UNCOMPLICATED CELLULITIS

Exclusion criteria: *Skin and skin structure infections (SSSI) in immunocompromised hosts, surgical wounds. Refer to MRSA Skin and Soft Tissue Infection if there is a high clinical suspicion of MRSA infection.*

Laboratory Diagnosis:

- **Obtain blood cultures only in the presence of systemic toxicity (fever / hypothermia, tachycardia, or hypotension)**
- **Culture of fluid or pus in a sterile container is preferred to a swab. Indicate anatomic site of infection and any significant epidemiology.**

Uncomplicated cellulitis (i.e. mild and localized, <u>not</u> involving the head)
****Excludes diabetic foot ulcer, animal or human bites****

- Common pathogens: *Staphylococcus aureus*, beta-hemolytic streptococcus such as *Streptococcus pyogenes* (group A streptococcus)
- Can usually be managed with **PO** antibiotics
- 5 days of treatment is often sufficient in settings of uncomplicated cellulitis

<u>Empiric Therapy</u>

Cephalexin 500mg po QID (doses up to 1g/DOSE may be used in obese patients)

In cases of severe beta lactam allergies (e.g. angioedema, bronchospasm, anaphylaxis etc):
Clindamycin 300-450mg po QID

Uncomplicated cellulitis where intravenous is required initially for first 48-72 hours (e.g. unable to tolerate po, extensive infection):
Cefazolin 1-2 g IV q8h OR Cloxacillin 1-2 g IV q6h

In cases of severe beta lactam allergies:
Vancomycin 15mg/kg IV q12h (renal adjustment is required) OR Clindamycin 600mg IV q8h

MRSA Skin and Soft Tissue Infection

Consider <u>empiric</u> MRSA coverage, in particular in patients with:
Purulent skin infections that do not resolve with penicillin/cephalosporin therapy, known colonizers of MRSA, and in patients with increased risk for MRSA based on local epidemiology, e.g. IV drug users.

Oral therapy (uncomplicated MRSA infection)

- Consider incision and drainage
- Usual treatment duration is 5-10 days but should be based on patient's clinical response

Preferred:

- Trimethoprim/sulfamethoxazole (TMP/SMX) 10-15mg/kg/DAY (trimethoprim) in 2-4 divided doses
    - TMP/SMX lacks activity against group A Streptococci. Consider use in combination with cephalexin for empiric treatment of cellulitis

Alternatives:

- Doxycyline 100mg po BID OR
- Clindamycin 300-450mg po QID

Parenteral therapy (complicated MRSA infection)

Vancomycin 15mg/kg IV q12h (renal dosage adjustment is necessary)

- Alternatives include linezolid (po/IV) and daptomycin (IV). Please note that these require Infectious Diseases endorsement