Managing Common Infections

Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing

Stakeholder comments table

11/07/2017 – 07/08/2018

ID	ORGANISATION NAME	DOCUMENT	PAGE NO.	LINE NO.	COMMENTS	DEVELOPER'S RESPONSE
1	Neonatal and Paediatric Pharmacists Group (NPPG)	Guideline	9	3-7	We agree with the recommendations that these agents should not be used to prevent acute exacerbations of bronchiectasis in children.	Thank you for your comment.
2	Neonatal and Paediatric Pharmacists Group (NPPG)	Guideline	5-7	Table 1 & 2	We agree with the recommendation to review treatment after 7 days and either stop the antibiotic if clinically stable or continue for a further 7 days as appropriate.	Thank you for your comment. The Committee agreed to amend the recommendation to treat for 7 to 14 days, to reflect that course length will be based on an assessment of the person's severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous microbiology results and response to treatment.
3	British Infection Association				We support shortened antibiotic courses as described in this guideline.	Thank you for your comment. The Committee agreed to amend the recommendation to treat for 7 to 14 days, to reflect that course length will be based on an assessment of the person's severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous microbiology results and response to treatment.
4	British Infection Association		8 et seq		We are very concerned that in the absence of very strict criteria for initiation of prophylactic antibiotics, and moreover, specific recommendations on maximum duration in any given period, prophylaxis will be started at a low threshold and continued indefinitely, thereby a) providing modest, if any, benefit to the patient; b) increase risk of adverse effects / interactions; c) most importantly of all give rise to increased	Thank you for your comment. This was discussed by the Committee and changes to the guideline have been made which reflect the evidence identified, stakeholder comments and Committee discussion regarding antibiotic prophylaxis. The Committee agreed to add recommendations to seek specialist advice about management options for people with repeated acute exacerbations, which may include a trial of antibiotic prophylaxis. It is important to consider antibiotic prophylaxis

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					resistance, given that other guidance (eg draft guidance on antimicrobial prescribing in COPD exacerbations pg 13, ln 5) accepts worse clinical outcomes in order to support the AMR stewardship agenda. We would suggest initiation criteria of >=5 exacerbations in the previous 12 months and maximum duration of 3 months.	alongside other options, and as a trial with review. A recommendation has been added that a trial of antibiotic prophylaxis (with oral or inhaled antibiotics) in people with repeated acute exacerbations should only be initiated on the advice of a specialist, following an individualised and shared-decision making discussion of the potential risks and benefits.
5	Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the United Kingdom who practice in the field of Bronchiectasis. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments. The College welcomes this review of Bronchiectasis (non-Cystic Fibrosis), acute exacerbation: anti-microbial prescribing by NICE. It recognises that management protocols need to change with changes in the understanding of disease, its assessment and its treatment. It particularly notes that protocols need to take cognisance of anti-microbial resistance. It recognises the importance of working with Patients to manage their disease.	Thank you for your comment.
6	Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	Our expert reviewers make the following comments: The intention of reducing unnecessary antibiotic use is helpful. Healthcare professionals will have no issue with the technical wording.	Thank you for your comment. The Committee considered your comment and were satisfied that the wording was appropriate. NICE guidelines aim to include terms that will be understood by lay readers as far as possible, but some more technical language will be needed at times.

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					However, patients/families will struggle to follow some of the technical terms. They may be unnecessarily alarmed by the use of some terms – such as cardiorespiratory failure and sepsis when describing deteriorating symptoms. This may drive them to seek antibiotics in an attempt to avoid this.	
7	Royal College of Nursing				Advised that they have no comments to submit on this occasion	Thank you.
8	British Thoracic Society	General			The British Thoracic Society (BTS) had no prior knowledge of the preparation of this guideline. The guideline refers to the 2010 BTS guideline on non-CF bronchiectasis. However, the Society has produced an update to the 2010 BTS Guideline which was made available for public consultation in April/May 2018. The final guideline is now in press for publication before the end of the year. We would be happy to share the final content of the guideline with colleagues at NICE to ensure consistency of advice to both clinicians and patients. There are several discrepancies with current BTS guidance with recommendations of treatment of exacerbations, use of muco-active therapies and discussion of long term prophylactic antibiotic therapy. These discrepancies are unhelpful and will cause confusion in management for readers. The muco-active treatments and prophylactic sections are incomplete- we strongly recommend these sections be	Thank you for the offer, we would welcome a copy of the final guideline content and we welcome the BTS contributions. Thank you for your comment. This antimicrobial prescribing guideline covers the management of exacerbations only, not managing stable bronchiectasis which is outside of scope. The guideline has been developed in accordance with

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					removed and referral to the BTS guidelines for these topics.	the processes and methods set out in the interim process guide for antimicrobial prescribing guidelines, which is a different process to the BTS guideline, and there could be differences in the evidence considered and the recommendations made. Following consultation, the committee has agreed a number of changes to the guideline which include changes in the sections on treatment of exacerbations with antibiotics, prevention of exacerbations with antibiotics and prevention of exacerbations with non-antimicrobials.
9	British Thoracic Society	General			We note the composition of the guideline group which has recently been made available on the NICE website. It is disappointing that the guideline group had no representation or input from respiratory medicine with expertise in bronchiectasis – this is a significant omission.	Thank you for your comment. Two respiratory specialists have been recruited to the committee for this guideline to provide expertise and experience around bronchiectasis. They participated in the Committee meeting post-consultation and will continue to contribute as appropriate in the development and finalisation of this guideline.
10	British Thoracic Society	Table 1	4		In relation to the treatment of acute exacerbations we are concerned that it is not clear when antibiotics should be prescribed. The BTS guidelines make this clear. We would not recommend macrolides are first line treatment- see updated BTS guidelines.	Thank you for your comment. The remit of this guidance is the management of common infections not diagnosis. A definition of acute exacerbation of bronchiectasis is given, and the recommendation has been amended to offer an antibiotic for people with an acute exacerbation of bronchiectasis. The choice of antibiotics for the treatment of an exacerbation was discussed further by the Committee and choices refined to empirical treatment only. A macrolide antibiotic (clarithromycin) has been retained as an option for empirical treatment (unless people are already using a macrolide for prophylaxis) because the committee agreed, based on experience, that clarithromycin will cover a number of pathogens responsible for an acute exacerbation.

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11	British Thoracic Society		15		There is a recommendation for 7 days of antibiotic and review- this will create a huge burden on primary care and is not in keeping with BTS guidance. Even if a patient improves at 7 days, this does not imply safety to stop treatment at this stage.	Thank you for your comment. This was discussed further by the Committee and they agreed to amend the recommendation to treat for 7 to 14 days. This reflects that course length will be based on an assessment of the person's severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous microbiology results and response to treatment.
12	British Thoracic Society	Table 3	9		For antibiotic prophylaxis- there are no recommendations who should receive this, there are no alternatives to macrolides and no safety recommendations- see updated BTS guidelines.	Thank you for your comment. This was discussed by the Committee and changes to the guideline have been made which reflect the evidence identified, stakeholder comments and Committee discussion regarding antibiotic prophylaxis. The Committee agreed to add recommendations to seek specialist advice about management options for people with repeated acute exacerbations, which may include a trial of antibiotic prophylaxis. It is important to consider antibiotic prophylaxis alongside other options, and as a trial with review. A recommendation has been added that a trial of antibiotic prophylaxis (with oral or inhaled antibiotics) in people with repeated acute exacerbations should only be initiated on the advice of a specialist, following an individualised and shared-decision making discussion of the potential risks and benefits. The committee agreed to remove the table of antibiotics recommended for prophylaxis because this should only be initiated on the advice of a specialist and choice will be individualised.
13	British Thoracic Society		5		IV antibiotic choices- Ceftriaxone as apparent first choice is not helpful as we should use antibiotics that have a lower risk of *C. difficile*.	Thank you for your comment. The Committee agreed to remove intravenous ceftriaxone from the table of recommended antibiotics, when antibiotic choices were refined to provide empirical treatment only.
14	British Thoracic Society		17	7	We disagree with the statement in the guidelines that inhaled antibiotics have no effect on exacerbations. This will cause	Thank you for your comment. This was discussed further by the Committee and the wording in the rationale has been amended to 'The evidence for

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					confusion and is not in line with the 2018 BTS document. A meta-analysis of inhaled antibiotic studies shows that they do reduce exacerbations by around 30%. The lack of positive phase 3 trials is a concern of course, but there are no large phase 3 trials of macrolides either. This advice should be amended to avoid causing conflict with the 2018 BTS guidelines which will suggest a role for inhaled antibiotics for patients with recurrent infections due to *Pseudomonas aeruginosa* infection. The statement that "the evidence base was limited with low patient numbers in all studies" in the inhaled antibiotic section is incorrect - several of the trials of inhaled antibiotics are much larger than the macrolide studies.	nebulised or inhaled antibiotics was particularly limited, and not all products studied are available in the UK. As a class, prophylaxis with nebulised or inhaled antibiotics did not significantly reduce exacerbations in adults.' No reference has been given for the meta-analysis showing inhaled antibiotics reduce exacerbations by around 30%. The BTS 2018 document discusses a systematic review by Yang et al 2016, in which 43.3% had exacerbations with inhaled antibiotics compared with 57.8% in the control group; RR 0.75 (95% CI 0.61 to 0.92). This meta-analysis by Yang et al 2016, was deprioritised because a better quality systematic review, Hnin et al, 2015 (which reported individual study results more clearly for exacerbations) was included. In a subgroup analysis of Hnin et al 2015, inhaled antibiotics did not significantly reduce the number of participants with exacerbations compared with placebo or standard care: 32.9% versus 44.4%; RR 0.73, 95% CI 0.44 to 1.22). Following Committee discussion of the evidence identified and stakeholder comments, the recommendation on antibiotic prophylaxis has been amended to specialist initiation only. The committee agreed to remove the table of antibiotics recommended for prophylaxis because this should only be initiated on the advice of a specialist and choice will be individualised.
15	British Thoracic Society		18		Non-antimicrobial interventions: it is very disappointing that this section does not mention airway clearance, treatment of the underlying cause of bronchiectasis or management of co-morbidities but mentions recombinant DNAse. If mentioning DNAse	Thank you for your comment. This antimicrobial prescribing guideline covers the management of exacerbations only, not managing stable disease which is outside of scope. Airway clearance, which is an ongoing treatment for stable disease, treatment of the underlying cause of

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					why not also address hypertonic saline or mucoactive drugs like carbocisteine which are used widely in the UK?	bronchiectasis or management of co-morbidities were excluded at protocol stage. This guideline originally considered all non-antimicrobial interventions including hypertonic saline and mucoactive agents, but only included interventions which had studies with exacerbation outcomes, not other 'stable disease' outcomes, for example lung function. Following stakeholder consultation, the scope was amended to remove the section on non-antimicrobial interventions for the prevention of acute exacerbations of bronchiectasis, and related recommendations have been removed.
16	British Thoracic Society	General			We strongly urge NICE to ensure that this guideline is substantially revised to take account of the new BTS guidelines and the views and expertise of the respiratory specialty in providing recommendations for the management of this serious condition.	Thank you for your comments. The Committee have considered all of the BTS comments and have made amendments with consideration of the evidence and Committee discussion.
17	Royal College of General Practitioners		4	14	The course length for amoxicillin in this guideline is 7 days whilst that in the new guideline for acute exacerbation of COPD is 5 days. This may lead to some confusion	Thank you for your comment. The Committee agreed based on evidence and experience that 7 days is the minimum treatment duration for antibiotics in people with an acute exacerbation of bronchiectasis. The bacteria responsible for acute exacerbations of bronchiectasis can be different to those responsible for exacerbations of other respiratory conditions, such as COPD. Therefore, antibiotic choice and duration can differ.
18	Royal College of General Practitioners	General			There is no mention in the guideline about the guideline committee's view on the use of delayed scripts or prophylactic long-term antibiotics	Thank you for your comment. No evidence was identified regarding back-up antibiotics (delayed scripts), therefore no recommendations could be given. Recommendations are given on long-term prophylactic antibiotics in section 1.3 of the guideline: preventing acute exacerbations of bronchiectasis.

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19	Royal College of General Practitioners	General			There is no mention of the role of testing C reactive protein (CRP) or procalcitonin (PCT) in the decision to prescribe antibiotics	Thank you for your comment. The remit of this guidance is the management of common infections not diagnosis, therefore further detail on C reactive protein or procalcitonin testing is out of scope.
20	Scottish Antimicrobial Prescribing Group	Questions 1-4			No significant challenges with implementation as the recommendations reflect current practice. Key challenges for clinicians in primary care are deciding when to start and stop treatment.	Thank you for your comment.
21	Scottish Antimicrobial Prescribing Group	Visual summary	1 2		Clarify that initial treatment is empirical or based on last sputum sample Review choice of antibiotic – for clarity suggest adding 'if one has been started empirically' Box marked H - last bullet point suggests "(to explore giving intravenous antibiotics at home or in the community if appropriate)". Does the committee wish to specifically refer to OPAT services? It could also include "hospital at home" services. Perhaps "(to explore giving intravenous antibiotics at home or in the community using OPAT or Hospital at Home Services, if appropriate and available)". In the section on prophylaxis (bottom left), the use of nebulised antibiotics is not included. The full guideline does not support the use of nebulised antibiotics and this should be stated here and within section 1.3 of the guideline. Table on left (Choice of antibiotic for treatment....). Under "First choice	Thank you for your comments. The Committee have considered your comments and made changes to the guideline and visual summary. First choice antibiotics are now specified as being for empirical treatment in the absence of current susceptibility data (guided by most recent sputum culture and susceptibilities where possible). The wording around reviewing the choice of antibiotic when susceptibility results are available has not been amended. The recommendation around seeking specialist advice for an acute exacerbation of bronchiectasis if the person cannot take oral medicines is to explore locally available options for giving intravenous antibiotics at home or in the community, rather than in hospital, where this is appropriate. The committee discussed this wording and felt it was appropriate and general enough to cover various specific terms that may be used locally. The section on prophylaxis was discussed by the Committee and changes to the guideline have been made which reflect the evidence identified, stakeholder comments and Committee discussion. The Committee agreed to add

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					intravenous antibiotic" the entries for ciprofloxacin and co-amoxiclav should have the same information in brackets as in the lines above i.e. co-amoxiclav (**not** if *Pseudomonas aeruginosa*) and ciprofloxacin (**for** *Pseudomonas aeruginosa*). For footnote 5, add text similar to footnote 4 i.e. review intravenous antibiotics by 48 hours and consider stepping down to oral antibiotics where possible. Review again after 7 days and either stop the antibiotic if clinically stable or continue for a further 7 days as appropriate. In the notes section of the table for antibiotic prophylaxis, there should be a stronger and more specific reference to the risk of drug interactions with macrolides, the risk of QTc prolongation and the risk of sudden cardiac death when using these drugs. These issues are touched on the in full guideline document but I think they should be stated in the visual guide as there is space to do so. The dose of ciprofloxacin given for adults is a range either 500mg or 750mg orally or 400mg two or three times daily for intravenous administration. How should clinicians know which dose to choose and when? Some additional information would be useful in the table and the full guidance. All of this information should be replicated in the full guideline.	recommendations to seek specialist advice about management options for people with repeated acute exacerbations, which may include a trial of antibiotic prophylaxis. A recommendation has also been added that a trial of antibiotic prophylaxis (with oral or inhaled antibiotics) in people with repeated acute exacerbations should only be initiated on the advice of a specialist, following an individualised and shared-decision making discussion of the potential risks and benefits. The committee agreed to remove the table of antibiotics recommended for prophylaxis because this should only be initiated on the advice of a specialist and choice will be individualised. The committee agreed to remove reference to specific pathogens from the table of recommended antibiotics, when antibiotic choices were refined to provide empirical treatment only. The visual summary has been amended to reflect the updated guideline, and footnotes amended. The visual summary has been amended to reflect the updated guideline, but this is a summary of the recommendations and cannot give as much detail as the guideline. The Committee agreed to remove ciprofloxacin for adults from the table of recommended antibiotics, when antibiotic choices were refined to provide empirical treatment only. The visual summary has been amended to reflect the updated guideline.
22	Scottish Antimicrobial Prescribing Group	Draft guideline	4		Formatting - Table heading at bottom of page 4 instead of on page 5	Thank you for your comment. This guideline is a web-based document and the wording and

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						formatting has been considered by the NICE publishing team.
23	Scottish Antimicrobial Prescribing Group	Draft guideline	10		It would be helpful to include a definition of what bronchiectasis is here and in Visual summary background before describing what an exacerbation is	Thank you for your comment. The guideline has been amended to provide a definition of bronchiectasis in addition to a definition of an acute exacerbation of bronchiectasis. The visual summary has been amended to reflect the updated guideline, but this is a summary of the recommendations and cannot give as much detail as the guideline.
24	Scottish Antimicrobial Prescribing Group	Draft guideline	10 onwards		In the Rationales section some important issues appear not to have been considered: • There is evidence for nebulised colistin for Pseudomonas colonisation (paper by Howarth et al) so a recommendation about a trial of nebulised colistin would seem reasonable. • The suggestion of 7 days of antibiotics and then review may be read as 7 days and this 7 is rarely sufficient in an exacerbation. Antibiotics for 14 days with review at 7 days might be more reasonable, because occasionally they could be stopped. Problem faced in secondary care is that GPs don't give the antibiotics for long enough. • Not sure about use of doxycycline in bronchiectasis if there is an alternative, because of it being bacteriostatic, so not ideal in the context of impaired host defence.	Thank you for your comments. The Haworth et al (2014) paper was identified in the search, but was originally excluded on population and therefore was not considered in the development of the guideline. Following Committee discussion, this paper has been included in the evidence review, and a discussion of the evidence included in the rationale. The recommendations on prophylaxis were discussed by the Committee and changes to the guideline have been made which reflect the evidence identified, stakeholder comments and Committee discussion. The Committee agreed to add recommendations to seek specialist advice about management options for people with repeated acute exacerbations, which may include a trial of antibiotic prophylaxis. A recommendation has also been added that a trial of antibiotic prophylaxis (with oral or inhaled antibiotics) in people with repeated acute exacerbations should only be initiated on the advice of a specialist, following an individualised and shared-decision making discussion of the potential risks and benefits. The committee agreed to remove the table of antibiotics recommended for prophylaxis because this should only be initiated on the advice of a specialist and choice will be individualised.

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						The Committee discussed your comment regarding 7 days of antibiotics and review. They agreed to amend the recommendation to treat for 7 to 14 days, to reflect that course length will be based on an assessment of the person's severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous microbiology results and response to treatment. The Committee considered your comment regarding doxycycline and did not amend the guideline as the bacteriostatic nature of the antibiotic was felt to be less relevant in respiratory infections.
25	The British Society for Antimicrobial Chemotherapy (BSAC)	Non-CF bronchiectasis Draft Guideline	General	General	The document fails to recognise that for *chronic* infections with *Pseudomonas aeruginosa* in non-CF bronchiectasis antimicrobial susceptibilities are unreliable and are unlikely to predict clinical responses (see Gillham et al, J Antimicrob Chemother 2009; 63: 728-32) as is also observed in CF. At present the document makes a number of potentially misleading statements regarding basing the choice of antibiotics on susceptibilities (e.g. p2, sections 1.1.3 and 1.1.4, Tables 1 & 2 on p4-7, etc). The document should add caveats to make it clear that chronic *P. aeruginosa* infection (often manifest by the appearance of the mucoid phenotype) is an exception to this rule	Thank you for your comment. Gillham et al (2009) did not meet the inclusion criteria as it is not an intervention study. The Committee has considered your comment and agreed to remove reference to specific pathogens from the recommended antibiotics table. First choice antibiotics are now specified as being for empirical treatment in the absence of current susceptibility data. When current susceptibility data are available, antibiotics should be chosen accordingly, consulting local microbiologists as needed.
26	The British Society for Antimicrobial Chemotherapy (BSAC)	Draft for consultation	2	19	*1.1.4 When results of sputum culture and susceptibility testing are available:* □ *review the choice of antibiotic, and* □ *only change the antibiotic according to susceptibility results if bacteria are resistant and symptoms are not already improving*	Thank you for your comment. The committee discussed this and felt the word 'change' was appropriate.

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					Suggest the word 'escalate' instead of 'change' – I assume you don't intend to prevent people from de-escalating in response to sensitivity tests??	
27	NHS Leeds Clinical Commissioning Group	Guideline	General	General	We welcome a separate bronchiectasis treatment guideline.	Thank you.
28	NHS Leeds Clinical Commissioning Group	Visual summary	2 and 3	General	Could the intravenous antibiotics on pages 2 and 3 of the visual summary be made more obvious that they are IV meds for hospital consideration only e.g. add "IV" to the end of dose directions for each medication. This could ensure that these antibiotics are not inadvertently seen as options for oral use at the IV doses.	Thank you for your comment. Wording and formatting was considered by the NICE publishing team and no change has been made. The table heading for these sections states these are intravenous antibiotics.
29	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Draft Guidance	6	Tablet	BTS guidance for management of non CF bronchiectasis states for 14 days – however guidelines do comment that further studies are necessary. Evidence in paediatrics even more limited. However appreciate that shortest course that is likely to be effective should be used where possible and that guidance is for review at 7 days rather than stop. This would likely be a change in practice / may result in a cost saving.	Thank you for your comment. The Committee have discussed your comment and agreed to amend the recommendation to treat for 7 to 14 days. This reflects that course length will be based on an assessment of the person's severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous microbiology results and response to treatment.
30	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Draft Guidance	6	Table	We try to avoid prescribing erythromycin in children due to the QDS dosing regimen / GI side effect profile – clarithromycin would be preferred macrolide much better tolerated often resulting in better adherence / less risk of resistance than azithromycin.	Thank you for your comment. The Committee considered your comment and erythromycin has been removed from the recommended antibiotics table for children, and clarithromycin retained.
31	UK Clinical Pharmacy Association (UKCPA)	Draft Guidance	6	Table	Both ceftriaxone SPC and BNF-C quote doses for children > 12 years (and over 50kg) as per adult dosing. However in many paediatric centres children > 12 years of age are still prescribed	Thank you for your comment. The Committee agreed to remove ceftriaxone from the table of recommended antibiotics, when antibiotic choices were refined to provide empirical treatment only.

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	Pharmacy Infection Network				ceftriaxone on a mg/kg basis as for children < 12 years of age, with a maximum dosage of 4g daily. For example a 13 year old weighing 45kg may be prescribed a dose of 3.6g (80mg/kg) or a 13 year old weighing 55kg may be prescribed a dose of 4g rather than 2g. I would have thought 50mg/kg dose would be sufficient unless you are wanting to achieve CNS penetration?	
32	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Draft Guidance	9	Table	Recommendation for prophylaxis – in practice azithromycin is the most frequently used antibiotic due to its once daily dosing regimen. Most evidence comes from CF population – specifically Mondays, Wednesdays, Fridays rather than 3 consecutive days of the week (i.e. discrete treatment doses). Azithromycin does have a long half-life being increased risk of resistance.	Thank you for your comment. The section on prophylaxis was discussed by the Committee and changes to the guideline have been made which reflect the evidence identified, stakeholder comments and Committee discussion. The committee agreed to remove the table of antibiotics recommended for prophylaxis because this should only be initiated on the advice of a specialist and choice will be individualised.
33	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Evidence Review	17	18	Agree re lack of evidence for prophylactic antibiotics in children – however to note in practice many specialist paediatric centres are initiating children on prophylactic azithromycin.	Thank you for your comment. The section on prophylaxis was discussed by the Committee and changes to the guideline have been made which reflect the evidence identified, stakeholder comments and Committee discussion. The committee agreed to remove the table of antibiotics recommended for prophylaxis because this should only be initiated on the advice of a specialist and choice will be individualised.
34	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Draft Guidance	5	Table	What is the rationale for choosing ceftriaxone (other than suitable for OPAT) compared with other cephalosporins such as cefuroxime	Thank you for your comment. The Committee agreed to remove ceftriaxone from the table of recommended antibiotics, when antibiotic choices were refined to provide empirical treatment only.
35	UK Clinical Pharmacy Association	Draft Guidance	5	Table	Why is co-amoxiclav at the bottom of the table below the anti-pseudomonals whereas	Thank you for your comment. Co-amoxiclav is now the first antibiotic listed in the relevant sections of the table.

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	(UKCPA) Pharmacy Infection Network				the rest of the agents that don't cover pseudomonas are at the top?	
36	NHS England	Guideline	General		A useful guide to antibiotic treatment of bronchiectasis exacerbations. It only focusses on antibiotics and not on other aspects of care. There is no mention of the importance of physiotherapy, hydration, nebulised saline mucolytics etc.A more comprehensive guideline would be more helpful. (CLR)	Thank you for your comment. This antimicrobial prescribing guideline covers management of exacerbations only, not managing stable disease which is outside of scope. Physiotherapy, which is an ongoing treatment for stable disease, was excluded at protocol stage. This guideline originally considered all non-antimicrobial treatments including hypertonic saline and mucoactive agents, but only included interventions which had studies with exacerbation outcomes, not other 'stable disease' outcomes, for example lung function. Following stakeholder consultation, the scope was amended to remove the section on non-antimicrobial interventions for the prevention of acute exacerbations of bronchiectasis, and related recommendations have been removed.
37	NHS England		3	14	Recommendation to seek specialist advice does not include considerations about prophylactic antibiotics. The recommendations would be clearer if it identified the practitioner/clinical settings where such decision would be best taken - primary care or secondary care (PC)	Thank you for your comment. The Committee discussed your comment and changes to the guideline have been made. The Committee agreed to add recommendations to seek specialist advice about management options for people with repeated acute exacerbations, which may include a trial of antibiotic prophylaxis. A recommendation has been added that a trial of antibiotic prophylaxis (with oral or inhaled antibiotics) in people with repeated acute exacerbations should only be initiated on the advice of a specialist, following an individualised and shared-decision making discussion of the potential risks and benefits.