- General practice
- Other provider as appropriate

- Skin redness and itching are common and may last for up to 10 days
- It is unlikely that the skin will become infected
- Avoiding scratching may reduce inflammation and the risk of infection

Acute Sore Throat

(For adults and children aged **5 years and over**)
Exclude: pregnant individuals under 16 years

Patient presenting with signs and symptoms of acute sore throat

Consider the risk of deterioration, red flags or serious illness.
Thorough consultation required for children.
(www.nhs.uk)

Suspected Epiglottitis
- 4Ds: dysphagia, dysphonia, drooling, distress
- Do not examine the throat of anyone with suspected epiglottitis as this may precipitate closure of the airway

Severe complications suspected (such as clinical dehydration, signs of pharyngeal abscess)

Stridor (noisy or high pitched sound with breathing)

Gateway Point

Consider calculating NEWS2 Score ahead of signposting patient to A&E or calling 999 in a life threatening emergency

- Does the patient have signs or symptoms indicating possible scarlet fever, quinsy or glandular fever? (refer to NICE CKS for list of symptoms)
- Does the patient have signs and symptoms of suspected [head/neck cancer](#)? E.g. persistent mouth ulcers or an unexplained lump in the neck.
- Is the patient immunosuppressed?

Onward referral
• General practice
• Other provider as appropriate

Use FeverPAIN Score to assess:
1 point for each

- ☐ Fever (over 38°C)
- ☐ Purulence
- ☐ First attendance within 3 days after onset of symptoms
- ☐ Severely inflamed tonsils
- ☐ No cough or coryza (cold symptoms)

FeverPAIN Score 0 or 1

Self-care and pain relief

- Antibiotic is not needed
- Offer over the counter treatment for symptomatic relief
- Drink adequate fluids

Ask patient to return to Community Pharmacy after 1 week if no improvement for pharmacist reassessment

FeverPAIN score 2 or 3

Gateway Point

Self-care and pain relief

- Antibiotics make little difference to how long symptoms last
- Withholding antibiotics is unlikely to lead to complications

Ask patient to return to Community Pharmacy if no improvement within 3-5 days for pharmacist reassessment

RETURNING PATIENT

Gateway Point

After pharmacist reassessment (including red flags) patient can be offered antibiotics if appropriate based on clinician global impression

FeverPAIN score 4 or 5

Gateway Point

Shared decision making approach using [TARGET RTI resources](#) and clinician global impression

Mild symptoms: consider pain relief and self care as first line treatment

Severe symptoms: consider offering an immediate antibiotic

Offer phenoxymethylpenicillin (if no allergy) for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

Reported penicillin allergy (via National Care Record or Patient/Carer)

YES

Offer clarithromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

If pregnant

Offer erythromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care

If symptoms do not improve after completion of treatment course

FOR ALL PATIENTS: If symptoms worsen rapidly or significantly at any time

Onward referral
• General practice
• Other provider as appropriate

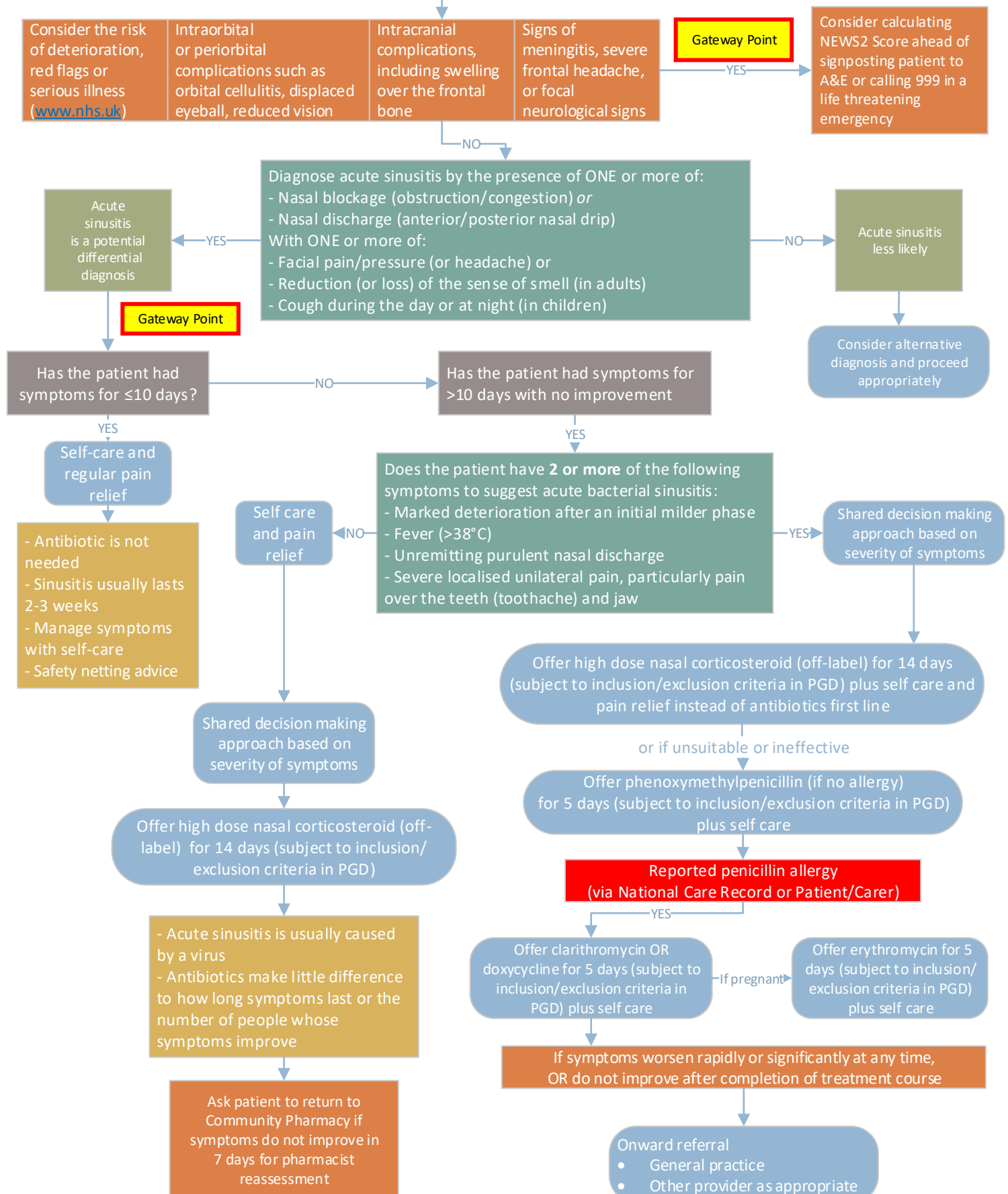
FOR ALL PATIENTS: share self-care and safety-netting advice using [TARGET Respiratory Tract Infection](#) leaflets

Acute Sinusitis (For adults and children aged 12 years and over)

Exclude: immunosuppressed individuals, chronic sinusitis (sinusitis that causes symptoms that last for more than 12 weeks), pregnant individuals under 16 years

Acute sinusitis is usually caused by a virus and is only complicated by bacterial infection in about 2 in 100 cases.
It takes 2–3 weeks to resolve, and most people will get better without antibiotics. Please share [NICE information for the public](#).

Patients presenting with signs and symptoms of acute sinusitis



Shingles (for adults aged 18 years and over)

Exclude: pregnant individuals

Patient presents with signs and symptoms of shingles

Consider the risk of deterioration, red flags or IF ANY of the serious complications are suspected (www.nhs.uk)

Serious complications suspected

- Meningitis (neck stiffness, photophobia, mottled skin)
- Encephalitis (disorientation, changes in behaviour)
- Myelitis (muscle weakness, loss of bladder or bowel control)
- Facial nerve paralysis (typically unilateral) (Ramsay Hunt)

Shingles in the ophthalmic distribution

- Hutchinson's sign — a rash on the tip, side, or root of the nose
- Visual symptoms
- Unexplained red eye

- Shingles in severely immunosuppressed patient

- Shingles in immunosuppressed patient where the rash is severe, widespread or patient is systemically unwell
- Shingles affecting the head and neck

Gateway Point

Consider calculating NEWS2 Score ahead of signposting patient to A&E or calling 999 in a life threatening emergency

Gateway Point

NO

Does the patient follow typical progression of shingles clinical features (To be used as a guide to support diagnosis – not all below may be present):

- First signs of shingles are an abnormal skin sensation and pain in the affected area which can be described as burning, stabbing, throbbing, itching, tingling and can be intermittent or constant.
- The rash usually appears within 2-3 days after the onset of pain, and a fever and/or a headache may develop.
- Shingles rash appears as a group of red spots on a pink-red background which quickly turn into small fluid-filled blisters.
- Some of the blisters burst, others fill with blood or pus. The area then slowly dries, crusts and scabs form.
- Shingles rash usually covers an area of skin on one side of the body.

☐ Refer to NHS.UK website for images of Shingles

Shingles more likely

Shingles less likely

Consider alternative diagnosis and proceed appropriately

Does the patient have shingles within 72 hours of rash onset?

YES

Does the patient meet (ANY) of the following criteria:

- Immunosuppressed (see below)
- Non-truncal involvement (shingles affecting the limbs, or perineum)
- Moderate or severe pain
- Moderate or severe rash (defined as confluent lesions)
- All patients aged over 50 years

YES

Does the patient have shingles up to one week after rash onset?

YES

Does the patient meet (ANY) of the following criteria:

- Immunosuppressed (see below)
- Continued vesicle formation
- Severe pain
- High risk of severe shingles (e.g. severe atopic dermatitis/eczema)
- All patients aged 70 years and over

YES

Offer aciclovir (subject to inclusion/exclusion criteria in PGD) plus self care

or if unsuitable

Offer valaciclovir (subject to inclusion/exclusion criteria in PGD) plus self care

Offer valaciclovir:

- Immunosuppressed patients
- Adherence risk: already taking 8 or more medicines a day or is assisted in taking their medicines

FOR ALL PATIENTS: If symptoms worsen rapidly or significantly at any time, OR do not improve after completion of 7 days treatment course

Onward referral
General practice
Other provider as appropriate

FOR IMMUNOSUPPRESSED PATIENTS:

- Offer treatment if appropriate and call patient's GP or send urgent for action email if out of hours to notify supply of antiviral and **request review by GP Practice**
- Advise patient, if your symptoms worsen rapidly or if you become systemically unwell or the rash becomes severe or widespread - attend A&E or call 999

FOR ALL PATIENTS:

- Share self-care and safety-netting advice using [British Association of Dermatologists Shingles leaflet](#)
- For pain management recommend a trial of paracetamol, a NSAID such as ibuprofen, or co-codamol over the counter. If this is not effective, refer patient to general practice
- Signpost eligible individuals to information and advice about receiving the shingles vaccine after they have recovered from this episode of shingles

Acute Otitis Media (For children aged 1 to 17 years)

Exclude: recurrent acute otitis media (3 or more episodes in 6 months or four or more episodes in 12 months), pregnant individuals under 16 years

Acute otitis media mainly affects children, can last for around 1 week and over 80% of children recover spontaneously without antibiotics 2-3 days from presentation

Patients presenting with signs and symptoms of acute otitis media

