Clinical Guidelines for the State of Qatar

The diagnosis and management of the common cold in adults and children

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# Table of contents

1 Information about this guideline ........................................................................................................4
  1.1 Objective and purpose of the guideline .........................................................................................4
  1.2 Scope of the guideline ..................................................................................................................4
  1.3 Editorial approach .......................................................................................................................4
  1.4 Sources of evidence .....................................................................................................................5
  1.5 Evidence grading and recommendations ....................................................................................5
  1.6 Guideline Development Group members ......................................................................................6
  1.7 Responsibilities of healthcare professionals ................................................................................7
  1.8 Abbreviations used in this guideline ............................................................................................7
2 Organisation of care in Qatar ..............................................................................................................8
  2.1 Role of the Ministry of Public Health ...........................................................................................8
  2.2 Provision of care ..........................................................................................................................8
3 Key recommendations of the guideline ...............................................................................................9
4 Background information ....................................................................................................................10
  4.1 Definition ...................................................................................................................................10
  4.2 Aetiology .....................................................................................................................................10
  4.3 Natural history ............................................................................................................................10
  4.4 Complications ............................................................................................................................10
  4.5 Higher risk groups .......................................................................................................................10
5 Presentation .......................................................................................................................................11
  5.1 Clinical presentation ....................................................................................................................11
  5.2 Indications for immediate referral to the Emergency Department ................................................11
6 History ..............................................................................................................................................12
7 Examination ......................................................................................................................................13
  7.1 Clinical examination ....................................................................................................................13
  7.2 Recognising the unwell, at-risk feverish child .............................................................................13
8 Investigations .....................................................................................................................................13
9 Differential diagnosis ........................................................................................................................14
10 Management ....................................................................................................................................16
  10.1 Advice to patients, parents and carers .......................................................................................16
  10.2 Pharmacological treatment .........................................................................................................17
    10.2.1 Over-the-counter (OTC) and symptom-control medications ..............................................17
    10.2.2 Antibiotic therapy ...............................................................................................................19
  10.3 Safety-netting and follow-up ......................................................................................................20
11 Referral ...........................................................................................................................................20
12 References ......................................................................................................................................21

Diagnosis and management of the common cold in adults and children
(Date of next revision: December 2018)
1 Information about this guideline

1.1 Objective and purpose of the guideline

The purpose of this guideline is to define the appropriate diagnosis and management of the ‘common cold’ in adults and children aged over two years. The objective is to reduce inappropriate prescribing and referral of patients presenting to any provider organisation (i.e. hospitals or clinics) in Qatar. It is intended that the guideline will be used primarily by primary care physicians.

1.2 Scope of the guideline

This guideline covers the following aspects of care:
- Presentation and management of the ‘common cold’.
- Adults and children aged over two years.

Aspects of care not covered in this guideline are:
- Management of complications or bacterial infection of the upper respiratory tract e.g. tonsillitis or acute rhinosinusitis.
- Management of influenza.
- Non-infectious causes of rhinitis.
- Management of pregnant women.
- Management of immunocompromised patients.
- Children aged less than two years.

1.3 Editorial approach

This guideline document has been developed and issued by the Ministry of Public Health of Qatar (MOPH), through a process which aligns with international best practice in guideline development and localisation. The guideline will be reviewed on a regular basis and updated to incorporate comments and feedback from stakeholders across Qatar.

The editorial methodology, used to develop this guideline, has involved the following critical steps:

- Extensive literature search for well reputed published evidence relating to the topic.
- Critical appraisal of the literature.
- Development of a draft summary guideline.
- Review of the summary guideline with a Guideline Development Group, comprised of practising physicians and subject matter experts from across provider organisations in Qatar.
- Independent review of the guideline by the Clinical Governance body appointed by the MOPH, from amongst stakeholder organisations across Qatar.

Explicit review of the guideline by patient groups was not undertaken.

Whilst the MOPH has sponsored the development of the guideline, the MOPH has not influenced the specific recommendations made within it.
1.4 Sources of evidence
The professional literature published in the English language has been systematically queried using specially developed, customised, and tested search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximise retrieval of articles with certain desired characteristics pertinent to a guideline.

For each guideline, all retrieved publications have been individually reviewed by a clinical editor and assessed in terms of quality, utility, and relevance. Preference is given to publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals (i.e. journals that are read and cited most often within their field).
3. Address an aspect of specific importance to the guideline in question.

Where included, the ‘goal length of stay’ stated within this guideline is supported by and validated through utilisation analysis of various international health insurance databases. The purpose of database analysis is to confirm the reasonability and clinical appropriateness of the goal, as an achievable benchmark for optimal duration of inpatient admission.

1.5 Evidence grading and recommendations
Recommendations made within this guideline are supported by evidence from the medical literature and where possible the most authoritative sources have been used in the development of this guideline. In order to provide insight into the evidence basis for each recommendation, the following evidence hierarchy has been used to grade the level of authoritativeness of the evidence used, where recommendations have been made within this guideline.

Where the recommendations of international guidelines have been adopted, the evidence grading is assigned to the underlying evidence used by the international guideline. Where more than one source has been cited, the evidence grading relates to the highest level of evidence cited:

- **Level 1 (L1):**
  - Meta-analyses.
  - Randomised controlled trials with meta-analysis.
  - Randomised controlled trials.
  - Systematic reviews.

- **Level 2 (L2):**
  - Observational studies, examples include:
    - Cohort studies with statistical adjustment for potential confounders.
    - Cohort studies without adjustment.
    - Case series with historical or literature controls.
    - Uncontrolled case series.
  - Statements in published articles or textbooks.

- **Level 3 (L3):**
  - Expert opinion.
  - Unpublished data, examples include:
    - Large database analyses.
    - Written protocols or outcomes reports from large practices.
In order to give additional insight into the reasoning underlying certain recommendations and the strength of recommendation, the following recommendation grading has been used, where recommendations are made:

- **Recommendation Grade A1 (RGA1):** Evidence demonstrates at least moderate certainty of at least moderate net benefit.
- **Recommendation Grade A2 (RGA2):** Evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care.
- **Recommendation Grade B (RGB):** Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
- **Recommendation Grade C1 (RGC1):** Evidence demonstrates a lack of net benefit; additional research is recommended.
- **Recommendation Grade C2 (RGC2):** Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.
- **Recommendation of the GDG (R-GDG):** Recommended best practice on the basis of the clinical experience of the Guideline Development Group members.

### 1.6 Guideline Development Group members

The following table lists members of the Guideline Development Group (GDG) nominated by their respective organisations and the Clinical Governance Group. The GDG members have reviewed and provided feedback on the draft guideline relating to the topic. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

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1.7 Responsibilities of healthcare professionals
This guideline has been issued by the MOPH to define how care should be provided in Qatar. It is based upon a comprehensive assessment of the evidence as well as its applicability to the national context of Qatar. Healthcare professionals are expected to take this guidance into account when exercising their clinical judgement in the care of patients presenting to them.

The guidance does not override individual professional responsibility to take decisions which are appropriate to the circumstances of the patient concerned. Such decisions should be made in consultation with the patient, their guardians, or carers and should consider the individual risks and benefits of any intervention that is contemplated in the patient’s care.

1.8 Abbreviations used in this guideline
The abbreviations used in this guideline are as follows:

- COPD: Chronic Obstructive Pulmonary Disease
- MERS: Middle East Respiratory Syndrome
- OTC: Over-the-counter
- RSV: Respiratory syncytial virus
- URTI: Upper Respiratory Tract Infection
2 Organisation of care in Qatar

2.1 Role of the Ministry of Public Health
The Ministry of Public Health of Qatar (MOPH) has been given the responsibility to guide reform in Qatar in order to establish one of the world’s most admired and renowned healthcare systems. The MOPH’s role is to create a clear vision for the nation’s health direction, set goals and objectives for the country, design policies to achieve the vision, regulate the medical landscape, protect the public’s health, set the health research agenda, and monitor and evaluate progress towards achieving those objectives.

The MOPH has the dual mandate to develop policies and programmes to improve the people’s health so that they may enjoy longer and more productive lives, and to lay the foundation for a vibrant country for decades to come.

The MOPH does not provide clinical services. Instead its goal is to vest responsibility for care in the hands of both public and private sector healthcare institutions, whilst regulating, monitoring, and evaluating this care against agreed upon outcomes. The MOPH is committed to establishing an environment that promotes quality and wellness through policies in such areas as public health, health insurance, information technology, licensure and credentialing; and continuing medical education.

2.2 Provision of care
Healthcare provision in Qatar comprises of the following main entities:

- **Public Sector:**
  - Primary care health centres - provided by the Primary Health Care Corporation of Qatar.
  - Secondary and tertiary care hospitals and outpatient clinics - provided by the Hamad Medical Corporation (HMC).
  - Paediatric Emergency Care provided by specialist Paediatric Emergency Centres within HMC.
  - QP Clinics for personnel and families of Qatar Petroleum.
  - Sports Medicine centre provided by a specialist Sport Medicine Hospital – Aspetar.
  - Ministry of Interior clinics for personnel and families of Qatar’s police services.
  - Ministry of Defence clinics for personnel and families of Qatar’s armed forces.
  - Specialist obstetric, gynaecological and paediatric care provided by Sidra Medical & Research Center.

- **Private sector:**
  - A range of single-handed generalist and specialist clinics.
  - Polyclinics.
  - Specialist hospitals.

The aim of the MOPH’s National Health Strategy is to rebalance healthcare delivery with a greater emphasis on primary and community care and an expansion of the role played by the private sector.
3 Key recommendations of the guideline

The key recommendations of this guideline are:

Care settings:
- The common cold is a condition that should primarily be managed in a primary care setting [R-GDG].
- Management in a secondary care setting should only be considered in patients with or at risk of serious complications [R-GDG].

Investigation:
- Routine investigation of the common cold is not required [2,5,9,13][L2, RGA1].

Treatment:
- Routine treatment should primarily be symptomatic [10,25][L1, RGA1].
- Prescribing of antibiotics should be reserved for groups of patients who are at particular risk of developing complications [8,21][L1, RGA1].
4 Background information

4.1 Definition
The common cold is the conventional term used to describe [1]:
- A mild, self-limiting upper respiratory tract infection characterised by rhinorrhoea or nasal congestion.

4.2 Aetiology
There are more than 200 viral causes of common cold, the commonest being rhinoviruses. Other viruses include [2]:
- Coronavirus.
- Enteroviruses.
- Respiratory syncytial virus (RSV).

Transmission may be by [2]:
- Direct contact.
- Airborne transmission via inhalation of droplets.

4.3 Natural history
For the majority of patients, the following apply [3,4,5]:
- A common cold is a self-limiting illness.
- Symptoms peak at 3-5 days and then decrease.
- Typically resolves within 7 days, but may last up to 14 days.
- Patients with comorbidities experience more severe symptoms.

4.4 Complications
Potential complications of the common cold include [5,6]:
- Acute rhinosinusitis.
- Acute otitis media in younger children.
- Croup in young children.
- Lower respiratory tract infection.
- Acute exacerbation of bronchial asthma.
- Acute exacerbation of chronic obstructive pulmonary disease (COPD).

4.5 Higher risk groups
People most at risk of developing more severe disease and complications include [2]:
- People with comorbidities especially:
  - Chronic lung disease.
  - Chronic heart disease.
  - Chronic kidney disease.
  - Chronic liver disease.
  - Chronic neurological disease.
  - Immunosuppression.
  - Diabetes mellitus.
- Pregnant women.
- People aged 65 years and older.

Diagnosis and management of the common cold in adults and children
(Date of next revision: December 2018)
5 Presentation

5.1 Clinical presentation
The common cold, is characterised by [1,3,4,7,8]:
- Rhinorrhea.
- Nasal congestion.
- Sore throat:
  - Usually occurs on the first day and resolves shortly after.
- Cough, usually appears few days after onset of illness.
- Headache.
- Fever:
  - Fever is unusual in adults and if present will be low-grade.
- General feeling of malaise and being unwell.
- Young children may present with:
  - Mild irritability.
  - Loss of appetite.
  - Disturbed sleep.
  - Reduced activity.
  - Lack of interest.
  - Gastrointestinal symptoms.
Symptoms usually [3]:
- Peak at 3-5 days.
- Resolve within 7 days but may last up to 14 days.
- NB: A mild cough may persist at night for 2-3 weeks.

5.2 Indications for immediate referral to the Emergency Department
It is important to recognise serious illness by looking for the following symptoms and signs, and ensure patients are assessed and managed immediately in an appropriate secondary care setting [3]. If indicated, transfer to hospital should be by ambulance [R-GDG].

Possible serious illnesses include:
- Upper airway complication [3]:
  - Characterised by:
    - Stridor.
    - ‘Air hunger’.
    - Respiratory distress.
    - Toxic appearance.
    - Cyanosis.
    - Drooling.
    - Inability to swallow.
    - Trismus.
  - May be caused by:
    - Epiglottitis.
    - Peritonsillar/retropharyngeal abscess.
    - Croup (in younger children).
- Lower airway complication [3,5]:
  - Characterised by moderate or severe respiratory distress.
  - May be caused by:
    - Pneumonia.
• Exacerbation of chronic obstructive pulmonary disease or bronchial asthma.
• Foreign body inhalation.
• Cardiac condition.

• Severe headache [3,5]:
  o May be described as ‘the worst headache of their life’.
  o Accompanying symptoms may include:
    ▪ Neck stiffness.
    ▪ Vomiting.
    ▪ Severe headache.
    ▪ Focal neurological symptoms.
  o May be caused by:
    ▪ Meningitis.

6 History

Adults and children presenting with symptoms that suggest the common cold, should be offered a clinical assessment [8]. Ask specifically about the following [3,9,10,11]:

• Presenting symptoms and duration.
• Use of over-the-counter medication.
• All current medication or any other self-medication including recent courses of antibiotics.
• In children, ask about:
  o Feeding.
  o Irritability.
  o Urine output.
• Fever/rigors.
• Past medical history.
• Potential complicating factors:
  o Chronic illness such as:
    ▪ Chronic lung disease e.g. COPD, bronchial asthma, cystic fibrosis.
    ▪ Congestive heart failure.
    ▪ Sickle-cell disease.
    ▪ Diabetes.
  o Recurrent streptococcal pharyngitis.
  o Elderly patients.
  o History of rheumatic fever.
  o Immunocompromise.
  o Pregnancy.
  o Smoking history.
• Symptoms of whooping cough or recent exposure.
• Travel history to areas at high risk of respiratory epidemics e.g. MERS.
• Contact with farm animals especially close contact with camels.
7 Examination

7.1 Clinical examination
General examination is recommended in all patients and should be extended according to symptoms and signs. At a minimum, examination should include the following [10,12]:

- Measurement of vital signs.
- Examination of the chest to exclude pneumonia.

In children, consider examining [1,4,7,8,13]:

- Cervical lymph nodes.
- The ear drum.
- The throat:
  - NB: Do not examine the throat if epiglottitis is suspected as this may cause complete airway obstruction (see Section 9).

7.2 Recognising the unwell, at-risk feverish child
The following features in children with a fever should be considered as high-risk and referred as an emergency to a Paediatric Emergency Centre [10][L1, RGA1]:

- Pale/mottled/ashen/blue colour of skin lips or tongue.
- No response to social cues.
- Does not wake or if roused doesn’t stay awake.
- Weak, high-pitched or continuous cry.
- Respiratory grunting.
- Respiratory rate greater than 40 breaths per minute.
- Moderate or severe chest in-drawing.
- Reduced skin turgor.
- Non-blanching rash.
- Neck stiffness.
- Status epilepticus.
- Focal neurological signs or seizures.
- Oxygen saturation 95% or lower.
- Capillary refill rate 3 seconds or more.

8 Investigations

There are no specific investigations to diagnose the common cold [1,4,7,8][L2, RGA1].
9  Differential diagnosis

Differential diagnoses of the common cold includes:

- **Influenza [1,3,5]:**
  - Is a common cause of upper respiratory tract infection (URTI).
  - Has the potential to be more serious.
  - Milder symptoms are often misdiagnosed as the common cold.
  - Characterised by a rapid onset of:
    - Fever.
    - Myalgia.

- **Bacterial rhinosinusitis [3,14]:**
  - Usually follows an URTI.
  - Acute rhinosinusitis is usually viral initially, but antibiotics may be needed for bacterial superinfection if symptoms are dramatic.
  - Features include:
    - Prolonged upper respiratory tract symptoms.
    - One or more of the following factors present:
      - Facial pain or headache.
      - Fever.
      - Purulent nasal discharge.
      - Cough.

- **Streptococcal pharyngitis/tonsillitis [3,13,15,16]:**
  - Can be difficult to distinguish from a viral cause.
  - Symptoms vary in intensity but include:
    - Pharyngeal pain.
    - Painful swallowing.
    - High temperature.
  - More likely if the patient has the following features.
  - NB: The following features make up the Centor score and are used to assess the likelihood of streptococcal infection (see National Clinical Guideline for tonsillitis):
    - Tonsillar exudate (follicular).
    - Tender anterior cervical lymph nodes.
    - History of fever.
    - Absence of cough.

- **Infectious mononucleosis [1,5]:**
  - Features include:
    - Prolonged fever.
    - Severe sore throat.
    - Fatigue.
    - Swollen lymph nodes.
    - Marked tonsillar exudate.
    - Abdominal pain.

- **Acute otitis media [3]:**
  - Features include:
    - Ear pain.
    - Ear discharge.
- Hearing loss.
- Dizziness.
- In children, symptoms and signs may also include: fever; cough; poor feeding; irritability; pulling an ear.

- Pneumonia/bronchitis [3,10]:
  o Features include:
    ▪ Fever.
    ▪ Cough.
    ▪ Purulent mucus.
    ▪ Chest tightness.
    ▪ Dyspnoea.
    ▪ Pleuritic chest pain.
    ▪ Crepitations.
    ▪ Wheezing/rhonchi.
  o Particularly consider if the patient:
    ▪ Is a smoker.
    ▪ Is asthmatic; or has other lung disease.
  o Particularly consider in children with:
    ▪ Vomiting
    ▪ Oxygen saturation of 95% or less.
    ▪ Cyanosis.
    ▪ Tachypnoea
    ▪ Nasal flaring.
    ▪ Chest in-drawing.
    ▪ Chest crepitations on auscultation.
    ▪ Abdominal pain.

- Epiglottitis [3]:
  o Features include:
    ▪ Severe sore throat.
    ▪ Painful swallowing.
    ▪ Alteration in voice.
    ▪ Drooling.
    ▪ Stridor.
  o NB: If suspected, do not examine the throat.

- Whooping cough (pertussis) [1,3,5]:
  o Prodromal symptoms may be similar to the common cold but it is distinguishable once the characteristic cough develops.
  o Features include:
    ▪ Paroxysmal cough.
    ▪ Characteristic ‘whoop’.
    ▪ Vomiting after coughing.

- Croup [3]:
  o Features include:
    ▪ Change in voice.
    ▪ Stridor.
    ▪ Barking cough.
• Non-infectious/allergic rhinitis [3].
  o Features include:
    ▪ History of aggravating factors.
    ▪ Itching of eyes, nose or ears.
    ▪ Watery rhinorrhea.
    ▪ Sneezing.
    ▪ Nasal congestion.
    ▪ Postnasal drip.

• Bacterial meningitis [1,3,5,10]:
  o Features include:
    ▪ Fever.
    ▪ Severe headache.
    ▪ Photophobia.
    ▪ Vomiting.
    ▪ Loss of appetite.
    ▪ Neck stiffness.
    ▪ Non-blanching rash.
    ▪ Decreased conscious level or confusion.

• Foreign body [3]:
  o Consider in children with unilateral nasal obstruction or discharge.
  o Child may present with a foul-smelling, unilateral, nasal discharge.

10 Management

If clinical features are consistent with the common cold, management generally consists of self-care advice, appropriate symptomatic treatment and safety-netting [9,10][L1, RGA1].

10.1 Advice to patients, parents and carers
Advise patients, parents and carers on the following aspects of management:

• The natural history of the illness [3,9][L1, RGA1]:
  o Symptoms of a common cold, typically:
    ▪ Peak at 3-5 days.
    ▪ Resolve within 7 days but may last up to 14 days.
    ▪ NB: A mild cough may persist at night for 2-3 weeks.

• Prevention [3,5][L1, RGA1]:
  o Hand washing or hand sanitisers prevent the spread of the common cold.
  o Avoid sharing towels and toys.
  o Encourage and support mothers to continue breastfeeding for an appropriate time as this can protect babies from infection [3].

• Sick leave [5][L1, RGA1]:
  o There are no specific recommendations on when people should avoid going to work.
  o If the patient has a fever, they should be advised to rest at home.
  o Duration of sick leave should be based on individual patient circumstances [R-GDG].
• Managing symptoms:
  o Temperature control [10][L1, RGB]:
    ▪ Tepid sponging is not recommended.
    ▪ Children should not be under-dressed or over-wrapped.
  o Fluid intake [10][L1, RGA2]:
    ▪ Warm fluids can soothe irritated throats.
    ▪ Adequate fluid should be taken to compensate for water lost through sweating and rhinorrhoea.
    ▪ Children with fever should be encouraged to drink more fluids.
  o Rest [3][L1, RGA2]:
    ▪ The amount of rest needed is indicated by how the person feels.
    ▪ Normal activity should not prolong the illness.
  o Comfort measures:
    ▪ Steam or mist [17][L1, RGB]:
      • May help to relieve symptoms.
      • However, trials are inconsistent so not routinely recommended.
      • As scalding/burns have been reported with use of steam, the recommended method is to stand in a hot shower or sit in the bathroom when the hot shower is running.
    ▪ Nasal saline irrigation [3,17][L1, RGB]:
      • May help loosen secretions and relieve nasal congestion.
      • Commercial or homemade drops/sprays can be used.
    ▪ Vapour rubs [5][L2, RGB]:
      • Although evidence is lacking, some children may experience some symptom relief.
    ▪ Salt water gargle for sore throat [3][L2, RGB]:
      • Evidence is lacking but is unlikely to be harmful.
      • Elevate the head of the bed [10][L2, RGA2].

10.2 Pharmacological treatment
Explain to patients that [5,18,19][L1, RGA1]:
• There are no treatments that can ‘cure’ the common cold.
• Most available treatments are of limited efficacy in relieving symptoms.
• Some over-the-counter treatments should not be used in children aged under 6 years.

10.2.1 Over-the-counter (OTC) and symptom-control medications
• Paracetamol [10,20][L1, RGA1]:
  o Consider using paracetamol or ibuprofen for children and adults:
    ▪ Do not give both simultaneously.
    ▪ They do not prevent febrile convulsions in children.
    ▪ Continue only if the child is distressed with fever.
    ▪ Consider other diagnoses and treatments if symptoms persist.
  o May help relieve rhinorrhoea and nasal obstruction in adults.
• Over-the-counter (OTC) cough medication use in children [3,19,21][L1, RGB]:
  o There is no good evidence for or against the effectiveness of OTC cough medication.
  o Only consider for children aged 6 to 12 years if not contraindicated, and after basic measures have been tried:
    ▪ Do not give more than one preparation at a time.
    ▪ Restrict use to 5 days or less.
    ▪ Take care to give the correct dose.

• Codeine-containing and codeine-like medications [21-23][L1, RGB]:
  o There is limited evidence that codeine is effective for treating cold symptoms in children.
  o Are contraindicated in the following groups of patients:
    ▪ Children under 12 years of age.
    ▪ Known CYP2D6 ultra-rapid metabolisers.
    ▪ Breastfeeding women.
  o Are not recommended for adolescents (12-18 years) with breathing problems.

• Topical (intranasal) decongestants (e.g. xylometazoline) [19,21][L1, RGA1]:
  o Can improve symptoms of nasal congestion in the short term.
  o Can lead to rebound congestion when withdrawn.
  o Should usually be used for no longer than 5 days.
  o Should not be used in children under 6 years.

• Oral decongestants e.g. pseudoephedrine [19,21][L1, RGB]:
  o May not be as effective as local preparations.
  o Should not be used in children under 6 years.

• Topical ipratropium bromide [24][L1, RGA2]:
  o Limited trials show ipratropium bromide is likely to be effective in treating rhinorrhea but not in managing nasal obstruction.

• Antihistamines [25][L1, RGA2]:
  o Evidence suggests that antihistamine-analgesic-decongestant combinations have some general benefit in adults and older children.
  o These benefits must be weighed against the risk of adverse effects.
  o There is no evidence of effectiveness in young children.

• Expectorants [19,21][L1, RGC2]:
  o Containing guaifenesin or ipecacuanha should not be used in children under 6 years.

• Simple cough remedies [5,18,26][L1, RGB]:
  o Generally have little benefit for cough and cold symptoms.
  o May have a placebo effect.
  o Some are licensed for children under 6 years.
  o Natural honey should not be used in children aged less than one year.
  o For children over age 2 years, a warm drink of honey and lemon can be given [R-GDG].

• Other alternative therapies [3,27][L1, RGC2]:
  o The following are generally NOT recommended due to lack of supporting evidence or unfavourable risk/benefit balance:
    ▪ Vitamin C.
Zinc.
- Echinacea.
- Chinese herbal remedies.

10.2.2 Antibiotic therapy

Antibiotics [3,28][L1]:
- Will not cure or shorten viral URTIs including the common cold.
- Are only effective for treating bacterial infections.
- Cause side effects and can lead to bacterial resistance.

A ‘No-antibiotic’ or ‘Delayed-antibiotic’ prescribing strategy for acute, self-limiting common cold can be considered [9,29][L1, RGA1]

- ‘No-antibiotic’ prescribing strategy [9][L1, RGA1]:
  - Reassure the patient that antibiotics are not needed immediately because they are likely to make little difference to symptoms and may have side effects.
  - Offer a clinical review if the condition worsens or becomes prolonged.

- ‘Delayed-antibiotic’ prescribing strategy (i.e. providing a prescription to be used later in the event of no improvement in symptoms) [9][L1, RGA1]:
  - Reassure the patient as described above.
  - Offer advice about using the prescription if symptoms are not starting to settle as expected or there is a significant worsening of symptoms.
  - Advise to return for further assessment if there is significant worsening of symptoms despite using the prescription.
  - NB: A delayed prescription can either be given to the patient or left at an agreed location to be collected at a later date.

- Immediate antibiotics and/or further investigation and management, should be only offered to adults and children if [9,30][L1, RGA1]:
  - They are systematically very unwell.
  - There are symptoms or signs suggestive of serious illness or complications.
  - They are at high risk of serious complications due to comorbidities such as:
    - Significant heart, lung, renal, liver or neuromuscular disease.
    - Immunosuppression.
    - Cystic fibrosis.
    - NB: Referral to secondary care should also be considered.
  - Antibiotics should also be considered in patients aged over 65 years with acute cough and 2 or more of the following, or if aged over 80 with one or more of the following:
    - Hospitalisation in the previous year.
    - Type 1 or type 2 diabetes.
    - History of congestive heart failure.
    - Current use of oral glucocorticoids.
10.3 Safety-netting and follow-up

Parents/carers of children with a fever should be advised [10][L1, RGA1]:

- To seek help if signs of dehydration develop, including:
  - Dry mouth.
  - Sunken eyes.
  - Absence of tears.
  - Poor overall appearance.
- How to recognise a non-blanching rash.
- To check their child during the night.

Children should return for further assessment if [3,5,10][L1, RGA1]:

- Fever lasts 3 days or more.
- Symptoms worsen after 3-5 days or new symptoms appear.
- Symptoms have not improved after 7-10 days.
- The parent/carer feels that the child is less well than when they previously sought advice.
- They have developed:
  - Loss of appetite leading to dehydration.
  - Laboured breathing.
- ‘Red flag’ symptoms develop – see Section 5.2.
- The parent/carer is distressed, or concerned that they are unable to look after their child.

Adults should return if [3][L1, RGA1]:

- Symptoms worsen after 3-5 days.
- Symptoms haven’t improved after 14 days.
- New symptoms develop.

11 Referral

The common cold should be managed in a primary care setting with admission to hospital only indicated if the patient is at risk of serious complications [R-GDG].

Refer to the Section 5.2 for the indications for immediate referral to an Emergency Department.
References