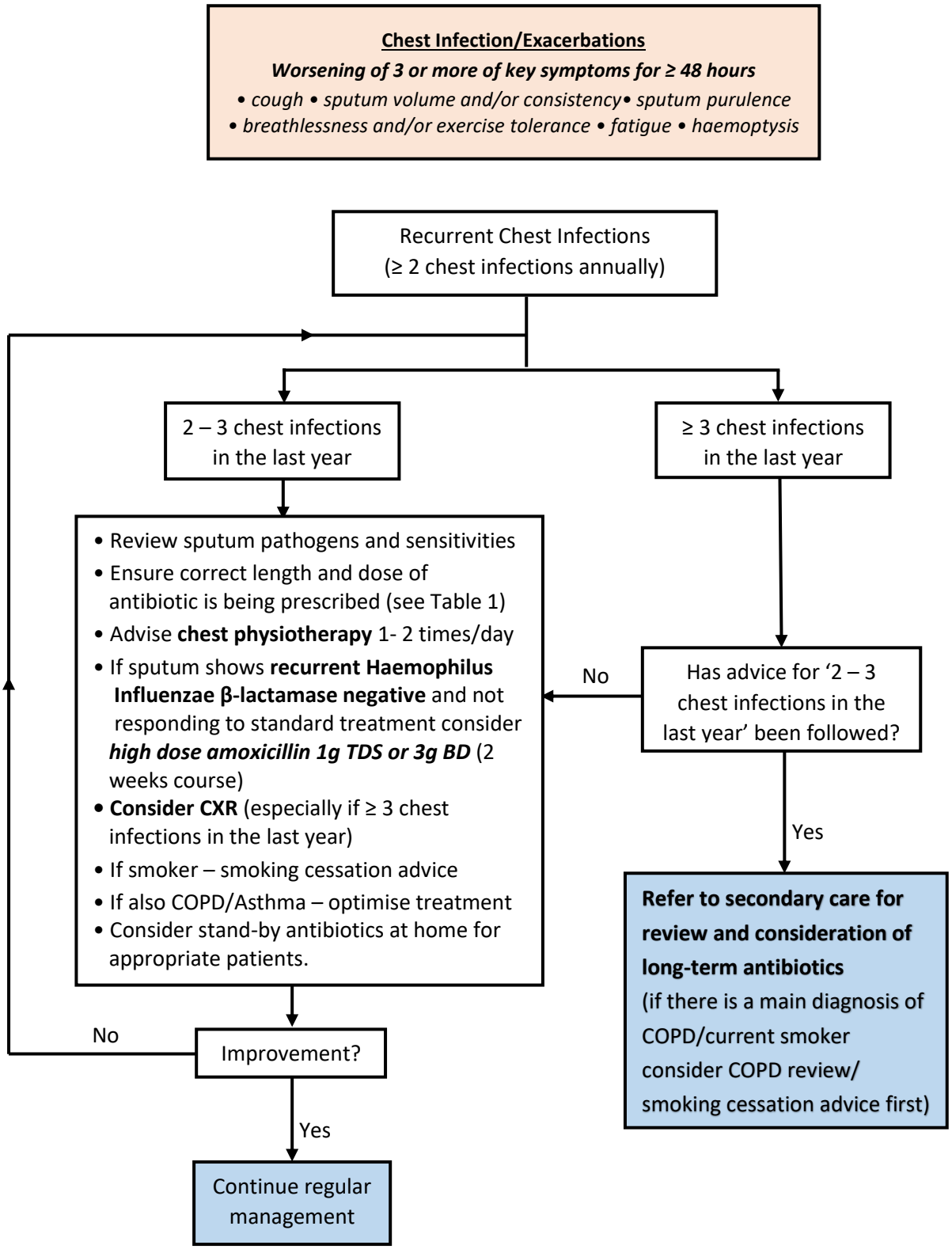
Guidelines for Managing Recurrent Chest Infections in Non-CF Bronchiectasis in Primary Care

Do NOT diagnose a chest infection based only on a positive sputum sample **sent for routine microbiology**



For advice on obtaining an optimal SPUTUM sample and result please see 'FAQs on bronchiectasis'

Sputum Pathogen	Antibiotics (14 days)
Haemophilus Influenzae* β-*lactamase negative	Amoxicillin 500mg TDS **or** doxycycline 100mg BD
Haemophilus Influenzae* β-*lactamase positive	Co-amoxiclav 625mg TDS **or** doxycycline 100mg BD
Moraxella catarrhalis	Co-amoxiclav 625mg **or** doxycycline 100mg BD
Streptococcus pneumonia	Amoxicillin 500mg TDS **or** doxycycline 100mg BD
Staphylococcus aureus	Flucloxacillin 500mg QDS **or** clarithromycin[†] 500mg BD
Pseudomonas aeruginosa	Ciprofloxacin 500mg BD[††]
Methicillin-resistant Staphylococcus aureus (MRSA)	Doxycycline 100mg BD

Table 1: Recommended antibiotics and doses for common sputum pathogens found in bronchiectasis.

[†] Macrolide antibiotics (including short courses) can prolong QTc interval. Advise patients to monitor for dizziness or palpitations especially in patients with pre-existing cardiac disease.

[††] Patients should be **advised to stop ciprofloxacin (and other fluoroquinolones) at first sign of tendon pain, muscle pain, muscle weakness, joint pain, joint swelling and peripheral neuropathy**. Adverse events **include tendonitis and tendon rupture** as well as **peripheral neuropathy**. Other side-effects include photosensitivity, joint pain, joint swelling, muscle pain and muscle weakness.

- **Do not use in patients with a history of serious adverse reaction (e.g. tendon damage) to ciprofloxacin or other fluoroquinolones.**
- Co-administration of corticosteroids and fluoroquinolones should be avoided if possible as there is increased risk of tendon damage.
- **Prescribe with caution** in people over 60 years old, with renal impairment and solid organ transplants as there is a higher risk of tendon injury.

For further information (including other side-effects) see 'MHRA sheet to discuss measures with patients' (https://assets.publishing.service.gov.uk/media/5c9364c6e5274a48edb9a9fa/FQ-patient-sheet-final.pdf).

Why are longer courses of antibiotics needed in bronchiectasis (up to 14 days)?

There is *evidence of higher microbial load in the airways of bronchiectasis patients* which can cause airway irritation and inflammation. Although the evidence is still needed, expert consensus recommends patients with *moderate to severe bronchiectasis should have a course of 14 days.*
The duration of antibiotic for each patient should be specified in their last bronchiectasis/respiratory hospital letter.