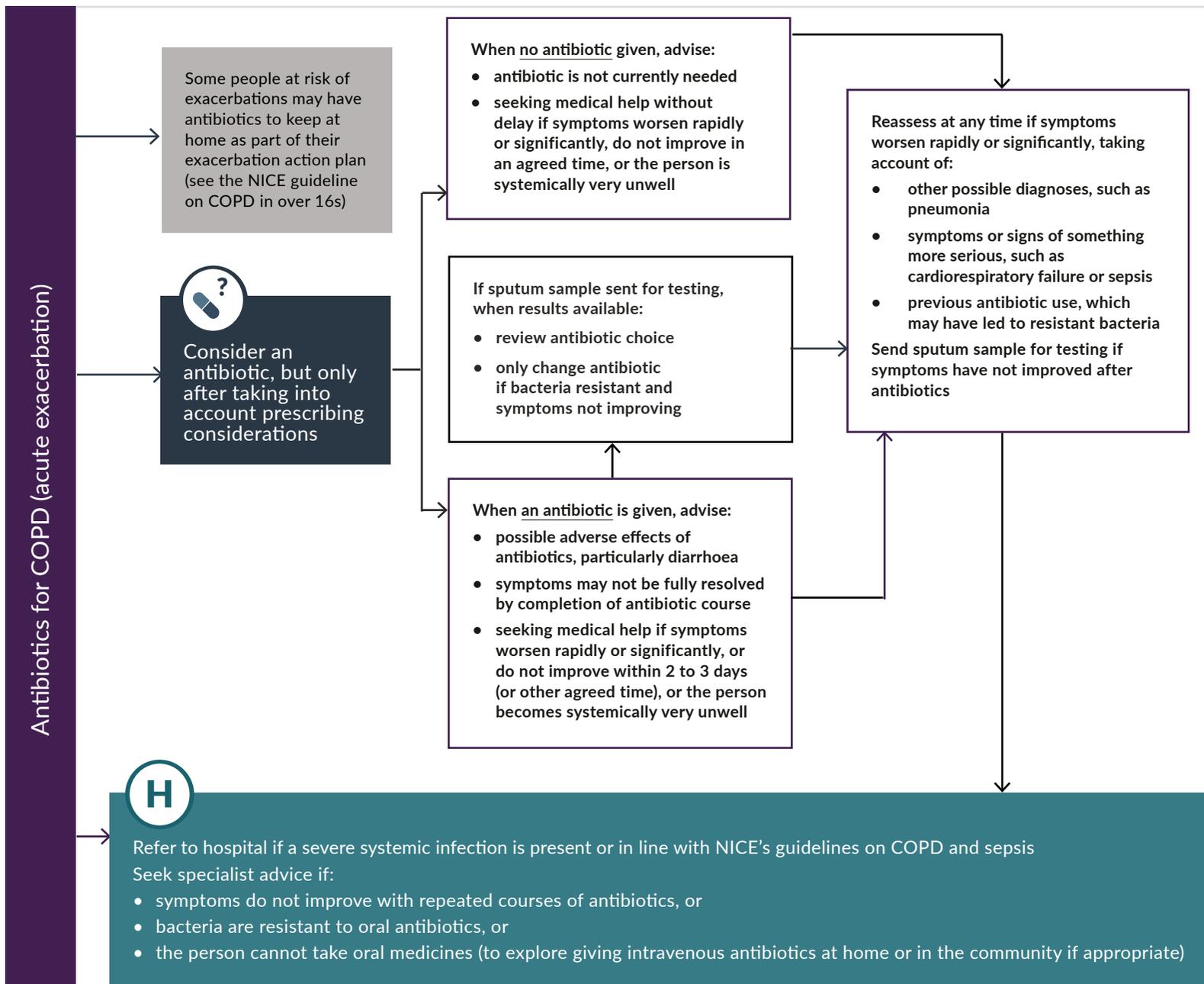


COPD (acute exacerbation): antimicrobial prescribing



i Background

- An acute exacerbation of COPD is a sustained worsening of symptoms from a person's stable state
- A range of factors (including viral infections and smoking) can trigger an exacerbation
- Many exacerbations (including some severe exacerbations) are not caused by bacterial infections so will not respond to antibiotics

🩹 Prescribing considerations

When considering antibiotics, take into account:

- the severity of symptoms, particularly sputum colour changes and increases in volume or thickness beyond the person's normal day-to-day variation
- whether they may need to go into hospital for treatment (see the NICE guideline on COPD)
- previous exacerbation and hospital admission history, and the risk of developing complications
- previous sputum culture and susceptibility results
- the risk of antimicrobial resistance with repeated courses of antibiotics

Give oral antibiotics first line if possible

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Choice of antibiotic for treating an acute exacerbation: adults aged 18 years and over

Antibiotic ^{1,2}	Dosage and course length
First choice oral antibiotics (empirical treatment or guided by most recent sputum culture and susceptibilities)	
Amoxicillin	500 mg three times a day for 5 days (see BNF for dosage in severe infections)
Doxycycline	200 mg on first day, then 100 mg once a day for 5-day course in total (see BNF for dosage in severe infections)
Clarithromycin	500 mg twice a day for 5 days (see BNF for dosage in severe infections)
Second choice oral antibiotics (no improvement in symptoms on first choice taken for at least 2 to 3 days; guided by susceptibilities when available)	
Use alternative first choice (from a different class)	As above
Alternative choice oral antibiotics (if person at higher risk of treatment failure ³ ; guided by susceptibilities when available)	
Co-amoxiclav	500/125 mg three times a day for 5 days
Levofloxacin ⁴	500 mg once a day for 5 days
Co-trimoxazole ⁵	960 mg twice a day for 5 days
First choice intravenous antibiotics (if unable to take oral antibiotics or severely unwell; guided by susceptibilities when available) ⁶	
Amoxicillin	500 mg three times a day (see BNF for dosage in severe infections)
Co-amoxiclav	1.2 g three times a day
Clarithromycin	500 mg twice a day
Co-trimoxazole ⁵	960 mg twice a day (see BNF for dosage in severe infections)
Piperacillin with tazobactam	4.5 g three times a day (see BNF for dosage in severe infections)
Second choice intravenous antibiotics	
Consult local microbiologist (guided by susceptibilities)	
<p>¹See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, and for administering intravenous antibiotics.</p> <p>²Where a person is receiving antibiotic prophylaxis, treatment should be with an antibiotic from a different class.</p> <p>³People who may be at higher risk of treatment failure include people who have had repeated courses of antibiotics, a previous or current sputum culture with resistant bacteria, or people at higher risk of developing complications.</p> <p>⁴The European Medicines Agency's Pharmacovigilance Risk Assessment Committee has recommended restricting the use of fluoroquinolone antibiotics following a review of disabling and potentially long-lasting side effects mainly involving muscles, tendons, bones and the nervous system. This includes a recommendation not to use them for mild or moderately severe infections unless other antibiotics cannot be used (press release October 2018).</p> <p>⁵Co-trimoxazole should only be considered for use in acute exacerbations of COPD when there is bacteriological evidence of sensitivity and good reason to prefer this combination to a single antibiotic (BNF, October 2018).</p> <p>⁶Review intravenous antibiotics by 48 hours and consider stepping down to oral antibiotics where possible.</p>	

When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers.