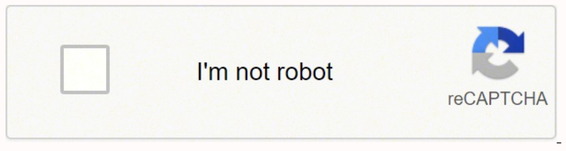

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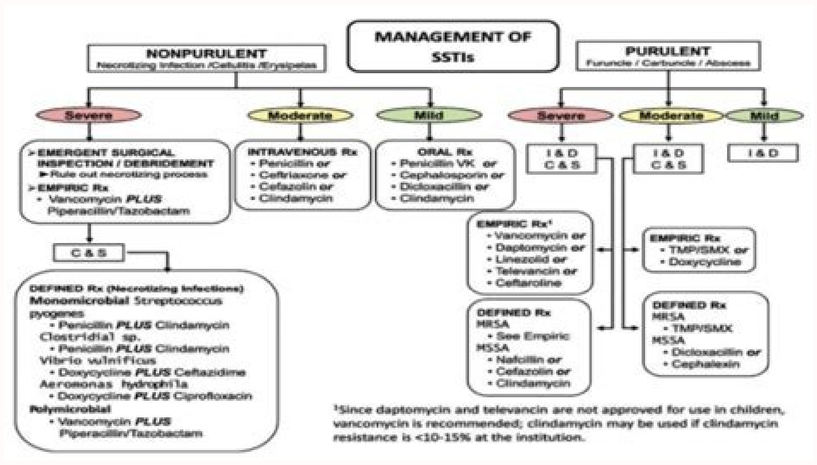
Skin and soft tissue infections guidelines 2017



Condition	Organism	Antibiotic	Duration	Comments
Cellulitis	*S.pyogenes* *S.aureus*	Cefazolin Or cephalexin Or Amoxicillin-clavulanate +/- Clindamycin	5-7 days (longer if clinically indicated)	-Obtain blood/ pus cultures before starting antibiotics -Consider poly-microbial pathogens in diabetics -Consider risk factors for MRSA and presence of TSS before using clindamycin
Necrotizing fasciitis	*S. pyogenes* *S.aureus*, anaerobes, Gram negative organisms (polymicrobial)	Piperacillin-tazobactam + Clindamycin	Generally, 14 days if adequate source control achieved	Early surgical debridement essential Send blood and intraoperative specimens for bacterial cultures. Consider use of IVIG for streptococcal NF/TSS
Necrotizing fasciitis	*Aeromonas/ V.vulnificus* (suspect when history of exposure to fresh water or salt water respectively)	Ciprofoxacin + Doxycycline	Generally, 14 days if adequate source control achieved	
Erysipelas	*Propionibacterium acnes*/MSSA	Amoxicillin-clavulanate	5-7 days	
Abscess	*S. pyogenes, Oral anaerobes*	Clindamycin **OR** Ampicillin-sulbactum **OR**Amoxicillin-clavulanate	5-7 days	
	S.aureus, facultative gram negative anaerobes	Linezolid **OR** Vancomycin **PLUS** Ciprofloxacin	Generally, 14 days	

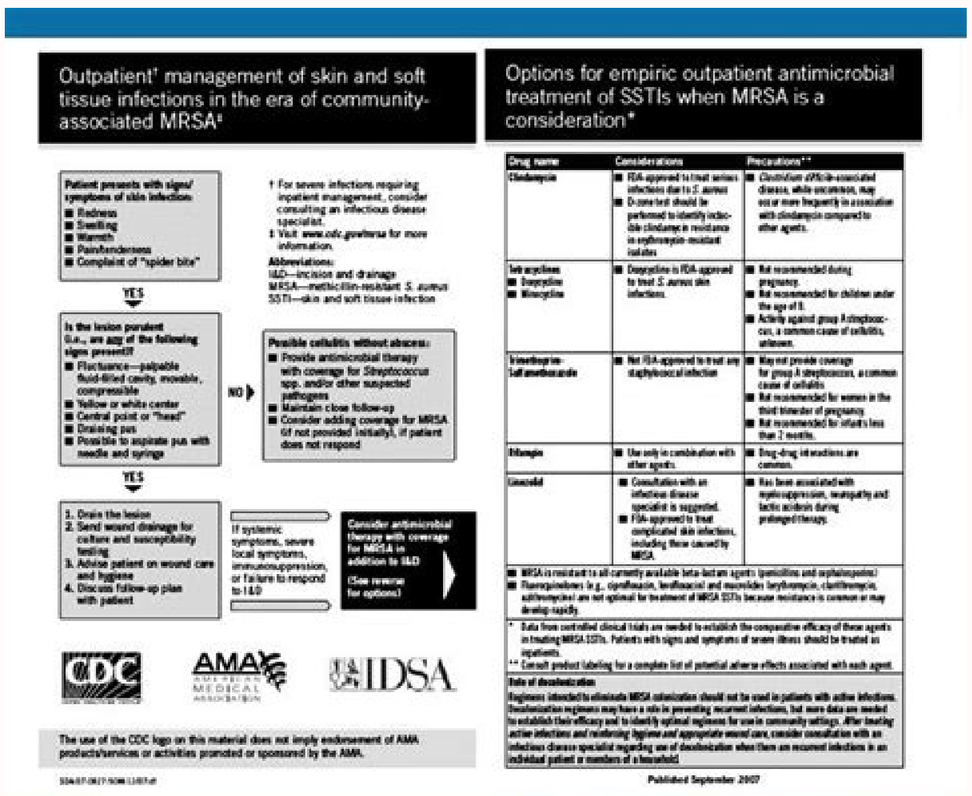


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TABLE 152-5 Empiric Treatment of Nonpurulent Cellulitis*/Erysipelas

Guide by Severity of Illness	Antibiotics	Comments
Oral antibiotics for mild disease: Typical cellulitis/erysipelas with no focus of purulence, and no signs of systemic infection	Cephalexin, 500 milligrams PO every 6 h† **Or** dicloxacillin, 500 milligrams PO every 6 h† **Or** clindamycin, 150–450 milligrams PO every 6 h†	Cultures are not recommended because of poor yields.
Monotherapy IV antibiotics for moderate disease: Typical cellulitis/erysipelas with mild to moderate systemic signs of infection‡ **If** immunocompromised, see below	Ceftriaxone 1 gram IV every 24 h† **Or** cefazolin 1 gram every 8 h† **Or** clindamycin 600 milligrams IV every 8 h†	Patients who have failed to improve on outpatient antibiotics or are unable to tolerate oral antibiotics should be admitted to the hospital and receive IV antibiotics, with coverage dependant on severity of illness.
Broad-spectrum antibiotics for severe disease (including necrotizing fasciitis): Those with sepsis§ or those with clinical signs of deeper infection such as bullae, skin sloughing, hypotension, or evidence of organ dysfunction **Or** an immunocompromised patient	Vancomycin 15 milligrams/kg IV every 12 h† **Plus** piperacillin-tazobactam, 4.5 grams IV every 6 h† **Or** meropenem, 500–1000 milligrams IV every 8 h† **Or** imipenem-cilastatin, 500 milligrams IV every 6 h†	1. Consider immediate consultation with surgery for possible debridement (see later section on necrotizing fasciitis for further recommendations). 2. Blood cultures recommended in this treatment group.
Different/additional coverage for patients with selected indications	**Fresh water** exposure (suspected *Aeromonas* species): Doxycycline 100 milligrams IV every 12 h† **Plus** ciprofloxacin 500 milligrams IV every 12 h† **Salt water** exposure (suspected *Vibrio* species): Doxycycline 100 milligrams IV every 12 h† **Plus** ceftriaxone 1 gram every 24 h† **Suspected *Clostridium*** species: Clindamycin 600–900 milligrams IV every 8 h† **Plus** penicillin 2–4 million units IV every 4 h†	1. Consider immediate consultation with surgery for possible debridement (see later section on necrotizing fasciitis below for further recommendations). 2. Blood cultures recommended in this treatment group.

Practice Guidelines for the Diagnosis and Management of Skin and Soft-Tissue Infections

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EXECUTIVE SUMMARY

Soft-tissue infections are common, generally of mild to modest severity, and are easily treated with a variety of agents. An etiologic diagnosis of simple cellulitis is frequently difficult and generally unnecessary for patients with mild signs and symptoms of illness. Clinical assessment of the severity of infection is crucial, and several classification schemes and algorithms have been proposed to guide the clinician [1]. However, most clinical assessments have been developed from either retrospective studies or from an author's own "clinical experience," illustrating the need for prospective studies with defined measurements of severity coupled to management issues and outcomes.

Until then, it is the recommendation of this committee that patients with soft-tissue infection accompanied by signs and symptoms of systemic toxicity (e.g., fever or hypothermia, tachycardia [heart rate, >100 beats/min], and hypotension [systolic blood pressure, <90 mm Hg or 20 mm Hg below baseline]) have blood drawn to determine the following laboratory parameters: results of blood culture and drug susceptibility tests, complete blood cell count with differential, and creatinine, bicarbonate, creatine phosphokinase, and C-reactive protein levels. In patients with hypotension and/or an elevated creatinine level, low serum bicarbonate level, elevated creatine phosphokinase level (2–3 times the upper limit of normal), marked left shift, or a C-reactive protein level >13 mg/L, hospitalization should be considered and a definitive etiologic diagnosis pursued aggressively by means of procedures such as Gram stain and culture of needle aspiration or punch biopsy specimens, as well as requests for a surgical consultation for inspection, exploration, and/or drainage. Other clues to potentially severe deep soft-tissue infection include the following: (1) pain disproportionate to the physical findings, (2) violaceous bullae, (3) cutaneous hemorrhage, (4) skin sloughing, (5) skin anesthesia, (6) rapid progression, and (7) gas in the tissue. Unfortunately, these signs and symptoms often appear later in the course of necrotizing infections. In these cases, emergent surgical evaluation is of paramount importance for both diagnostic and therapeutic reasons.

Emerging antibiotic resistance among *Staphylococcus aureus* (methicillin resistance) and *Streptococcus pyogenes* (erythromycin resistance) are problematic, because both of these organisms are common causes of a variety of skin and soft-tissue infections and because empirical choices of antimicrobials must include agents with activity against resistant strains. Minor skin and soft-tissue infections may be empirically treated with semi-

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