# Management of Uncomplicated Skin and Skin Structure Infections

## PURULENT SKIN INFECTIONS

ABSCESSES[1,2,3]

**EXCLUSIONS**

The following infections are not addressed in the guidelines: Dental abscesses, deep neck abscesses, abscesses due to bites, diabetic feet or orbital infections, ischiorectal, perirectal, and pilonidal abscesses

## DIFFERENTIAL DIAGNOSIS

- epidermoid cyst
- hematoma
- bursitis

**Purulent Abscess**

## INVESTIGATIONS

For uncertain diagnosis consider Ultrasound or large bore (16-18G) needle aspirate

## TREATMENT

### FIRST OCCURRENCE

- Incision and drainage
- Culture not routinely recommended
- There is no consensus on the clinical value of packing the wound

### TREATMENT FAILURE OR SPONTANEOUS RECURRENCE

**WITHIN 30 DAYS**

- Incision and drainage
- Send specimen for microbiological diagnosis
- Start empiric antimicrobial therapy

**FIRST LINE THERAPY**

- co-trimoxazole** 1 DS tablet orally twice a day
- doxycycline *** 100 mg orally twice a day

### SUBSEQUENT RECURRENCES

**WITHIN 6 MONTHS**

- Incision and drainage
- Send specimen for microbiological diagnosis
- Start empiric antimicrobial therapy
- Ensure that the pathogen identified during the previous incident is susceptible to the antibiotic chosen
- Consider referring patient to an Infectious Disease Clinic for follow-up

Empiric antimicrobial therapy should cover *Staphylococcus aureus* including community-acquired methicillin-resistant *Staphylococcus aureus* (CA-MRSA). If the organism cultured is NOT MRSA consider switching to cephalexin

## DURATION

When antibiotic therapy is necessary it should be prescribed for a duration of **7 days**

Ontario
Toronto Central Local Health Integration Network

# Management of Skin and Skin Structure Infections
# Additional Tools

| Antibiotic | Daily Cost* |
|---|---|
| co-trimoxazole** 1 DS tablet orally twice a day | $0.25 |
| doxycycline*** 100 mg orally twice a day | $1.18 |

* Daily cost refers to drug cost only and does not include dispensing fees
** Should not be given to patients taking warfarin, sulfonylureas, and drugs that raise serum potassium levels or patients with renal dysfunction (especially the elderly).
*** Currently not a benefit under the Ontario Drug Benefit Formulary

## REFERENCES


1. Hankin A, Everett WW. Are antibiotics necessary after incision and drainage of a cutaneous abscess? Ann Emerg Med 2007; 50:49-51.

2. Korowyk C, Allan GM. Evidence-based approach to abscess management. Can Fam Physician 2007; 53:1680-3.

3. Schmitz GR, Brunder D, Pitotti R, Olderog C, Livengood T, et al. Randomized controlled trial of trimethoprim-sulfmethoxazole for uncomplicated skin abscessese in patients at risk for community-associated methicillin-resistant Staphylococcus aureus infection. Ann Emerg Med 2010; 56:283-7.

4. Stevens DL, Bisno AL, Chambers HF, et al. Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Disease Society of America. IDSA Guidelines http://cid.oxfordjuornals.org/ June 2014



Ontario
Toronto Central Local Health Integration Network