



Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy

Common Conditions Service Protocol Oral Thrush (Final)

V1.6 26/09/2025

This protocol does not impede the sale and supply of medicines
'over the counter' where this legal route of supply is relevant

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1. Critical Elements

1.1 Protocol Version
Version 1.6
1.2 Protocol Authors
Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy (See Appendix A for membership)
- Pharmacists wishing to deliver this service must: - Complete the mandatory Common Conditions Service training. Training can be accessed on the Irish Institute of Pharmacy website. - Adhere to the information and recommendations included in the Clinical Protocol for this common condition, and always ensure that they are following the current version of the protocol. Current versions of the Clinical Protocols can be accessed on the HSE website. - Comply with legislation in place that relates to delivery of the service and any associated guidance from the PSI. - NOTE: Locum pharmacists employed on a temporary basis who have successfully completed the training may be authorised to provide the service. They must be able to produce a record of their training upon request.

2. Clinical Criteria

2.1 Clinical condition for use of the protocol and differential diagnosis

Oral Thrush (Oral candidiasis)

Background

Oral candidiasis, commonly known as oral thrush, is a fungal infection caused by the yeast *Candida sp.*

Oral thrush is common in babies, in individuals who have taken antibiotics or steroids (inhaled or systemic), and in older individuals with dentures. Individuals who are immunocompromised due to underlying medical conditions or treatments may also be susceptible to this type of infection.

Signs and Symptoms

Signs of oral thrush include a superficial mucosal infection which presents as white spots or patches adhering to the oral mucosal membrane (curd-like presentation). On occasion, these white spots may join together to form larger patches (or plaques) with a yellow appearance. These white spots or patches can usually be wiped off revealing a red erythematous base (red spot), which may bleed lightly once the coating is removed.

Spots or plaques that do not rub off may indicate that the diagnosis is not oral thrush and require further investigation. Individuals with red spots not indicative of oral thrush should be signposted to a dentist for diagnosis, in some circumstances these red areas may be associated with erythroplakia (a lesion that has high potential for malignant change).

In denture wearers, oral thrush may present as a red or sore area under their dentures mirroring (i.e. demarcated by) the fitting surface of the denture. Oral thrush may also present as a red and sore mouth without white spots especially after an individual has taken antibiotics or steroids (inhaled or systemic). It is important to differentiate this presentation from mucositis, which may have a similar appearance and often develops following radiation or chemoradiation therapy.

Other symptoms in adults may include:

- cracks at the corners of the mouth (angular cheilitis).
- an unpleasant taste or mild pain in the mouth (for example, a sore tongue) which may cause discomfort eating and drinking.

Oral thrush in adults is not contagious, however the infection can spread to other parts of the body if it is not treated. Individuals may be asymptomatic.

Signs of oral thrush in babies may include:

- a white coating on the baby's tongue (it can look like milk, but a milk coating will come off easily).
- a white coating on the baby's palate (palatal white plaque which rubs off easily).
- white spots in the baby's mouth.
- the baby not wanting to feed.

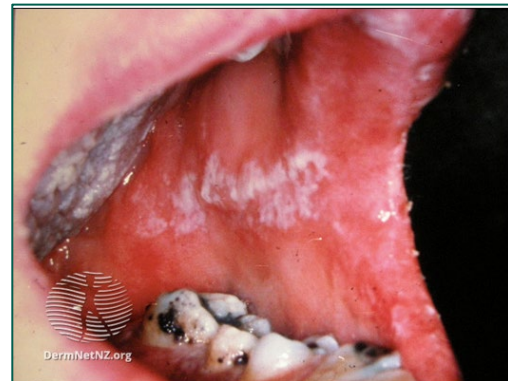
Note: Breastfed Babies and Oral Thrush

Should a breastfed infant present with oral thrush, the breastfeeding mother must be treated contemporaneously for nipple thrush with topical treatment (See Section 3.1).

Note: Breastfeeding Mothers with Nipple Rash

Should a breastfeeding mother present self-reporting "nipple thrush", in the absence of oral thrush in the breastfed infant, she should be directed to her GP for a breast

examination. There are a number of significant differential diagnoses which need to be excluded, including infection (impetigo, Herpes Simplex, Herpes Zoster, lactational mastitis, breast abscess) and breast cancer. Should the woman describe a breast rash with features of systemic illness (e.g. fever or flu-like illness), she should be advised to seek urgent medical attention, via the Emergency Department, GP or GP out-of-hours service.



Differential Diagnosis:

Mouth ulcer

Round, painful and swollen sores can appear on the tongue, inside of the cheeks, or on the lips. These types of mouth ulcers are known as aphthous ulcers. It is important to note that a “normal” aphthous ulcer is self-limiting and should not last longer than 14 days. Ulcers which persist for longer than 3 weeks require examination by a Dental Practitioner to exclude malignancy.



Lichen planus

Lichen planus is a chronic inflammatory condition and, when the mouth is affected, presents as white patches more commonly on the tongue and inside of the cheek. Sore gums are less commonly associated with this presentation. Symptoms may also include burning and stinging in the mouth, especially when the individual eats spicy foods. There are a number of different types with different presentations. It typically presents with white patches that do not rub off, often with a characteristic spider web appearance called Wickham Striae. The erosive type of lichen planus presents with large shallow areas of ulceration. Lichen planus may also be asymptomatic. All presentations of lichen planus require referral to a Dental Practitioner as a small percentage undergo malignant change and should be closely monitored and biopsied as required. Lichen planus may also present elsewhere on the body.

Oral lichen planus



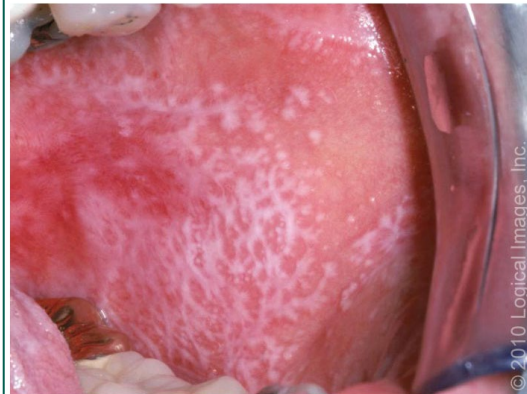
Lichen planus. Oral lesions with a white, lacy pattern and an erythematous erosion are present on the buccal mucosa.

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Oral lichen planus (UpToDate®)

Oral lichen planus: Wickham striae



Lacy, white plaques (Wickham striae) are present on the buccal mucosa.

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UpToDate®

Oral lichen planus: Wickham striae (UpToDate®)

Leukoplakia

This presents as persistent, white, and sometimes raised patches on the tongue, inside of the cheeks, palate, floor of the mouth, lips, tonsillar area or on the gums. The white patch **does not** wipe off when you rub it. All white patches without an obvious cause require further clinical examination by a dentist and/or a biopsy. Some leukoplakia lesions may be malignant or pre-malignant and those with malignant characteristics require urgent assessment by a Dental Practitioner, as outcomes are dependent on speed at which the diagnosis is made.

Leukoplakia



A white plaque is present on the buccal mucosa.

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Leukoplakia (UpToDate®)

Leukoplakia



A white plaque is present on the tongue.

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UpToDate®

Leukoplakia (UpToDate®)

Geographic tongue

Geographic tongue is a benign oral inflammatory condition and presents as blotchy, red patches on the tongue that have a white or light-coloured border. Its appearance is due to desquamation of the papillae on the dorsum of the tongue. It often migrates – changes shape and appearance. In the image below, the red areas are those that have lost their papillae and the paler areas are normal tongue surface – so rather than being a white lesion to be differentiated from thrush it is a “red lesion” due to lack of papillae. This presentation does not require treatment.

Geographic tongue



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Geographic tongue (UpToDate®)

Mucositis

Mucositis is the inflammation of the mucosa of the mouth, membranes, or gastrointestinal tract. It is a common side effect of radiation and chemoradiation therapy, which impair the replacement of cells in the superficial mucosa layers. This results in the mucosa of the mouth being more susceptible to ulceration and infection. It can lead to pain and difficulty eating or drinking, significantly impacting individuals receiving treatment. Symptoms include burning and dryness, sores in the mouths and gums, swollen gums, and increased mucous and saliva. Individuals undergoing treatment should be signposted to their treating medical team for follow-up.

Chemotherapy-related mucositis

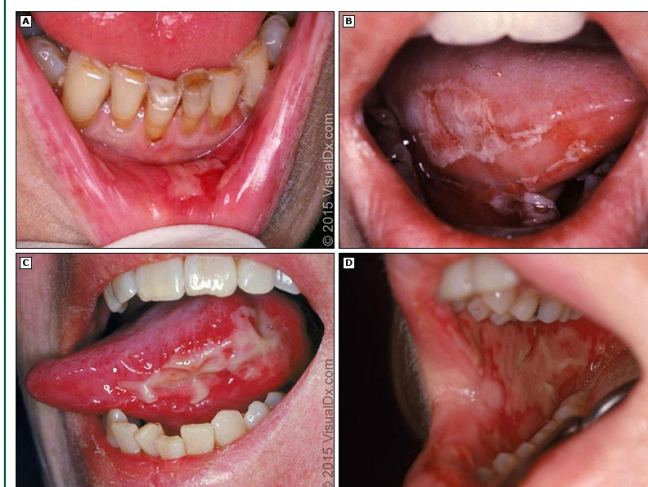


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Mucositis (UpToDate®)

Angular cheilitis

Angular cheilitis is inflammation of the angles of the mouth, characterised by fissures, scaling, erythema and/or crusting. The cause is usually multifactorial, due either to a primary infection or to a non-infectious entity such as:

- Ill-fitting dentures.
- Nutritional deficiency.
- Dermatologic condition.
- Inflammatory bowel disease.

Furthermore, underlying systemic disease such as diabetes or immunodeficiency can result in recurrent infection. Identifying and treating all contributing factors is necessary for successful treatment.

It can be associated with *Candida* sp. infection but may also be due to bacterial infection (*Staphylococcus aureus*). Symptoms which persist for longer than 14 days with or without treatment require follow-up with a Dental Practitioner or GP.

Other causes of symptoms similar to Oral Thrush

Taste disturbances or an unpleasant taste in the mouth can also be attributable to side effects of certain medication or bacterial infections such as draining sinuses, periodontal disease or pericoronitis. Individuals should be signposted to their Dental Practitioner or GP for further investigation.

Persistent sore tongue can be indicative of a vitamin/iron deficiency. Individuals should be signposted to their GP for further investigation.

2.2 Summary of Clinical Features

- White spots or patches adhering to the oral mucosal membrane (curd-like presentation). On occasion, these white spots may join together to form larger patches (or plaques) with a yellow appearance. These white spots or patches can usually be wiped off revealing a red erythematous base (red spot), which may bleed lightly once the coating is removed.
- Spots or plaques that do not rub off may indicate that the diagnosis is not oral thrush and require further investigation.
- In denture wearers, the infection may present as a red or sore area under their dentures mirroring (demarcated by) the fitting surface of the denture.
- May present as a red and sore mouth without white spots, especially after an individual has taken antibiotics or steroids (inhaled or systemic).
- Oral thrush in adults is not contagious, however the infection can spread to other parts of the body if it is not treated. Individuals may be asymptomatic.
- Signs of oral thrush in babies may include:
 - a white coating on the baby's tongue (it can look like milk, but a milk coating will come off easily).
 - a white coating on the baby's palate (palatal white plaque which rubs off easily).
 - white spots in the baby's mouth.
 - the baby not wanting to feed.
- If a breastfed baby develops oral thrush, their breastfeeding mother must be contemporaneously treated for nipple thrush, even in absence of symptoms.

2.3 Inclusion criteria

2.3.1 CRITERIA FOR INCLUSION

- Informed consent given by an individual or parent/legal guardian for a child aged under 16 years.
- Individuals aged 1 month and older (corrected age for infants who are pre-term. The corrected age is the age based on the date they should have been born e.g. if a 10-month-old baby was born 2 months early, their corrected age is 8 months old).
- Individual with suspected or confirmed oral thrush.
- Pharmacists can **consider prescribing an initial supply of treatment if clinically appropriate**, while referring individuals who meet the criteria set out in **Section 2.4.4**.

2.4 Exclusion criteria and Referral Pathways

2.4.1 CRITERIA REQUIRING EMERGENCY REFERRAL TO HOSPITAL EMERGENCY DEPARTMENT/CONTACTING EMERGENCY SERVICES

- Individual is systemically very unwell, or showing symptoms of severe/life-threatening infection, or systemic [sepsis](#): **Refer urgently to emergency department via ambulance.**

2.4.2 CRITERIA REQUIRING URGENT MEDICAL ASSESSMENT (TREATING SERVICE/GENERAL PRACTITIONER/GENERAL PRACTITIONER OUT OF HOURS/HOSPITAL EMERGENCY DEPARTMENT)

- Signs/symptoms of a more serious condition/illness.
- Complications suspected – unable to swallow, unable to drink due to severe pain or discomfort (risk of dehydration) or a failure to respond to treatment.
- Individual has moderate to severe immunocompromise due to underlying medical conditions or treatments.

2.4.3 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER, DENTAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER

Note: Pharmacist prescribing not permitted

- Individuals under 1 month of age (corrected age for infants who are pre-term).
- Contraindications as specified in the medication Summary of Product Characteristics.
- Pregnancy or suspected pregnancy (refer to GP / treating obstetrician / gynaecologist).
- Lesions are present for more than 14 days.
- Signs and symptoms not resolved after 14 days of treatment.
- Presence of white spots or plaques which do not rub off.
- Recent trauma to the mouth e.g. burn / open wound.
- Recurrence of oral thrush.
- Pain on swallowing not attributable to oral thrush.
- Known hypersensitivity or adverse reaction to medication treatment options as included in Section 3.1, or any of the components within the formulation.

- Individual has started a new medication and is presenting with symptoms of a sore mouth such as blisters or ulcerative lesions.

2.4.4 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER, DENTAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER – INITIAL LIMITED SUPPLY*

*Pharmacists can consider prescribing an initial limited supply of treatment if clinically appropriate to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.

- Individuals who wear dentures should be signposted to a Dental Practitioner to review if the denture is not fitting correctly.
- Individuals with a diagnosis of diabetes should be advised to see GP for a check-up to review control of blood sugar levels.
- Individual who has no obvious underlying risk factors with recurrent oral thrush should be advised to see GP or Dental Practitioner for a check-up, as may be symptomatic of further underlying conditions.
- Individual is immunocompromised due to underlying medical conditions or treatments (excluding those with moderate to severe immunocompromise: see Section 2.4.2).
- Suspected oesophageal candidiasis. This is often associated with individuals who are immunocompromised. Symptoms may include pain or discomfort when swallowing, general discomfort behind the neck and the sternum (retrosternal pain), the feeling that food is sticking in the oesophagus. This can occur with or without the presence of oropharyngeal thrush. Individuals who are engaged in care for a HIV infection or other immunosuppressing condition (e.g. current cancer treatment) should be referred to their treating physician.

2.5 Action to be taken where individual meets exclusion criteria, or treatment is not indicated, or the individual/parent/legal guardian declines treatment

- If individual meets exclusion criteria, they should be referred or signposted as per the protocol (see Section 2.4).
- Advise individual/parent/legal guardian to seek medical advice if symptoms deteriorate or persist for longer than 14 days.
- Signpost to available resources on HSE A-Z and the HSE app if appropriate.
- Follow record keeping procedures.

3. Details of medication

3.1 Name of medication, dose, and duration

Treatment Options & Formulary

Oropharyngeal candidiasis

Drug	Dose	Duration	Notes
Nystatin 100,000 units/mL oral suspension	Infant: 1 month – 2 years: 1-2mL dropped into the mouth every 6 hours after feeds Adult and children > 2 years: 1-6mL every 6 hours after meals	Usually for 7 days - continue for 48 hours after clinical cure, if signs and symptoms persist beyond 14 days re- evaluate	Keep suspension in contact with oral mucosa for as long as possible before swallowing or spitting out. Nystatin is the treatment of choice for mothers who are breastfeeding.
OR			
Miconazole 20mg/g oral gel	≥4 months: 1.25mL (quarter of measuring spoon provided) to be applied four times a day after feeds Adults and children 2 years of age and older: 2.5mL (half of measuring spoon provided) to be applied four times a day after meals	The treatment should be continued for at least a week after the symptoms have disappeared	Lower age limit increased to 5- 6 months for infants who are pre-term or exhibiting slow neuromuscular development. The gel should not be swallowed immediately; it should be kept in the mouth as long as possible. Infants from 4-24 months: The dose should be divided into smaller pea-sized portions; gel should be smeared in baby's mouth after feeds with a clean finger, ensuring there are no clumps of gel in the mouth. For oral candidiasis, dental protheses (dentures) should be removed at night, cleaned and disinfected. Small amount of gel may be used on fitting surface if appropriate. Miconazole has a significant interaction profile, as specified in the Summary of Product Characteristics Pharmacists must check for interactions before prescribing. For example, Miconazole oral gel should be avoided with warfarin.

For Breastfeeding Mothers* – treatment of the nipple and areola area			
Drug	Dose	Duration	Notes
Miconazole Cream 2% w/w	Apply cream to nipple and areola after every feed	Continue for at least 7 days after symptoms have cleared.	Apply after every feed. Any visible cream should be wiped off gently prior to the next feed. (This differs to the usual two times daily dosing to ensure adequate dosing for breastfeeding mothers)

*See Section 2.1

3.2 Summary of Product Characteristics including warnings, cautions, contraindications, interactions and side effects.

Visit the [Health Products Regulatory Authority \(HPRA\) website](https://www.hpra.ie) for detailed drug information (summary of product characteristics and patient information leaflets). Dosing details, contraindications and drug interactions can also be found in the Irish Medicines Formulary (IMF) or other reference sources such as British National Formulary (BNF) / BNF for children (BNFC).

3.3 Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, website: www.hpra.ie

3.4 Procedure for the reporting and documentation of errors and near misses involving the medication including open disclosure.

PSI Advice on Medication Error Management:

<https://www.psi.ie/practice-supports/practice-updates-and-learning/advice-medication-error-management>

PSI Open Disclosure:

[Open Disclosure | PSI](#)

3.5 Resources and equipment necessary for care under the protocol to be specified. This is dependent on the assessment requirements and best practice guidelines identified for the clinical condition.

- HSE National Consent Policy
- Chaperone Policy
- Patient Consultation Area
- Oral Examination Equipment if required:
 - Light source
 - Disposable spatula
- Infection Prevention Control Measures
- Protecting Staff – Occupational Health

4. Patient/service-user care information

4.1 General Advice for Self-Care and Safety Netting

An individual should see their GP or Dental Practitioner if symptoms deteriorate, or persist for longer than 14 days, with or without treatment.

There are some things individuals can do to help prevent oral thrush:

Do

- Brush their teeth twice a day – if an individual does not have any teeth they should be advised to brush their gums and tongue with a soft toothbrush.
- Discard their old toothbrush and use a new toothbrush while undergoing antifungal treatment. When treatment is complete and the infection has resolved, they should use another new toothbrush.
- Individuals should be advised to stick out their tongue and brush their tongue using a soft toothbrush to clean the tongue carefully from back to front – if heavily coated e.g. thrush present, a tongue scraper may be more effective. Individuals should avoid going too far back as it may cause them to gag.
- Go for regular dental check-ups, even if an individual has dentures.
- Avoid use/overuse of antiseptic mouthwashes, as they alter the flora of the mouth – an individual can use warm saline water as a mouth wash to relieve symptoms
- Rinse their mouth after eating or taking medicine.
- Rinse their mouth and spit rinse out after using steroid inhalers - an individual's pharmacist, GP or practice nurse can review their inhaler technique.
- If necessary, the individual should be advised to take simple over-the-counter (OTC) analgesia e.g. paracetamol or ibuprofen to ease the pain.

Do Not

- Wear dentures overnight
- Wear dentures that do not fit properly – advise individual to attend a Dental Practitioner to have them adjusted.
- Smoke, smoking is a risk factor for oral candidiasis and smoking cessation should be considered - [Create your quit smoking plan - Quit.ie](#)

Helping a child's oral thrush at home

A child's oral thrush can be helped to heal by:

- Offering regular milk feeds - parents may need to offer more if they are not taking as much as usual.
- Feeding them bland foods - spicy or acidic foods could sting their mouth.
- Keeping their hands clean so that the infection does not spread.
- Sterilising any soothers or dummies regularly, as well as any toys they put in their mouth, such as teething rings.
- Sterilising any bottles and other feeding equipment regularly, especially the teats
- Washing hands after changing nappies and before any feeds.

Denture Wearers

- Even if an individual has full dentures, they should regularly go for dental check-ups.
- If oral thrush is diagnosed, additional denture care is necessary in conjunction with any prescribed antifungal treatment to ensure denture does not act as a reservoir for reinfection.
- If oral gel is prescribed as a treatment, it may also be applied to the fitting surface of the clean denture and corners of mouth.
- Dentures should be left out for as long as possible.

- In addition to standard cleaning, disinfect denture by soaking in appropriate disinfectant such as Milton diluted 1 part Milton to 10 parts cold water (if there are no metal parts), chlorhexidine may be used undiluted if there are metal parts, for no more than 10 minutes **twice per day** until signs of candida are gone.
- Dentures should be removed and brushed clean using a denture brush and mild soap. The denture should be rinsed before inserting into the mouth after cleaning.

Breastfeeding

- Mothers should continue to breastfeed.
- Probiotics may be taken to help to rebalance the yeast levels in the mother's system.
- If using breast pads, the mother should be advised to change them after every feed.
- Wash hands frequently. Avoid touching the affected area and wash hands with soap and water if it has been touched or cream/ointment applied. Do not share towels.
- Soothers or any other feeding equipment (like breast pumps or bottles), should be sterilised after each use, especially the teats.
- Any milk which has been expressed and stored in the freezer during the time when the mother has had thrush should be discarded. They should be advised to wait until they have finished treatment and are symptom-free before they express milk for freezing.
- The mother should be advised to go to their nurse, midwife, public health nurse, lactation consultant or local breastfeeding support group for help with positioning and attachment or latching on, if required.

4.2 Medication information to be provided to the individual/parent/legal guardian using the authorised patient information leaflet if one is available.

- Signpost to available resources on HSE A-Z and the HSE app.
- Medication Patient Information Leaflets (PILs).

Key References

- HPRA <https://www.hpra.ie/>
- HSE Antibiotic Prescribing <https://www.hse.ie/eng/services/list/2/gp/antibiotic-prescribing/>
- HSE A-Z <https://www2.hse.ie/conditions/>
- HSE – Breastfeeding: A good start in life
<https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/child-health-and-wellbeing/breastfeeding-healthy-childhood-programme/breastfeeding-factsheets/breastfeeding-good-start.pdf>
- HSE National Guideline on Oral Health – Supporting Smiles for Health and Social Care Professionals (and their teams) who support or provide oral care for adults
- UpToDate Oropharyngeal candidiasis in adults and related images
<https://www.uptodate.com/contents/oropharyngeal-candidiasis-in-adults>
- DermNet [DermNetNZ.org](https://www.dermnetnz.org/) (Images as identified)

Appendix A – Clinical Sub-Group Membership

Core Membership

- Dr. Siobhán Ní Bhriain - HSE National Clinical Director Integrated Care (Chair)
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Linda Fitzharris - HSE PCRS Head of Pharmacy
- Dr. Diarmuid Quinlan - Medical Director ICGP & GP
- Ms. Elaine Dobell - HSE General Manager, Office of National Clinical Director Integrated Care
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist
- Dr. Clíona Murphy – National Women and Infants Health Programme
- Ms. Sarah Clarke - Medicines Management Programme

General Membership as needed

- Ms. Aoife Doyle - HSE National Clinical Lead for Ophthalmology
- Prof. Anne Marie Tobin - HSE National Clinical Lead for Dermatology
- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. Seán O'Dowd - HSE National Clinical Lead for National Dementia Office representing National Clinical Programme for Neurology on behalf of Prof. Sinéad Murphy
- Ms. Ruth Hoban - HSE West Assistant Director of Nursing and Midwifery for Nurse Prescribing on behalf of Dr. Geraldine Shaw
- Prof. Fiona Lyons - HSE National Clinical Lead for Sexual Health
- Ms. Caoimhe Gleeson - HSE National Office for Human Rights and Equality Policy
- Dr. Andrew Bolas - Assistant National Oral Health Lead
- Dr. Myra Herlihy - Assistant National Oral Health Lead Special Care and Training

Oral Thrush CSG Working Group

- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Dr. Andrew Bolas - Assistant National Oral Health Lead
- Dr. Myra Herlihy - Assistant National Oral Health Lead Special Care and Training
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist