

Management of Uncomplicated Skin and Skin Structure Infections

NON-PURULENT CELLULITIS AND ERYSIPELAS^{1,2,3}

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

Cellulitis / Erysipelas still considered

RISK FACTORS

- lymphedema
- toe web intertrigo
- leg ulcer
- 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♦

FIRST LINE THERAPY

- cephalexin 500mg orally every 6 hours



If severe reactions to β -lactam antibiotics:
levofloxacin 500 mg orally daily
moxifloxacin 400 mg orally daily
clindamycin** 300 mg orally every 6 hours

PATIENTS REQUIRING IV THERAPY

- cefazolin 1g IV every 8 hours
- cloxacillin 2g IV every 6 hours



If severe reactions to β -lactam antibiotics:
clindamycin** 600 mg IV every 8 hours

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.

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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).

Antibiotic	Daily Cost*
cephalexin 500 mg orally every 6 hours	\$1.80
levofloxacin 500 mg orally daily	\$1.37
moxifloxacin 400 mg orally daily	\$5.94
clindamycin ** 300 mg orally every 6 hours	\$1.77
cefazolin 1 g IV every 8 hours	\$19.50
cloxacillin 2 g IV every 6 hours	\$36.50
clindamycin** 600 mg IV every 8 hours	\$27.40

* 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%.

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