TARGET Paediatric RTIs Clinical Scenario Webinar – Panel Questions

The following document covers questions and answers given during the live webinar "From guidance to practice: Managing paediatric respiratory tract infections through clinical scenarios" in January 2026.

Find the live webinar recording here.

Answers have been provided by a group of clinical experts. They do not reflect the views of UK Health Security Agency (UKHSA) or the Royal College of General Practitioners (RCGP). *Please note the content of these webinars and this accompanying Q&A are accurate at the time of the event and are not reviewed for changes to guidance. Our clinical scenario slides are subject to evidence reviews and updated.*

1. How is the target of 25% of children receiving antibiotics annually chosen? How do we know what the correct target should be?

    - The current target is at or below 27% of children aged 0-9 years receiving one or more antibiotics in a 12-month period. This is a metric based on the population registered with a general practice.

    - 27% was chosen as the most up to date data we had for the pre-COVID pandemic period, up to March 2020, when the overall figure for England was 27%. We've seen a substantial increase since then, post pandemic and post Group A strep outbreak in 2022/23. Aside from those two challenges, there is no evidence that children now are any sicker/more co-morbid than in 2020, so it was appropriate to aim to get back to that pre-pandemic state.

    - It is hard to know what the correct target should be - we've not had the volume of prescribing characterised at a population level like this before to be able to compare to historical data.

2. What temperature is regarded as a fever in children?

    - Fever in children is defined as 38.0$^{\circ C}$ and above.

3. Is there evidence to support that the presence of exudate on swollen tonsils is an indicator that antibiotics are necessary?

- There is no evidence that to support that exudate on swollen tonsils indicates a bacterial infection or that antibiotics would be required to treat it.

- Viral pathogens, such as Epstein-Barr virus, are also associated with pus on the tonsils.

- Scoring using FeverPAIN is an accurate way of estimating the probability to Group A/C/G strep. While FeverPAIN was developed using a study population of those aged 3 and over, it has yet to be validated in children under the age of 5. NICE guidance advises that young children (under 3 years) are unlikely to present with sore throat symptoms alone and prescribers should follow the NICE guideline on fever in under 5s to support treatment in this population.

4. Should treatment with the same antibiotic persist if the patient returns after 7 days with partial relief?

    - Extended duration of antibiotic use is unlikely to help if symptoms did not respond in the first place.

    - Recommendations would include reviewing for a differential diagnosis, such as a viral infection that antibiotics would be ineffective against or a resistant infection.

5. How should comorbidities and the child presenting as ‘clinically unwell’ be considered in the decision to prescribe antibiotics for lower RTIs?

    - In managing a lower respiratory infection, where it is difficult to distinguish between bacterial and viral infection, a severity-based approach should be adopted to decide if treatment is indicated.

    - If there is evidence of a fever, respiratory distress (tachypnoea/increased work of breathing), oral antibiotics may be indicated.

    - In children with significant co-morbidities (congenital heart disease, chronic lung disease, immunodeficiency etc) a lower threshold for prescription of antibiotics may be considered.

6. Why is erythromycin not recommended for treating sore throat or otitis media in children under 8 years old, but clarithromycin is?

    - Clarithromycin is generally tolerated better than erythromycin, exhibiting fewer gastrointestinal side effects.

- Additionally, twice-a-day (BD) dosing is better for children compared to four-times-per-day (QDS) as doses can be given before and after school rather than having to be administered during the school day.

7. Would taking a throat swab at the GP contribute effectively to the management of sore throat?

    - Possibly, however, 16-18% of people asymptomatically carry *Streptococcus spp.* in their throat.

    - While a negative test may be reassuring, a positive result does not confirm a diagnosis of acute streptococcal pharyngitis on its own.

8. How many days should patients wait to start a delayed antibiotic prescription?

    - The duration of the wait to start a delayed antibiotic prescription will depend on how unwell the child is.

    - It may be recommended to start the prescription after 24 hours if the child is presenting with a fever, cough and is clearly unwell. Alternatively, if the child does not seem overly unwell and the typical duration of symptom resolution is a week, you may make a different judgement. Recommendations will be made on a case-specific basis.

9. If a patient has received antibiotics previously and they responded but symptoms did not completely resolve, would another short course of the same treatment increase risk of resistance?

    - Any antibiotic exposure, whether it is needed or not, will promote resistance.

    - It is important to aim for the shortest duration of antibiotic courses to treat infection. If there is a concern over poor response to antibiotics, it is best practice to send a sample for culture.