**NON-PURULENT CELLULITIS AND ERYsipelas**

**EXCLUSIONS**

The following are not addressed in the guidelines: mammalian bites, diabetic foot infections, orbital cellulitis, water immersion injuries, surgical site infections and skin infections in patients with neutropenia or severe cell-mediated immunity.

**DIFFERENTIAL DIAGNOSIS**

- stasis dermatitis
- insect bites
- contact dermatitis
- peripheral arterial disease
- deep vein thrombosis
- necrotizing fasciitis
- gout
- septic arthritis

**RISK FACTORS**

- lymphedema
- leg ulcer
- toe web intertrigo
- traumatic wounds
- saphenous vein harvesting
- previous cellulitis

**INVESTIGATIONS**

No routine investigations

- No routine blood work is recommended
- Wound swab/cultures are not indicated

**EMPIRIC ANTIMICROBIAL THERAPY**

<table>
<thead>
<tr>
<th>FIRST LINE THERAPY</th>
<th>PATIENTS REQUIRING IV THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• cephalexin 500mg orally every 6 hours</td>
<td>• cefazolin 1g IV every 8 hours</td>
</tr>
<tr>
<td>If severe reactions to β-lactam antibiotics: levofloxacin 500 mg orally daily</td>
<td>• cloxacillin 2g IV every 6 hours</td>
</tr>
<tr>
<td>moxifloxacin 400 mg orally daily</td>
<td>If severe reactions to β-lactam antibiotics: clindamycin** 600 mg IV every 8 hours</td>
</tr>
<tr>
<td>clindamycin** 300 mg orally every 6 hours</td>
<td></td>
</tr>
</tbody>
</table>

**EVALUATION OF TREATMENT AND DURATION OF THERAPY**

It is reasonable to anticipate that patients on appropriate therapy may not show signs of clinical improvement for up to 72 hours. The recommended duration of therapy is 5 to 7 days. Patients who do not respond after three full days of therapy should be reassessed on day 4.
Management of Skin and Skin Structure Infections
Additional Tools

◆ Empiric Antimicrobial Therapy
There is no evidence that shows superiority of intravenous antibiotics over oral antibiotics to treat cellulitis or erysipelas. The oral antibiotics recommended below are well tolerated and highly bioavailable (>95%). Intravenous antibiotics should be considered third line: when patients cannot tolerate the oral route or in obese patients (Body Mass Index greater than 30) where the dose required cannot be administered orally. Patients who have cellulitis and are hemodynamically unstable should be treated according to local guidelines for management of sepsis (MRSA coverage should be considered).

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Daily Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>cephalaxin 500 mg orally every 6 hours</td>
<td>$1.80</td>
</tr>
<tr>
<td>levofloxacin 500 mg orally daily</td>
<td>$1.37</td>
</tr>
<tr>
<td>moxifloxacin 400 mg orally daily</td>
<td>$5.94</td>
</tr>
<tr>
<td>clindamycin ** 300 mg orally every 6 hours</td>
<td>$1.77</td>
</tr>
<tr>
<td>cefazolin 1 g IV every 8 hours</td>
<td>$19.50</td>
</tr>
<tr>
<td>cloxacillin 2 g IV every 6 hours</td>
<td>$36.50</td>
</tr>
<tr>
<td>clindamycin** 600 mg IV every 8 hours</td>
<td>$27.40</td>
</tr>
</tbody>
</table>

* Daily cost refers to drug cost only and does not include dispensing fees
** Based on microbiology data from Toronto hospitals the incidence of invasive Group A streptococcal (GAS) resistance to clindamycin ranges from 4% to 40%. The incidence of non-invasive GAS infections to clindamycin is unknown as most microbiology laboratories do not routinely test the sensitivity of non-invasive GAS. Resistance to Penicillin G is 0% and resistance to levofloxacin (based on organisms tested) is 0%.

REFERENCES