Antibacterials, use for prophylaxis

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Rheumatic fever: prevention of reccurence

- Phenoxymethylpenicillin p. 350 by mouth *or* erythromycin p. 341 by mouth.

Invasive group A streptococcal infection: prevention of secondary cases

- Phenoxymethylpenicillin by mouth.

If child penicillin allergic, *either* erythromycin by mouth or azithromycin p. 339 by mouth [unlicensed indication].

For details of those who should receive chemoprophylaxis contact a consultant in communicable disease control (or a consultant in infectious diseases or the local Public Health England Laboratory).

Meningococcal meningitis: prevention of secondary cases

- Ciprofloxacin p. 361 by mouth [unlicensed indication] *or* rifampicin p. 379 by mouth *or* ceftriaxone p. 332 by intramuscular injection [unlicensed indication].

For details of those who should receive chemoprophylaxis contact a consultant in communicable disease control (or a consultant in infectious diseases or the local Public Health England laboratory). Unless there has been direct exposure of the mouth or nose to infectious droplets from a patient with meningococcal disease who has received less than 24 hours of antibacterial treatment, healthcare workers do not generally require chemoprophylaxis.

Haemophilus influenzae type b disease: prevention of secondary cases

- Rifampicin by mouth *or* (if rifampicin cannot be used) ceftriaxone by intramuscular injection, or by intravenous injection, or by intravenous infusion [unlicensed indication].

For details of those who should receive chemoprophylaxis contact a consultant in communicable disease control (or a consultant in infectious diseases or the local Public Health England laboratory). Unless there has been direct exposure of the mouth or nose to infectious droplets from a patient with meningococcal disease who has received less than 24 hours of antibacterial treatment, healthcare workers do not generally require chemoprophylaxis.

Within 4 weeks of illness onset in an index case with confirmed or suspected invasive *Haemophilus influenzae* type b disease, give antibacterial prophylaxis to all household contacts if there is a vulnerable individual in the household. Also, give antibacterial prophylaxis to the index case if they are in contact with vulnerable household contacts or if they are under 10 years of age. Vulnerable individuals include the immunocompromised, those with asplenia, or children under 10 years of age. If there are 2 or more cases of invasive *Haemophilus influenzae* type b disease within 120 days in a pre-school or primary school, antibacterial prophylaxis should also be given to all room contacts (including staff). Also see immunisation against *Haemophilus influenzae* type b disease.

Diphtheria in non-immune patients: prevention of secondary cases

- Erythromycin (*or* another macrolide e.g. azithromycin *or* clarithromycin p. 340) by mouth.

Treat for further 10 days if nasopharyngeal swabs positive after first 7 days' treatment.

Pertussis, antibacterial prophylaxis

- Clarithromycin (*or* azithromycin *or* erythromycin) by mouth.

Within 3 weeks of onset of cough in the index case, give antibacterial prophylaxis to all close contacts if amongst them there is at least one unimmunised or partially immunised child under 1 year of age, *or* if there is at least one individual who has not received a pertussis-containing vaccine more than 1 week and less than 5 years ago (so long as that individual lives or works with children under 4 months of age, is pregnant at over 32 weeks gestation, or is a healthcare worker who works with children under 1 year of age or with pregnant women).

Pneumococcal infection in asplenia or in patients with sickle-cell disease, antibacterial prophylaxis

- Phenoxymethylpenicillin by mouth.

If cover also needed for *H. influenzae* in child give amoxicillin p. 351 instead.

If penicillin-allergic, erythromycin by mouth.

Antibacterial prophylaxis is not fully reliable. Antibacterial prophylaxis may be discontinued in children over 5 years of age with sickle-cell disease who have received pneumococcal immunisation and who do not have a history of severe pneumococcal infection.

Staphylococcus aureus lung infection in cystic fibrosis, antibacterial prophylaxis

- *Primary prevention*, flucloxacillin p. 357 by mouth.

Secondary prevention, flucloxacillin by mouth.

Tuberculosis antibacterial prophylaxis in susceptible close contacts or those who have become tuberculin positive

- See *Close contacts* and *Chemoprophylaxis for latent tuberculosis* under Tuberculosis p. 375.

Urinary-tract infection, antibacterial prophylaxis

- Trimethoprim p. 373 by mouth *or* nitrofurantoin p. 384 by mouth.

EvGr Antibacterial prophylaxis may be considered in children with recurrent symptomatic urinary-tract infection, vesicoureteric reflux, or those awaiting imaging investigations. A

Animal and human bites, antibacterial prophylaxis

- Co-amoxiclav p. 354 alone (*or* clindamycin p. 337 if penicillin-allergic).

Cleanse wound thoroughly. For tetanus-prone wound, give human tetanus immunoglobulin p. 798 (with a tetanus-containing vaccine if necessary, according to immunisation history and risk of infection).

Consider rabies prophylaxis for bites from animals in endemic countries. Assess risk of blood-borne viruses (including HIV, hepatitis B and C) and give appropriate prophylaxis to prevent viral spread. Antibacterial prophylaxis recommended for wounds less than 48–72 hours old when the risk of infection is high (e.g. bites from humans or cats; bites to the hand, foot, face, or genital area; bites involving oedema, crush or puncture injury, or other moderate to severe injury; wounds that cannot be debrided adequately; patients with diabetes mellitus, cirrhosis, asplenia, prosthetic joints or valves, or those who are immunocompromised). Give antibacterial prophylaxis for up to 5 days.