

ACUTE SINUSITIS (ADULTS) V2.1

Comments from the Expert Advisory Group

- GPs can use the [Respiratory infection information leaflet \(including self-care and safety-netting advice\)](#) during consultations with patients presenting with acute sinusitis where there is no immediate need for an antibiotic.
- Acute sinusitis usually follows a common cold. Symptoms for 10 days or less are more likely to be associated with a cold rather than an acute sinusitis.
- Prolonged symptoms (10 days or more with no improvement) could be due to either viral or bacterial acute sinusitis.
- Consider the use of high dose intranasal steroids in people presenting with symptoms for around 10 days or more. See table below.
- Bacterial sinusitis is usually self-limiting and does not routinely need antibiotics. 80% of cases resolve in 14 days without antibiotics and offer only marginal benefit after day 7.
- Advise self-care for all patients.
- Consider a no antibiotic strategy for patients with symptoms less than 10 days unless systemically very unwell.
- Consider a no antibiotic or delayed antibiotic prescription in people presenting with symptoms for around 10 days or more without clinical improvement.
- Offer an immediate antibiotic prescription for patients systemically very unwell, with immunosuppression, or signs of severe infection or high risk of complications.
- Refer to hospital if symptoms of sinusitis with a severe systemic infection, intraorbital or periorbital complications.
- Reassess if symptoms worsen rapidly or significantly despite taking treatment.
- Bacterial cause may be more likely if several of the following are present:
 - Symptoms for more than 10 days
 - Discoloured or purulent nasal discharge
 - Severe localised unilateral pain (particularly pain over teeth and jaw)
 - Fever
 - Marked deterioration after an initial milder phase

Symptom relief

- For pain or fever, consider paracetamol (or ibuprofen where appropriate).
- Little evidence of benefit but patients may wish to try short-term use of systemic decongestants, topical decongestants or saline preparations for local irrigation (e.g. nasal rinses, sprays, drops).
- Advise to consult pharmacist for symptom relief.

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Treatment

ACUTE SINUSITIS NON-ANTIBIOTIC TREATMENT TABLE			
<ul style="list-style-type: none"> For adults who have symptoms > 10 days consider topical intranasal corticosteroid. Examples of intranasal corticosteroids that have been shown in studies to improve symptoms of acute sinusitis include: 			
Drug	Dose	Duration	Notes
Fluticasone Furoate 27.5 microgram/dose nasal spray	Two sprays per nostril every 24 hours (i.e total of 110 micrograms every 24 hours)	14 days	Off-label use
OR			
Mometasone Furoate 50 microgram/dose nasal spray	Two sprays per nostril, every 12 hours (i.e. total of 200 micrograms every 12 hours)	14 days	Off-label use
SINUSITIS ANTIBIOTIC TREATMENT TABLE			
<ul style="list-style-type: none"> Consider no antibiotic strategy if symptoms <10 days Consider a no or delayed antibiotic strategy if symptoms > 10 days if not systemically very unwell, no signs of severe infection or not at high risk of complications Offer immediate antibiotic prescription if systemically very unwell, signs of severe infection or high risk of complications. 			
If antibiotics deemed clinically indicated:			
Drug	Dose	Duration	Notes
1st choice options			
Amoxicillin	500mg every 8 hours	5 days	Avoid in penicillin allergy
OR			
Doxycycline <i>(First line in penicillin allergy)</i>	200mg every 24 hours OR 100mg every 12 hours. OR in non-severe infection, doxycycline 200mg stat then 100mg every 24 hours	5 days	Contraindicated in pregnancy. Advise to take with a glass of water and sit upright for 30 minutes after taking. Absorption of doxycycline significantly impaired by antacids, iron/ calcium/ magnesium/ zinc-containing products and should be separated by at least 3 hours. Risk of photosensitivity.
OR			
Clarithromycin <i>(Second line in penicillin allergy)</i>	500mg every 12 hours	5 days	See macrolide warnings and check drug interactions before prescribing. Macrolides should be used with caution in pregnancy. Clarithromycin should only be used in 2nd and 3rd trimester in pregnancy. Alternative macrolide in all trimesters of pregnancy: azithromycin 500mg stat then 250mg every 24 hours from Day 2 to Day 5.
For severe/ worsening infection			
Co-amoxiclav	500/125mg every 8 hours	5 days*	Avoid in penicillin allergy. See alternatives above.

* The general recommendation is for 5 days initial antibiotic treatment. However, a total of 7 to 10 day course of antibiotics may be considered in select cases.

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Patient Information

- [HSE A-Z, Sinusitis](#)