# Area Prescribing Committee Bulletin December 2025

📌 **Quick Overview**

Stay up to date with the Nottinghamshire APC decisions from September and November guideline meetings.


*1 - Link to APC website*


*2 - Link to APC Joint Formulary*

## Contents



**Short on time?** Click on the grey square bulletin icon, bottom right of your screen, review the thumbnails and jump to the section you want to read first.

# New and updated Guidelines

## *Antimicrobial Guidelines:*

### Community Acquired Pneumonia (CAP)

- NICE recommendation of **3-days** treatment for certain age groups of children.
- When to refer and the addition of patient and parent/carer advice.
- Additional information added for children and young adults, advice around prescribing capsules and tablets. Hyperlinks to the supporting materials aimed to educate parents/carers/children/young people on how to swallow capsules and tablets have been included.
- Additional advice added regarding the recovery timeframe for CAP.

**Antibiotic Treatment for Children and Young People Over 1 Month and Under 18 Years**

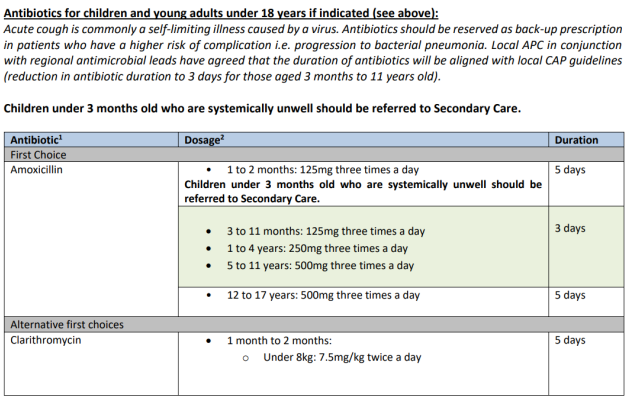
| Medicine | Oral Dose | Duration of Treatment |
|---|---|---|
| **First Choice oral antibiotics if non-severe signs and symptoms** | | |
| Amoxicillin (higher doses can be used for all ages; see BNF for children) | 1 month to 2 months: 125 mg three times a day | 5 days |
| | 3months – 11 months: 125mg three times a day<br>1 – 4 years: 250mg three times a day<br>5 – 11 years: 500mg three times a day | **3 days** |
| | 12 - 17 years, 500 mg three times a day | 5 days |
| Alternative oral antibiotics if non-severe symptoms or signs, for penicillin allergy or if amoxicillin unsuitable e.g.atypical pathogens suspected. | | |
| Clarithromycin | 1 month to 2 months:<br>Under 8 kg, 7.5 mg/kg twice a day | 5 days |
| | 3 months to 11 years:<br>Under 8 kg: 7.5mg/kg twice a day<br>8 kg – 11 kg: 62.5mg twice a day<br>12 kg – 19 kg: 125mg twice a day<br>20 kg – 29 kg: 187.5mg twice a day<br>30 kg – 40 kg: 250mg twice a day | **3 days** |
| | 12 to 17 years: 250mg to 500mg twice a day | 5 days |
| **OR** Erythromycin (In pregnancy) | 8 years to 11 years, 250 mg to 500 mg four times a day | **3 days** |
| | 12 years to 17 years, 250 mg to 500 mg four times a day | 5 days |
| **OR** Doxycycline (See BNF for children for use of doxycycline in children <12years) | 12 to 17 years: 200mg first day then 100mg once daily for 4 days | 5 days in total |

### Acute cough bronchitis

Acute cough is commonly a self-limiting illness caused by a virus. **Antibiotics should be reserved as back-up prescription in patients who have a higher risk of complication** i.e. progression to bacterial pneumonia.

- Local APC in conjunction with regional antimicrobial leads have agreed that **the duration of antibiotics will be aligned with local CAP guidelines (reduction in antibiotic duration to 3 days for those aged 3 months to 11 years old)**.
- Children under 3 months old who are systemically unwell should be referred to Secondary Care.

- The term ‘delayed antibiotics’ was changed to ‘back-up’ to align with National Institute of Clinical Excellence (NICE) terminology.
- Links to the Treat Antibiotics Responsibly, Guidance, Education and Tools (TARGET) tools have been added. This aims to support the conversations around the back-up antibiotic prescription.



**Antibiotics for children and young adults under 18 years if indicated (see above):**

*Acute cough is commonly a self-limiting illness caused by a virus. Antibiotics should be reserved as back-up prescription in patients who have a higher risk of complication i.e. progression to bacterial pneumonia. Local APC in conjunction with regional antimicrobial leads have agreed that the duration of antibiotics will be aligned with local CAP guidelines (reduction in antibiotic duration to 3 days for those aged 3 months to 11 years old).*

**Children under 3 months old who are systemically unwell should be referred to Secondary Care.**

| Antibiotic[1] | Dosage[2] | Duration |
|---|---|---|
| First Choice | | |
| Amoxicillin | • 1 to 2 months: 125mg three times a day<br>**Children under 3 months old who are systemically unwell should be referred to Secondary Care.** | 5 days |
| | • 3 to 11 months: 125mg three times a day<br>• 1 to 4 years: 250mg three times a day<br>• 5 to 11 years: 500mg three times a day | 3 days |
| | • 12 to 17 years: 500mg three times a day | 5 days |
| Alternative first choices | | |
| Clarithromycin | • 1 month to 2 months:<br>  ○ Under 8kg: 7.5mg/kg twice a day | 5 days |

## Otitis Externa

- Added information for children from the *Pragmatic antimicrobial prescribing guidelines for children & young people in primary care*, Feb 25.
- New section on Urgent referral criteria to Ear, Nose and Throat (ENT) specialist.
- The information regarding **Aminoglycoside antibiotic preparations** was highlighted in the table with the treatment options, to be visible at the point of prescribing rather than just in the comments box: ***Contraindicated in perforated tympanic membrane and patent grommet as contains an aminoglycoside - unless advised by a specialist for treatment of obvious infection.***
- Otosporin® and Betnesol-N® were added to table - already on the formulary.
- **Ciprofloxacin drops** are only available from the specialists, being classified as **Amber2.** We added clarification in the table for when it is appropriate to use: ***Ciprofloxacin ear drops can be considered if there are contraindications or resistance detected on culture to aminoglycoside preparations and an antibiotic preparation is still required.***
- Added the combination of ciprofloxacin with dexamethasone drops to the table - already classified as Amber2 on the formulary.
- Corticosteroid only drops were moved lower in the treatment table and we added some examples as to when it is advisable to chose a steroid only ear drop vs a combined one: ***Consider in positive culture resistant to both Ciprofloxacin & Gentamicin; or if it is primarily an inflammatory skin condition; and to reduce***

***inflammation and give a break from antibiotics (excess use of ear drops with antibiotics can cause contact dermatitis).***

| Medicine | Dosage | Duration | Comments |
|---|---|---|---|
| **FIRST LINE** | | | |
| Acetic Acid 2% spray or drops **(Available OTC)** | One spray at least three times a day. Maximum 2-3 hourly (≥12 years) | 7 days | **As effective as topical antibiotics in mild otitis externa.** |
| **SECOND LINE** | | | |
| Combined corticosteroid and **Aminoglycoside antibiotic** preparations **CONTRAINDICATED IN PERFORATED TYMPANIC MEMBRANE AND PATENT GROMMET** | | | |
| Betamethasone 0.1% with Neomycin 0.5% (drops: Betnesol-N®) | Apply 2–3 drops 3–4 times a day. (Adult and child*) | 7 days | Contraindicated in perforated tympanic membrane and patent grommet as contains an aminoglycoside - unless advised by a specialist for treatment of obvious infection. |
| Dexamethasone 0.1% with Neomycin 0.5% and acetic acid 2% (spray) (Previously branded as Otomize®spray.) | One spray three times a day. (Adult and children ≥2 years) | 7 days | Contraindicated in perforated tympanic membrane and patent grommet as contains an aminoglycoside - unless advised by a specialist for treatment of obvious infection |



| | | | |
|---|---|---|---|
| Hydrocortisone 1%, neomycin sulphate 3400 units, polymyxin B sulphate 10,000 units/mL (drops: Otosporin®) | Apply 3 drops 3–4 times a day (Adults and children ≥3 years) | 7 days | Contraindicated in perforated tympanic membrane and patent grommet as contains an aminoglycoside - unless advised by a specialist for treatment of obvious infection. |
| Dexamethasone with framycetin 0.5% and gramicidin 0.005% (drops: Sofradex®) | Apply 2-3 drops every 3-4 hours. (Adult and child *) | 7 days | Contraindicated in perforated tympanic membrane and patent grommet as contains an aminoglycoside - unless advised by a specialist for treatment of obvious infection. |
| Hydrocortisone Acetate 1% with Gentamicin 0.3% **(Note - high cost)** | Apply 2-4 drops 4-5 times a day including a dose at bedtime. (Adult and child*) | 7 days | Contraindicated in perforated tympanic membrane and patent grommet as contains an aminoglycoside - unless advised by a specialist for treatment of obvious infection. |
| Corticosteroid preparations Consider in positive culture resistant to both Ciprofloxacin & Gentamicin; or if it is primarily an inflammatory skin condition; and to reduce inflammation and give a break from antibiotics (excess use of ear drops with antibiotics can cause contact dermatitis). | | | |
| Prednisolone Sodium Phosphate 0.5% drops | 2-3 drops every 2-3 hours. (Adult and *) | 7 days | Lower potency. Reduce frequency when relief obtained |
| Betamethasone 0.1% drops | 2-3 drops every 2-4 hours. (Adult) | 7 days | Higher potency. Reduce frequency when relief obtained |

| | | | |
|---|---|---|---|
| Antifungal preparations | | | |
| Clotrimazole 1% solution **(Available OTC)** | 2-3 drops two to three times a day. (Adult and child *) | For at least 14 days after infection resolution | Prescribe as solution, no specific ear drop preparation available. **Counsel patient that once the symptoms have improved/disappeared, to continue treatment for 14 days.** |
| Combined corticosteroid and antibiotic/antifungal preparations | | | |
| Flumetasone pivalate 0.02% + clioquinol 1% (Previously branded as Locorten Vioform®.) | 2-3 drops twice a day. (Adult and children ≥2 years) | 7-10 days | |
| Other antibiotic preparations: Ciprofloxacin ear drops can be considered if there are contraindications or resistance detected on culture to aminoglycoside preparations and an antibiotic preparation is still required. | | | |
| Ciprofloxacin 0.2% (Cetraxal® UDV drops) ***Amber 2** - On specialist advice only* | Instil contents of ONE ampoule twice a day. (Adults and children ≥1year) | 7 days | Previously used eye drops, now available as licensed ear drops 0.2%. |
| Ciprofloxacin 0.3% and dexamethasone 0.1% combination ear drops ***Amber 2** - On specialist advice only* | Apply 4 drops twice daily (Adults and children ≥1year) | 7 days | |
| * The terms child or children are used generically to describe the entire range from infant to adolescent (1 month–17 years). An age range is specified when the dose information applies to a narrower age range than a child from 1 month–17 years. BNF | | | |

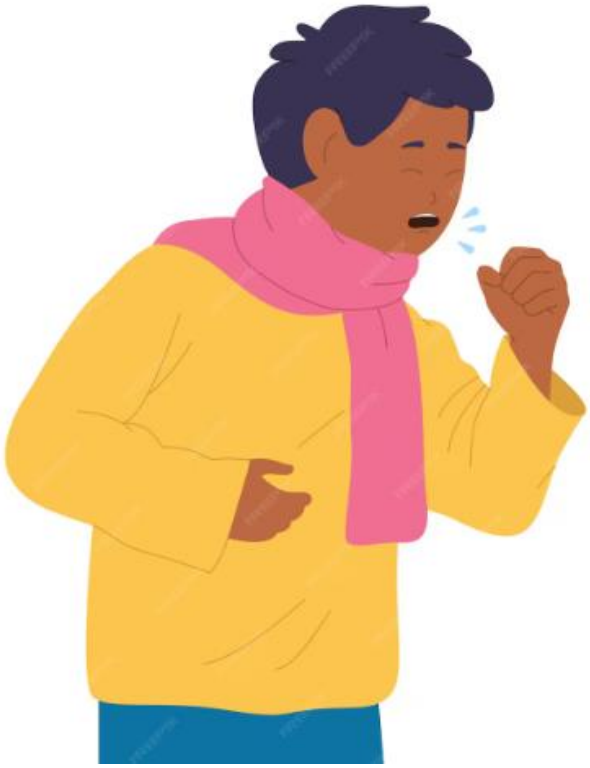
## Whooping Cough

In the ***treatment section***, the advice regarding antibiotic prescribing 14 days vs 21 days from cough onset was clarified:

- **If admission is not necessary and the onset of the cough is within the previous 14 days→** prescribe antibiotic treatment at dose and duration as outlined in table.
- **If the infected patient has household or other close contact who is in the priority** Group 1 **for public health action →** the **window for prescribing antibiotics** from the onset of cough can be **increased to 21 days** (usually 14 days).

In the ***prophylaxis section,*** the advice is to prescribe antibiotics to close contacts of the 'index case' when coughing in the 'index case' started within the previous 14 days and the close contact is in a priority group for public health action.

More information was added as per UKHSA guidance regarding exclusion from school/work of contacts with suspected/confirmed Pertussis.



## Acute Diverticulitis

There were no significant changes to the recommendations, but the guideline has been rearranged to enhance its readability. The main changes include:

- Table detailing features of complicated diverticulitis (it was previously noted in the guideline but without further details on the symptoms of complicated diverticulitis).
- Those with immunosuppression or significant comorbidities were included in the group where antibiotics should be offered, as per the NICE guideline/Clinical Knowledge Summary guideline and to offer consistency with the NUH acute diverticulitis guideline.

*Features which suggest complicated acute diverticulitis:

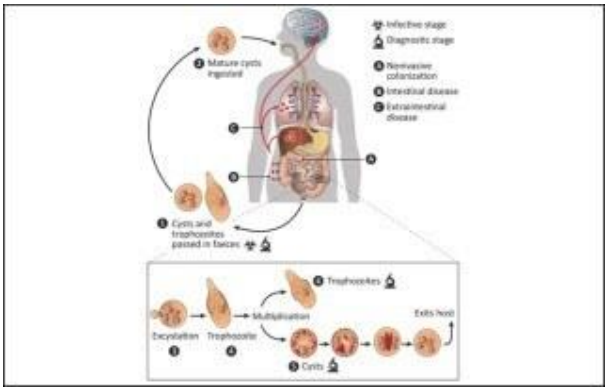
| Symptom or sign | Possible complication |
|---|---|
| Abdominal mass on examination or peri-rectal fullness on digital rectal examination | Intra-abdominal abscess |
| Abdominal rigidity and guarding on examination | Bowel perforation and peritonitis |
| Altered mental state, raised respiratory rate, low systolic blood pressure, raised heart rate, low tympanic temperature, no urine output or skin discolouration | Sepsis |
| Faecaluria, pneumaturia, pyuria or the passage of faeces through the vagina | Fistula into the bladder or vagina |
| Colicky abdominal pain, absolute constipation (passage of no flatus or stool), vomiting or abdominal distention | Intestinal obstruction |

## Amoebiasis

There are no changes to recommendations following the review against NICE CKS, however, more information was added to the following:

- The microorganism causing the infection and areas in the world with high rates of infection.

- Incubation period and what further tests required if continued suspicion after negative stool sample.
- **Microbiological clearance needed to confirm treatment success, 1 week after completing treatment**.
- Link to self-care have been added.



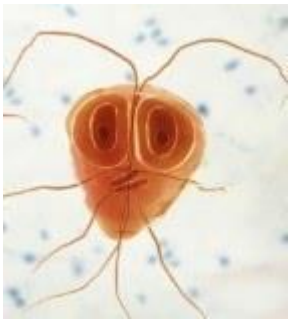
[Cryptosporidiosis]

There are no changes to recommendations, following the review against NICE CKS, however, more information was added with regards to:

- Transmission of Cryptosporidiosis, incubation period and duration of infection.
- Further investigations.
- Links have been added to: Self-care advice (NICE CKS), Public Health advice on how to avoid getting and passing the infection and where to report the disease.

**Giardiasis**

There are no significant changes to the recommendations, following the review against NICE CKS guidance, but the document has been rearranged to improve readability.



## Infectious Diarrhoea

There are no changes to recommendations following the review against NICE CKS, however, the guideline was slightly reformatted to include investigations and management as per NICE CKS.

The main changes include:

- Further information on when to consider a stool sample and what other investigations to order, depending on clinical scenarios and travel history.
- Included links to the APC Sick day rules guidance and the patient information leaflet (PIL).

**Investigations**:
Arrange for stool culture and sensitivity testing if indicated.

This is *not* routinely needed for children and adults presenting with acute diarrhoea, but should be considered, depending on clinical judgement, if:

- The person is systemically unwell or immunocompromised.
- There is acute painful diarrhoea or blood, mucus and/or pus in the stool (suggesting possible dysentery, such as caused by Shiga toxin-producing Escherichia coli [STEC] infection 0157, particularly in children).
- The person has had recent antibiotic or proton pump inhibitor treatment, or recent hospital admission (to exclude *Clostridium difficile* infection). See the CKS topic on Diarrhoea - antibiotic associated for more information.
- Diarrhoea has not resolved by day 7.
- There is suspected food poisoning.
- The person has recently travelled abroad to anywhere other than western Europe, North America, Australia, or New Zealand.
- Diarrhoea is recurrent or prolonged (lasts over 14 days).
- There is diarrhoea in a person at risk of transmission of infection, such as:
  - A food handler (work involves preparing or serving unwrapped ready to eat food and drink).
  - Clinical, social care, or nursery staff who work with young children, the elderly, or any other particularly vulnerable people.
  - Any person who is unable to perform adequate personal hygiene due to lack of capacity or ability to comply.
  - All children aged 5 years old or under (up to the sixth birthday) who attend school, pre-school, nursery, or other similar childcare or childminding groups (due to the increased risk of E. coli infection 0157).
- There is uncertainty about the diagnosis, to help exclude alternative causes for symptoms.

## Influenza

Main changes include:

• The recent change in regulations for prescribing of influenza anti-virals to allow year-round prescribing.

• Inclusion of a paragraph for empirical treatment and diagnostic testing.

• Treatment and PEP doses have been moved to separate tables for clarity.

- New section for when a patient on post-exposure prophylaxis (PEP) becomes symptomatic with influenza like illness (ILI).

**'At risk' adults and children ≥13 years of age (any circulating strain):**

| | 1st line | 2nd line (if oseltamivir cannot be given) | Duration |
|---|---|---|---|
| At risk* | **Oseltamivir PO/NG**<br><br>Dose: 75mg twice a day[1] | **Zanamivir INH**<br><br>Dose: 10mg twice a day (2 inhalations twice a day by diskhaler) | 5 days<br><br>(10 days if immunosuppressed) |

1 See BNF for appropriate use and dosing in specific populations, for example, hepatic/ renal impairment, in pregnancy and breastfeeding, or body weight <40kg

**'At risk' children <13years of age (any circulating strain):**

| | 1st line | | 2nd line | | Duration |
|---|---|---|---|---|---|
| At risk* | **Oseltamivir PO[1]** | | **Zanamivir INH** | | 5 days |
| | Infants 1-11 months[2] | 3mg/kg/dose twice a day | Children <5yr | Not licensed | (10 days if immunosuppressed) |
| | Children 1 to 12 years: 10-15kg | 30mg twice a day | Children >5y | 10mg twice a day (2 inhalations twice a day by diskhaler) | |
| | Children 1 to 12 years: >15-23kg | 45mg twice a day | | | |
| | Children 1 to 12years: >23-40kg | 60mg twice a day | | | |
| | Children 1-12 years: >40kg | 75mg twice a day | | | |

1 See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment or renal impairment.
2 off label use in <1yr children but supported by BNFC

**Antiviral dosage and schedules for post-exposure prophylaxis (PEP)**
For otherwise healthy adults (excluding pregnant women), antivirals are not recommended

**PEP for 'at risk' adults and children ≥13 years:**

| | 1st line | 2nd line | Duration |
|---|---|---|---|
| At risk* | **Oseltamivir PO**<br><br>75mg once daily | **Zanamivir INH**<br><br>10mg once daily | 10 days |

1 See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment or renal impairment, and in pregnancy and breastfeeding





**PEP for 'at risk' children <13 years:**

| | 1st line | | 2nd line | Duration |
|---|---|---|---|---|
| At risk * | **Oseltamivir PO[1]** | | **Zanamivir INH**<br><br>Children ≥5years: 10mg once daily [2] | 10 days |
| | Infants 1-11months | 3mg/kg once a day | | |
| | Children 1-12year ≤15kg | 30mg once a day | | |
| | Children 1-12year 15-23kg | 45mg once a day | | |
| | Children 1-12year 23-40kg | 60mg once a day | | |
| | Children 1-12year >40kg | 75mg once a day | | |

1 See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment or renal impairment.
2 Zanamivir is not licensed in children <5years of age.

## Oral Candidiasis

- Added clear sections for when referral is needed for children and adults.
- Information added about sterilising feeding equipment and dummies.
- Information about treating the breast feeding parent, if the baby has a candida infection.
- Added section with treatment considerations for children.
- Further information added into the table about topical treatment, to help with patient counselling.
- In the Oral treatment table, the Fluconazole dose and duration has been updated as per BNF and NICE CKS.

**Oral treatment:**

| Medicine[1] | Dosage | Duration |
|---|---|---|
| **For severe/extensive, unresponsive symptoms (after topical treatment has been tried)** | | |
| Fluconazole[2] | Adults >16 years:<br>Initially 200–400 mg for 1 dose, to be given on first day, then 100–200 mg once daily for 7–21 days (duration may be increased in severely immunocompromised patients).<br>Immunocompromised:<br>Adults >16 years:<br>fluconazole 200–400 mg on day one, followed by 100–200 mg once daily for 7–21 (or longer if necessary). | 7–21 days (max. 14 days except in severely immunocompromised) |

[1] See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment or renal impairment, and in pregnancy and breastfeeding.
[2] **Do not prescribe in pregnancy.**
Check Medicine interactions and contraindications when prescribing oral fluconazole using BNFc or Summary of Product Characteristics

**See treatment considerations in children:**

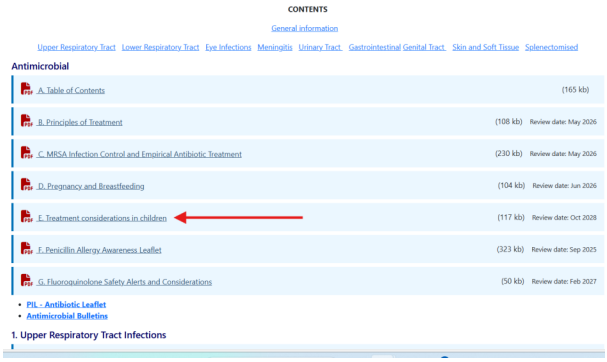
- See the local **Treatment consideration in children** document.
- Information regarding infants and breastfeeding:
  - **Thrush | Recent Illness or Concern | Healthier Together**
  - **Nystatin for Candida infections - Medicines For Children**
  - **Miconazole for oral thrush info. Miconazole cream - Patient**

## Treatment considerations in children

New document, produced following the review of the **Pragmatic Antimicrobial Prescribing Guidelines for Children & Young People in Primary Care**, published by NHS England earlier this year.

The intention is to support adherence, encourage pill swallowing in children and label penicillin allergy appropriately.

Contains links to and information from NHS Specialist Pharmacy Services, Medicines for Children website and KidzMed programme – RCPCH Learning.



CONTENTS

General information

Upper Respiratory Tract | Lower Respiratory Tract | Eye Infections | Meningitis | Urinary Tract | Gastrointestinal Genital Tract | Skin and Soft Tissue | Splenectomised

Antimicrobial

| | | |
|---|---|---|
| A. Table of Contents | (165 kb) | |
| B. Principles of Treatment | (108 kb) | Review date: May 2026 |
| C. MRSA Infection Control and Empirical Antibiotic Treatment | (230 kb) | Review date: May 2026 |
| D. Pregnancy and Breastfeeding | (104 kb) | Review date: Jun 2026 |
| E. Treatment considerations in children | (117 kb) | Review date: Oct 2028 |
| F. Penicillin Allergy Awareness Leaflet | (323 kb) | Review date: Sep 2025 |
| G. Fluoroquinolone Safety Alerts and Considerations | (50 kb) | Review date: Feb 2027 |

- PIL - Antibiotic Leaflet
- Antimicrobial Bulletins

1. Upper Respiratory Tract Infections

**Treatment considerations in children**
**Penicillin allergy labels, supporting adherence and pill swallowing**

General points:

- Incorrectly labelling a child with a **penicillin allergy** has a lifelong impact on mortality and morbidity (click here for information on correctly applying penicillin labels in children). Also see the APC penicillin allergy awareness leaflet.
- The first line antibiotics should always be trialled first as they have the best efficacy, following the measures below to optimise adherence. If a child still cannot take the medicine, then the second choice may be considered if this is likely to improve adherence.
- It is important to educate parents and carers on optimising adherence to reduce the chance of treatment failure. See information below on how to mask the taste of medicines. **If your child will not or cannot take the medicine on its own, even with a drink straight afterwards, speak with your doctor or pharmacist.**
- For information leaflets in multiple languages visit the Healthier Together website.

When to offer solid forms:

- Children should be encouraged to swallow oral solid dose forms (tablets and capsules) where possible.
- There is no right age on when children can safely and successfully start swallowing tablets - it varies widely.
- The literature suggests that tablets are potentially an acceptable formulation for children as young as 4 years old; one feasibility study showed that most children aged 4-8 years who attempted to swallow tables successfully did so.
- However, **developmental readiness should be assessed individually**.
- For children prescribed tablets/capsules, healthcare professionals should signpost parents/carers to pill swallowing information on the Medicines for Children website and resources which provide structured techniques such as the KidzMed six-step approach (KidzMed-Comic-Poster-English.pdf).

# Other updates

## Osteoporosis Guidelines

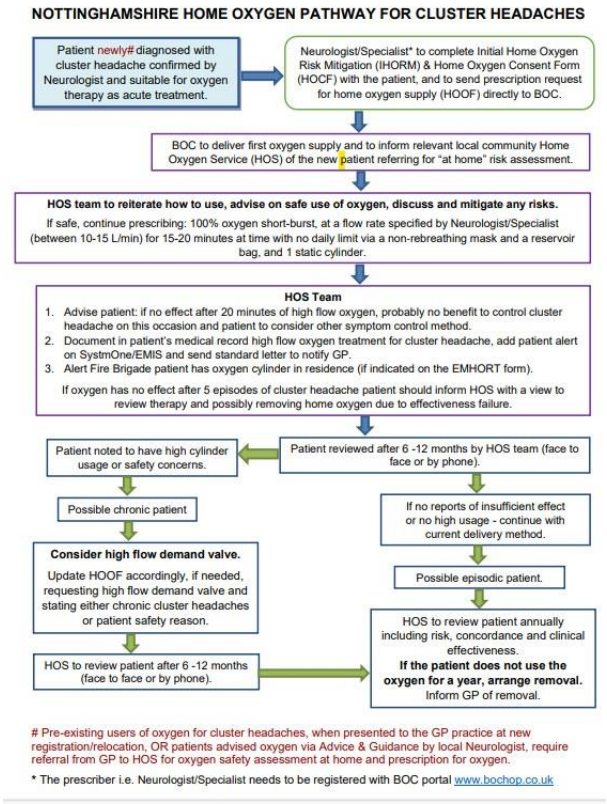
Minor update to the local Osteoporosis Guidelines. The reference values for C-terminal cross-linked telopeptide of type 1 collagen (CTX) within the guidelines have been updated to align with recently updated reference values for assays used by the local laboratory, to inform review of treatment effectiveness with oral bisphosphonates.

## Oxygen for cluster headache pathway

The Oxygen Cluster Headache Pathway has been updated and it contains some significant changes to the previous practice.  The following updates have been incorporated:

- For any patients to be newly initiated on oxygen therapy for cluster headaches, the initiating Neurology Specialist will now request oxygen supply directly from oxygen supply company (BOC), who will then report the new patient to the local home oxygen team (HOS).
- This removes the necessity to request referrals from GP to local home oxygen team (HOS) reducing the workload for neurology consultants associated with generating a request for onward referral to HOS and non-clinical workload within the GP practice, and will significantly reduce waiting times for the oxygen initiation therapy.

- GPs may occasionally be advised to generate a referral to the local HOS following advice and guidance from the Neurology Specialists, especially in cases of any pre-existing patients already established on oxygen for cluster headache management (i.e. relocated/new to the area), or when requesting initiation advice for new patients.
- Medical records of individual patients are to be flagged in clinical systems (i.e. SystmOne/EMIS) with safety alerts to inform clinical staff that the patient receives home oxygen therapy. This is to be completed by the local HOS team.
- Ongoing review of oxygen effectiveness has been clearly assigned to HOS, advising referral to the initiating consultant if deemed ineffective, rather than to a GP.
- Oxygen flow rates and maximum dosing updated as per national guidelines (NICE 2025 and British Association for the Study of Headache (BASH) 2019).




## Sick day rule guidelines

This update brings no significant changes to the current clinical practice, and the corresponding PIL required no amendments.

The following minor amendments have been incorporated:

- Extended the advice to relevant at risk patient groups to include those treated with medications for hypertension and chronic kidney disease.

- Included advice to check ketones in the affected patients with diabetes presenting within healthcare settings and taking SGLT2 inhibitors.
- Added advice on the necessary provision of information on preventing dehydration in patients with impaired renal function and taking GLP1-agonists to prevent further kidney deterioration.
- Table 1 containing the high-risk medications was modified to reverse the presentation order, listing the associated risks in the last column – for clarity and ease of navigation.
- Ketoprofen was removed from the list of oral NSAID – no local prescribing.

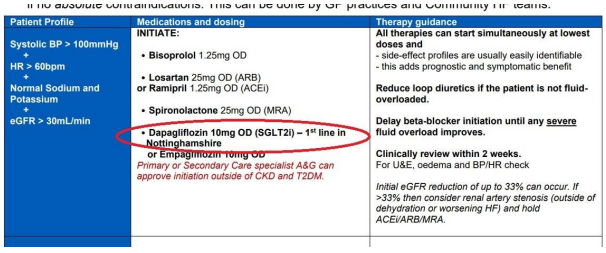
**Table 1: SADMAN Rules: classes of medication that should be temporarily stopped during intercurrent illness (non-exhaustive)**

| | Examples | | Associated risk if continued during an acute illness that can lead to dehydration: |
|---|---|---|---|
| S | **SGLT-2 Inhibitors** | Names ending with: *'flozins' dapagliflozin, empagliflozin, canagliflozin, ertugliflozin* | Euglycemic diabetic ketoacidosis – if a patient with diabetes presents unwell, their blood ketone levels should be checked by the clinician, even if blood glucose levels are in normal range. No routine prescrbing of ketone testing strips is advised solely for use by patients on SGLT-2 inhibitors. |
| A | **ACE-I inhibitors** | Names ending with: *'prils'* ramipril, lisinopril, perindopril, enalapril, captopril | Acute Kidney Injury (AKI) due to reduced renal efferent vasoconstriction. |
| D | **Diuretics*** | Names ending with: *'ide'* or *'one'* bendroflumethiazide, furosemide, bumetanide, or spironolactone, eplerenone | AKI |
| M | **Metformin** | metformin, metformin SR | Lactic acidosis |
| A | **ARBs** | Names ending in: 'sartans' losartan, candesartan, valsartan, irbesartan | AKI |
| N | **NSAIDs (oral)** | ibuprofen, naproxen, diclofenac | AKI due to reduced renal afferent vasodilation |

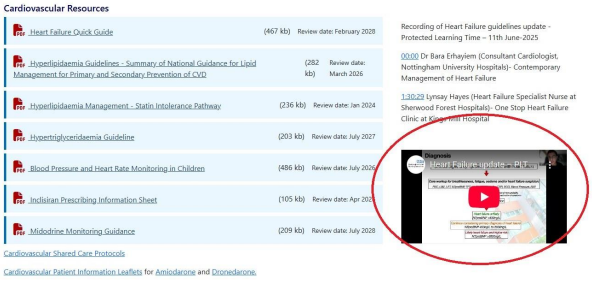
**Once the person is feeling better and is able to eat and drink for 24–48 hours, these medications should be restarted.**

## Heart Failure guideline

- Following communications from NHS England, the HF guideline will state that **dapagliflozin is the first line SGLT2 inhibitor to be used locally**.
- Following consultation with NUH, there is no need for changes to our local guidance following the NICE update in September.
- The term 'quick' to be removed from the Heart Failure Guideline.
- Recording from PLT session in June has now been uploaded on the APC website under the Cardiology section.



| Patient Profile | Medications and dosing | Therapy guidance |
|---|---|---|
| **Systolic BP > 100mmHg + HR > 60bpm + Normal Sodium and Potassium + eGFR > 30mL/min** | **INITIATE:**<br>• **Bisoprolol** 1.25mg OD<br>• **Losartan** 25mg OD (ARB) **or Ramipril** 1.25mg OD (ACEi)<br>• **Spironolactone** 25mg OD (MRA)<br>• **Dapagliflozin 10mg OD (SGLT2i) – 1st line in Nottinghamshire or Empagliflozin 10mg OD**<br>*Primary or Secondary Care specialist A&G can approve initiation outside of CKD and T2DM.* | **All therapies can start simultaneously at lowest doses and**<br>- side-effect profiles are usually easily identifiable<br>- this adds prognostic and symptomatic benefit<br>**Reduce loop diuretics if the patient is not fluid-overloaded.**<br>**Delay beta-blocker initiation until any severe fluid overload improves.**<br>**Clinically review within 2 weeks.**<br>For U&E, oedema and BP/HR check<br>*Initial eGFR reduction of up to 33% can occur. If >33% then consider renal artery stenosis (outside of dehydration or worsening HF) and hold ACEi/ARB/MRA.* |




## ASTHMA IN CHILDREN aged 5-11 years

The Nottinghamshire APC guideline has been updated in line with the national guideline NICE NG245 and offers a visual summary of the first-line treatment options and dosing, current licensing, prescribing tips, asthma review, non-pharmacological and greener NHS considerations.

The following changes have been incorporated:

- To mirror the NICE guideline structure, the guidance for young people aged 12 to 17 years has been removed from this guideline; this is now included in the current Nottinghamshire APC Asthma 12 and over guideline.
- Maintenance And Reliever Therapy (MART) is positioned as a default 2nd line option for a child with the ability to use it.
- In November 2025, only 1 budesonide/formoterol dry powder inhaler (100 micrograms/6 micrograms per inhalation) was licensed for MART in children aged 6 to 11. The use of any other ICS/formoterol inhalers for MART in children under 12 would therefore be *off label*.
- Conventional Pathway Inhalers: Fobumix® Easyhaler is now licensed for children 6 years and older and has therefore been added as an option for conventional/regular therapy.
- Referral information: amended to remove ‘specialist asthma’ and reads ‘refer to paediatrician’ to reflect the current pathways. Patient referrals are assessed and referred to the appropriate team.
- Max regular ICS doses per day table refers to Children's British National Formulary (CBNF) and NICE doses and is updated to include Symbicort MDI.
- Assess symptoms – now reads consider lung function, Fractional Exhaled Nitric Oxide (FeNo), spirometry, peak flow as per NICE.

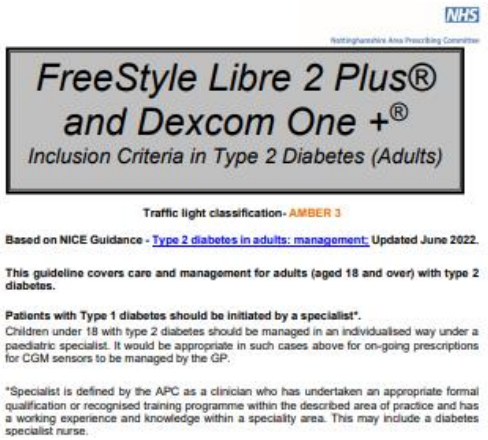

## FreeStyle Libre 2 Plus® and Dexcom One +®Inclusion Criteria in Type 2 Diabetes (Adults)

The inclusion criteria has been reviewed in accordance to the review date. There has been no update around CGM from NICE.

NHSE are working towards a standard CGM formulary, although a timescale for this is not yet confirmed.

Following the review of this document, it was confirmed that the criteria was aligned to the current product licence.

Although no change has been made to the main NICE criteria for inclusion, clarity has been added, with a specific section on CGM in pregnancy and CGM in dialysis.




# Publications

### Podcasts

Listen now to our latest podcast episode - PILS ep 20, December 2025, Influenza - where our guests

- **Dr Nancy Allen**, **Infectious Diseases and Virology Registrar at Nottingham University Hospitals** and
- **Fiona Branton**, **Head of Infection Prevention and Control, Nottingham City Care Partnership CIC**,

cover the latest updates in the Influenza guideline, the recent change in legislation, the Think Flu leaflet and common misconceptions around flu.


*3 - https://open.spotify.com/episode/59J6miu68A3BE10OA3x3SI?si=28bb76261e5c4dc7*

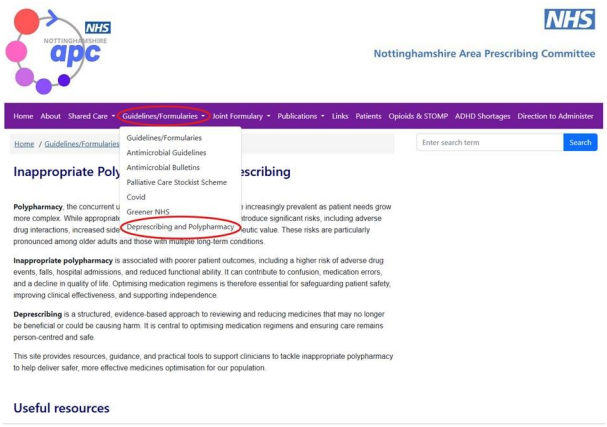
*4 - Link to APC webinars up to April 2025.*

*5 - Link to APC podcasts*

## Feature of the month: Deprescribing and Polypharmacy

A new Deprescribing and Polypharmacy drop-down section has recently been added to the APC website to support clinicians in tackling inappropriate polypharmacy. This section of the APC website seeks to provide a range of resources, guidance documents, and practical tools which have been designed to help healthcare professionals assess medication regimens and engage in meaningful conversations with patients. These practical tools offer clinicians navigation to tackle inappropriate polypharmacy and implement deprescribing safely and effectively.

Nottinghamshire APC : Inappropriate Polypharmacy and Deprescribing




## 📅 Coming Soon - APC work programme January 2026

APC work programme January 2025:

- Transgender collaborative care protocol and prescribing information (July 25)
- Endocrine Update Inappropriate request template letter (Nov 25)
- Bariatric Surgery - Monitoring and Medication Post Surgery (Sept 25)
- HRT guidance - New
- Sativex shared care protocol MS - New
- Valproate SCP (July 25) - Update
- Rosacea guidelines - New
- Adult headache pathway - Update
- Antimicrobial guidelines - Updates
- Vit D adults guidelines and PIL - Minor update
- End of Life Guidance - Update

## Merry Christmas and a Happy New Year!

The work of the Nottinghamshire Area Prescribing Committee is supported and managed by the interface team.

We can be contacted via

Email: nnicb-nn.nottsapc@nhs.net

**Visit:** Nottinghamshire APC Website

**View: Meeting Minutes, Bulletins, Formularies on Teamnet**