

Antibiotic prescribing in primary care:

Therapeutic Guidelines summary table 2025



Most antibiotic use in Australia occurs in primary care. This table summarises information in *Therapeutic Guidelines* about the management of common conditions in primary care with the aim of avoiding the unnecessary use of antibiotics and promoting narrow-spectrum therapy.

Information in this table should be used in conjunction with **clinical judgement**. Prescribers should consider the **benefit–harm profile** of a drug in each patient (eg consider potential drug interactions, risk of adverse effects).

For detailed and up-to-date information, including **second-line treatment** options and management of **special patient groups** (eg penicillin hypersensitivity, kidney impairment), see [Therapeutic Guidelines](#).

For indications not covered in this primary care summary table, see [Therapeutic Guidelines](#).

If the recommended antibiotic is in shortage, for general guidance, see the [Antimicrobial shortages – clinician guidance factsheet](#) from the Australian Commission on Safety and Quality in Health Care website. For current antibiotic shortages, check the Therapeutic Goods Administration [medicine shortage reports database](#).

	Indication	First-line treatment	Notes
EAR, NOSE AND THROAT	acute rhinosinusitis	symptomatic therapy	Antibiotic therapy is rarely required – most cases are viral and self-limiting. See Therapeutic Guidelines for an approach to discussing management with the patient or carer.
	acute otitis media in children	adequate pain relief alone for most children	More than 80% of cases spontaneously resolve without antibiotic therapy. Advise the patient or carer to return if symptoms do not improve within 2 days. Antibiotic therapy does not improve pain at 24 hours or significantly reduce the risk of complications. For every 100 children treated with an antibiotic, only 5 children will be better at 2 to 3 days; almost 5 000 children would need antibiotic therapy to prevent one case of mastoiditis. See Therapeutic Guidelines for resources to support discussion with the patient or carer. Antibiotic therapy is more likely to prevent complications in children: • with a cochlear implant • with immune compromise • who reside in a remote community with a prevalence of chronic suppurative otitis media more than 4%. Antibiotic therapy may reduce symptom duration by approximately 12 hours in children: • with otorrhoea • younger than 6 months • younger than 2 years with bilateral infection • who are systemically unwell (fever alone is not an indication). For children more likely to benefit from antibiotic therapy, use: amoxicillin 15 mg/kg up to 500 mg orally, 8-hourly for 5 days OR if adherence to an 8-hourly regimen is unlikely amoxicillin 30 mg/kg up to 1 g orally, 12-hourly for 5 days. For risk assessment and treatment recommendations for Aboriginal and Torres Strait Islander children, see the Otitis media guidelines for Aboriginal and Torres Strait Islander children.

	Indication	First-line treatment	Notes
	acute pharyngitis and tonsillitis	patients not at high risk of acute rheumatic fever: symptomatic therapy for most cases patients at high risk of acute rheumatic fever: phenoxymethylpenicillin 500 mg (child: 15 mg/kg up to 500 mg) orally, 12-hourly for 10 days OR benzathine benzylpenicillin intramuscularly, as a single dose adult: 1.2 million units (2.3 mL) child less than 10 kg: 0.45 million units (0.9 mL) child 10 kg to less than 20 kg: 0.6 million units (1.2 mL) child 20 kg or more: 1.2 million units (2.3 mL)	Most cases are viral. For patients not at high risk of acute rheumatic fever, even if infection is bacterial, antibiotic therapy is of limited benefit. See Therapeutic Guidelines for resources to support discussion with the patient or carer. For patients at high risk of acute rheumatic fever, antibiotic therapy is recommended because the increased risk of acute rheumatic fever and resultant rheumatic heart disease outweighs the risk of harms from potentially unnecessary antibiotic therapy. For assessment of risk of acute rheumatic fever, see Therapeutic Guidelines.
RESPIRATORY TRACT	acute bronchitis	symptomatic therapy	Antibiotic therapy is not indicated. Most cases are viral; even if infection is bacterial, antibiotic therapy is of limited benefit. See Therapeutic Guidelines for resources to support discussion with the patient or carer.
	COPD exacerbation	nonantibiotic therapy (eg inhaled bronchodilators, oral corticosteroid therapy)	Antibiotic therapy is not routinely recommended for a COPD exacerbation; the benefit of antibiotic therapy is related to the likelihood of bacterial infection and the severity of the exacerbation. For patients suitable to be managed in the community, it is safe to withhold antibiotic therapy because treatment does not consistently improve outcomes. However, consider antibiotic therapy if there is an increase in sputum purulence with increased sputum volume and/or increased dyspnoea. If antibiotic therapy is indicated, use: amoxicillin 500 mg orally, 8-hourly for 5 days OR if adherence to an 8-hourly regimen is unlikely amoxicillin 1 g orally, 12-hourly for 5 days OR doxycycline 100 mg orally, daily for 5 days. See Therapeutic Guidelines for more information and resources to support discussion with the patient or carer.
	low-severity community-acquired pneumonia in adults	amoxicillin 1 g orally, 8-hourly; see Notes column for duration of therapy	Review the patient's preferences, comorbidities and goals of care to decide whether hospital admission is required – see Therapeutic Guidelines. For patients suitable to be managed in the community, develop a follow-up plan. If the patient has a significant medical comorbidity (eg advanced heart, liver or kidney disease; frailty) and follow-up within 48 hours may not occur, consider using initial combination therapy (eg amoxicillin plus doxycycline) – see Therapeutic Guidelines. The usual duration of therapy is 5 days; consider stopping on review at day 3 if the patient is clinically stable. If the patient is not clinically stable by day 5, see <i>Therapeutic Guidelines</i> for advice on patient review and duration of therapy.
	low-severity community-acquired pneumonia in residents of an aged-care facility	amoxicillin 1 g orally, 8-hourly; see Notes column for duration of therapy	Establish whether the resident has an advance care plan, and if antibiotic therapy is appropriate. If antibiotic therapy is indicated, determine the location of care. If pneumonia is suspected to be caused by atypical pathogens [NB1] (eg Legionella species), see Therapeutic Guidelines. The usual duration of therapy is 5 days; consider stopping on review at day 3 if the resident is clinically stable. If the resident is not clinically stable by day 5, see <i>Therapeutic Guidelines</i> for advice on patient review and duration of therapy.

	Indication	First-line treatment	Notes
	low-severity community-acquired pneumonia in children 2 months or older	amoxicillin 25 mg/kg up to 1 g orally, 8-hourly for 3 days	Viruses are the main cause of community-acquired pneumonia in children 2 months or older, but clinical features do not reliably distinguish between viral and bacterial pathogens. Children who have widespread pulmonary wheeze or crackles but no focal changes on chest X-ray are more likely to have viral pneumonia. Consider performing NAAT (eg PCR) to detect respiratory viruses. If a viral cause is suspected or confirmed, symptomatic therapy alone is recommended. If the child is not improving after 48 to 72 hours, or symptoms worsen at any time, reassess the diagnosis – see Therapeutic Guidelines.
DENTAL	localised odontogenic infection	a dental procedure	Prescribe analgesia and refer the patient to the dentist for urgent treatment. Explain that antibiotic therapy without dental intervention will not be effective. If a dental procedure is unlikely to occur within 24 hours or the infection is spreading and causing facial swelling, see Therapeutic Guidelines.
URINARY TRACT	acute cystitis in nonpregnant adult females [NB2] who require antibiotic therapy, including residents of an aged-care facility	nitrofurantoin 100 mg orally, 6-hourly for 5 days	Nonpregnant adult females younger than 65 years may become symptom-free within 1 week without antibiotic therapy. See Therapeutic Guidelines for the approach to nonantibiotic therapy. For indications for taking a urine sample for culture and susceptibility testing, see Therapeutic Guidelines. Retrospective data suggest that nitrofurantoin is safe and effective for acute cystitis in patients with a GFR of 30 mL/min or more. Do not use ciprofloxacin or norfloxacin unless susceptibility testing rules out all alternative antibiotics – see Therapeutic Guidelines. For additional considerations for residents of an aged-care facility, see Therapeutic Guidelines.
	acute cystitis in pregnancy	nitrofurantoin 100 mg orally, 6-hourly for 5 days	Take a urine sample for culture and susceptibility testing before starting antibiotic therapy, and repeat 1 to 2 weeks after treatment is completed. Avoid using nitrofurantoin close to delivery – see Therapeutic Guidelines.
	acute cystitis in children 3 months or older	children who can swallow tablets or capsules: nitrofurantoin orally, 6-hourly for 5 days child 29 kg to 50 kg: 50 mg child more than 50 kg: 100 mg children who weigh less than 29 kg or cannot swallow tablets or capsules: cefalexin 12.5 mg/kg up to 500 mg orally, 6-hourly for 3 days OR if adherence to a 6-hourly regimen is unlikely cefalexin 20 mg/kg up to 750 mg orally, 8-hourly for 3 days	It can be difficult to distinguish pyelonephritis from cystitis in young children. If bacteriuria and either fever (38°C or higher) or loin pain or tenderness are present, treat as acute pyelonephritis; see Therapeutic Guidelines. Take a urine sample for culture and susceptibility testing before starting treatment. For information on methods to obtain urine samples, see Therapeutic Guidelines.
	infection of bites and other wounds caused by teeth (including human, cat, dog) not requiring surgery and not associated with systemic symptoms or deeper tissue involvement	amoxicillin+clavulanate 875+125 mg (child 2 months or older: 22.5+3.2 mg/kg up to 875+125 mg) orally, 12-hourly for 5 days	Wound care is essential for management; thoroughly clean, irrigate and debride wounds. Elevate and immobilise injured limbs. Check the patient's tetanus immunisation status and consider other vaccine requirements (eg rabies virus) – see Therapeutic Guidelines for more information. Antibiotic therapy may not be required if the wound is not infected – see Therapeutic Guidelines.

	Indication	First-line treatment	Notes
SKIN AND SOFT TISSUE	cellulitis or erysipelas without systemic symptoms or extensive erythema	dicloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly; see Notes column for duration of therapy OR flucloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly; see Notes column for duration of therapy if <i>Streptococcus pyogenes</i> (group A streptococcus [GAS]) or other beta-haemolytic streptococci are suspected based on clinical presentation (eg nonpurulent, recurrent cellulitis): phenoxymethylpenicillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly; see Notes column for duration of therapy	Beta-haemolytic streptococci, including <i>Streptococcus pyogenes</i> (group A streptococcus [GAS]), are the most common cause of nonpurulent, recurrent cellulitis. <i>Staphylococcus aureus</i> is often associated with purulent cellulitis, penetrating trauma or ulceration. See Therapeutic Guidelines for when to consider other pathogens, including MRSA. See <i>Therapeutic Guidelines</i> for the management of periorbital, orbital and peritonsillar cellulitis. In children, cefalexin is often preferred to dicloxacillin or flucloxacillin because the liquid formulation is better tolerated, use: cefalexin 12.5 mg/kg up to 500 mg orally, 6-hourly OR if adherence to a 6-hourly regimen is unlikely cefalexin 20 mg/kg up to 750 mg orally, 8-hourly. The usual duration of therapy is 5 days. Advise patients to return for review after 5 days if symptoms are not improving; see Therapeutic Guidelines for advice.
	impetigo	patients with nonrecurrent limited nonbullous impetigo (up to 2 sores) who are not at high risk of acute rheumatic fever: mupirocin 2% ointment or cream topically to crusted areas, 8-hourly for 5 days patients with extensive (more than 2 sores), recurrent or bullous impetigo and patients at high risk of acute rheumatic fever: dicloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 5 days. Stop after 3 days if infection has resolved OR flucloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 5 days. Stop after 3 days if infection has resolved	For assessment of risk of acute rheumatic fever, see Therapeutic Guidelines. For a printable patient handout with general measures to reduce the spread of impetigo, see Therapeutic Guidelines. In children, cefalexin is often preferred to dicloxacillin or flucloxacillin because it is dosed less frequently and the liquid formulation is better tolerated, use: cefalexin 25 mg/kg up to 1 g orally, 12-hourly for 5 days. Stop therapy after 3 days if infection has resolved. If impetigo is not improving, take a skin swab for culture and susceptibility testing.
	acute mild infection of diabetes-related foot ulcers	dicloxacillin 500 mg orally, 6-hourly for 10 days OR flucloxacillin 500 mg orally, 6-hourly for 10 days	See Therapeutic Guidelines if the patient has: • systemic symptoms • infection involving structures deeper than the skin or subcutaneous tissue • erythema extending more than 2 cm from the wound margin • infection or ulcer that has been present for 4 weeks or longer • used an antibiotic within the last few weeks • risk factors for MRSA infection.
	lactational mastitis	nonantibiotic therapy (see Notes column) patients who have not improved after 24 to 48 hours of nonantibiotic therapy: dicloxacillin 500 mg orally, 6-hourly. If clinical features resolve rapidly, 5 days of therapy may be sufficient; otherwise continue for 10 days OR flucloxacillin 500 mg orally, 6-hourly. If clinical features resolve rapidly, 5 days of therapy may be sufficient; otherwise continue for 10 days	Patients without systemic symptoms do not have lactational mastitis. Key aspects of nonantibiotic therapy for lactational mastitis are: • rest • adequate milk drainage; advise patients to continue breastfeeding and/or expressing milk • minimising inflammation and pain; this involves - applying heat to the breast before feeding (eg warm shower, heat pack) and cold packs after - avoiding pressure on the breast; any massaging should be gentle - using pain relief; paracetamol and ibuprofen are safe to use while breastfeeding. For detailed information on managing lactational mastitis, see Therapeutic Guidelines.

COPD = chronic obstructive pulmonary disease; GFR = glomerular filtration rate; MRSA = methicillin-resistant *Staphylococcus aureus*; NAAT = nucleic acid amplification testing; PCR = polymerase chain reaction.
NB1: There is no universally accepted definition of atypical pathogens. The term is used to describe bacteria that are intrinsically resistant to beta lactams and not identifiable by standard blood or sputum cultures.
NB2: The term 'female' is used to include all people [presumed female at birth](#).