Appendix 1: Guideline group members:

Professor Adam T Hill	Co-chair, Consultant Respiratory Physician Edinburgh
Professor Michael R Loebinger	Co-chair, Consultant Respiratory Physician, London Representing RCP London
Dr Anita L Sullivan	Co-chair, Consultant Respiratory Physician Birmingham
Dr Pallavi Bedi	Respiratory Specialty Trainee Edinburgh
Professor James Chalmers	Consultant Respiratory Physician Dundee
Professor Anthony De Soyza	Consultant Respiratory Physician Newcastle upon Tyne
Professor J Stuart Elborn	Consultant Respiratory Physician London and Belfast
Professor R Andres Floto	Consultant Respiratory Physician Cambridge
Ms Lizzie Grillo	Highly Specialist Physiotherapist, London Representing ACPRC
Dr Kevin Gruffydd-Jones	General practitioner and patient representative Representing via PCRS-UK
Ms Alex Harvey	Lecturer, Physiotherapy Representing ACPRC
Dr Charles S Haworth	Consultant Respiratory Physician Cambridge
Mr Edwin Hiscocks	Lay representative
Dr John Hurst	Consultant Respiratory Physician London
Dr Christopher Johnson	Consultant Respiratory Physician Cambridge
Dr Peter Kelleher	Consultant Immunologist London
Ms Karen Payne	Respiratory nurse specialist, Leicester Representing ARNS
Mr Hesham Saleh	Consultant Rhinologist London
Dr Nicholas Screaton	Consultant Radiologist Cambridge
Dr Maeve Smith	Consultant Respiratory Physician Alberta
Professor Michael Tunney	Professor of Clinical Pharmacy Belfast
Dr Deborah Whitters	Respiratory Specialty Trainee Glasgow
Professor Robert Wilson	Consultant Respiratory Physician London

Appendix 2

Protocol for test dose of a nebulised antibiotic

1. Explain the procedure to the patient, warning of possible side effects (cough, wheeze, chest tightness and breathlessness).
2. Ensure the dose of the antibiotic to be tested is prescribed and check for a history of sensitivity to the drug (which is a contraindication to administration).
3. Check the name, dose and expiry date of the test drug and all related diluents (where applicable)
4. Before starting the procedure check availability of a spirometer and all necessary nebulisation equipment, together with a supply of salbutamol 2.5mg nebules or 100 microG salbutamol MDI with spacer.
5. Ensure all procedures for spirometry and nebulisation follow infection control recommendations; the nebuliser used for the test dose should be the one subsequently taken home by the patient.
6. Carry out spirometry at baseline, then at 15 and 30 minutes after the end of the test dose
7. If the FEV drops by <15% and <200mls and the patient does not experience side effects, it is safe to give the nebulised antibiotic, but at follow up visits check there are no symptoms of bronchospasm related to the nebulised antibiotic.
8. If the FEV_1 drops by >15% and >200mls or if symptoms of bronchospasm occur, administer salbutamol by nebuliser or inhaler, repeating spirometry at 15 minute intervals until it returns to baseline.
9. If bronchospasm has occurred, repeat the test on a separate day giving nebulised salbutamol (inhaled or nebulised) 10 minutes before the nebulised antibiotic. If the FEV_1 drops by <15% and <200mls then it is safe to continue the nebulised antibiotic but giving a beta agonist prior to the nebulised antibiotic. If the FEV_1 drops by >15% and >200mls, consider an alternative formulation or drug.
10. If there are no side effects the patient may leave 30 minutes after the end of the test dose.

Appendix 3: Long term Antibiotic Regimes

Agent	Route	Dose - Adults
Gentamicin	Nebulised	80mg BD
Tobramycin	Nebulised	160mg BD
Tobi®	Nebulised	300mg BD
Colomycin	Nebulised	1MU BD or 2MU BD
Promixin	iNEB	1MU BD
Erythromycin	Oral	250mg BD
Azithromycin	Oral	250mg Thrice weekly
Doxycycline	Oral	100mg OD
Amoxicillin	Oral	250mg BD
Amoxicillin with clavulanic acid	Oral	375mg BD

OD Once a day, BD Twice a day