National Institute for Health and Clinical Excellence care pathway for respiratory tract infections

At the first face-to-face contact in primary care, including walk-in centres and emergency departments, offer a clinical assessment, including:

- history (presenting symptoms, use of over-the-counter or self medication, previous medical history, relevant risk factors, relevant comorbidities)
- examination as needed to establish diagnosis.

Address patients' or parents'/carers' concerns and expectations when agreeing the use of the three antibiotic strategies (no prescribing, delayed prescribing and immediate prescribing)

Agree a no antibiotic or delayed antibiotic prescribing strategy for patients with acute otitis media, acute sore throat/pharyngitis/acute tonsillitis, common cold, acute rhinosinusitis or acute cough/acute bronchitis.

However, also consider an immediate prescribing strategy for the following subgroups, depending on the severity of the RTI.

The patient is at risk of developing complications.

No antibiotic prescribing

Offer patients:

- reassurance that antibiotics are not needed immediately because they will make little difference to symptoms and may have side effects, for example, diarrhoea, vomiting and rash.
- a clinical review if the RTI worsens or becomes prolonged.

Delayed antibiotic prescribing

Offer patients:

- reassurance that antibiotics are not needed immediately because they will make little difference to symptoms and may have side effects, for example, diarrhoea, vomiting and rash.
- advice about using the delayed prescription if symptoms do not settle or get significantly worse
- advice about re-consulting if symptoms get significantly worse despite using the delayed prescription.

The delayed prescription with instructions can either be given to the patient or collected at a later date.

No antibiotic, delayed antibiotic or immediate antibiotic prescribing

Depending on clinical assessment of severity, also consider an immediate prescribing strategy for:

- children younger than 2 years with bilateral acute otitis media
- children with otorrhoea who have acute otitis media
- patients with acute sore throat/acute tonsillitis when three or more Centor criteria[1] are present.

[1] Centor criteria are: presence of tonsillar exudate, tender anterior cervical lymphadenopathy or lymphadenitis, history of fever and an absence of cough.

Immediate antibiotic prescribing or further investigation and/ or management

Offer immediate antibiotics or further investigation/management for patients who:

- are systemically very unwell
- have symptoms and signs suggestive of serious illness and/or complications (particularly pneumonia, mastoiditis, peritonsillar abscess, peritonsillar cellulitis, intraorbital or intracranial complications)
- are at high risk of serious complications because of pre-existing comorbidity. This includes patients with significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis, and young children who were born prematurely.
- are older than 65 years with acute cough and two or more of the following, or older than 80 years with acute cough and one or more of the following:
  - hospitalisation in previous year
  - type 1 or type 2 diabetes
  - history of congestive heart failure
  - current use of oral glucocorticoids.

Offer all patients:

- advice about the usual natural history of the illness and average total illness length:
  - acute otitis media: 4 days
  - acute sore throat/acute pharyngitis/acute tonsillitis: 1 week
  - common cold: 1½ weeks
  - acute rhinosinusitis: 2½ weeks
  - acute cough/acute bronchitis: 3 weeks
- advice about managing symptoms including fever (particularly analgesics and antipyretics). For information about fever in children younger than 5 years, refer to 'Feverish illness in children' (NICE clinical guideline 47).