NM Northwestern Medicine

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OUTPATIENT STEWARDSHIP TIP SHEET

Skin & Soft Tissue Infection
Excluding Bites

For most SSTIs, antibiotic decision-making is based on clinical presentation, not susceptibilities
Always consider alternate diagnoses: contact dermatitis/eczema, stasis dermatitis ± wounds, herpetic whitlow, erythema nodosum, gout
Non-purulent cellulitis rarely involves bilateral limbs

	Non-Purulent Cellulitis		Purulent Cellulitis	
Characteristics	new or rapid spread of pain, tenderness, erythema and/or edema **WITHOUT** focal pus collection		**focal region of pus** (e.g., abscess, furuncle, carbuncle) with or without surrounding erythema	
Likely pathogen(s)	streptococci (including group A Streptococcus) MSSA		MRSA MSSA	
Diagnosis	**Do not sent wound culture (even if bullae present)** UNLESS superficial debridement of wound performed		**Send wound culture ONLY if incision & drainage (I & D) performed AND any of the following:** • fever • antibiotic failure • immunocompromised status • prior history of abscesses **without known MRSA/MSSA susceptibilities over prior 6 months** • clinician discretion	
Treatment	**Co-prescribing cephalexin & TMP-SMX is not beneficial**		• **I & D alone** for abscess with <2 cm surrounding erythema • **I & D with antibiotic for abscess with ≥2 cm surrounding erythema – see below**	
	Adult	**Pediatric**	**Adult**	**Pediatric**
	Standard Antibiotics and Low Risk Penicillin Allergy History **Cephalexin** 1000 mg TID for **5 days** **Moderate or High Risk Beta-lactam Allergy History (see NM O/P Allergy Risk Assessment first):** **Clindamycin** 300 mg TID or QID for **5 days**	**Standard Antibiotics and Low Risk Penicillin Allergy History** **Cephalexin** 25-100 mg/kg/day divided TID for **5 days** (maximum dose: 3 g/day) **Moderate or High Risk Beta-lactam Allergy History (see NM O/P Allergy Risk Assessment first):** **Clindamycin** 30 mg/kg/day divided TID **5 days** (maximum dose: 900 mg/day)	**Standard Antibiotics** **TMP-SMX DS** 800 mg/160 mg BID for **5 days** **OR** **Doxycycline** 100 mg BID for **5 days (the Sulfa Allergy option)**	**Standard Antibiotics** **TMP-SMX** 8-12 mg/kg/day divided BID for **5 days** (dose based on TMP component) (maximum dose: 320 mg/day) OR **Children >8 years** **Doxycycline** 2-4 mg/kg/day divided BID for 5 days (maximum dose: 200 mg/day) **(the Sulfa Allergy option)** **Children ≤8 years with Sulfa allergy** **Clindamycin** 30 mg/kg/day divided TID for 5 days (maximum dose: 900 mg/day)
Adjunctive Measures	**Elevate limb** NSAIDs or acetaminophen		**Elevate limb** Apply warm packs NSAIDs or acetaminophen	

Key Points for Counseling Patients

1. Erythema can spread for 1 to 2 days despite starting appropriate antibiotics
2. Swelling and erythema can vary by gravity, and by time of day
3. Elevation of the involved limb and use of NSAIDs or acetaminophen can reduce pain rapidly
4. Reassuring signs of improvement after antibiotics have started include
   - Less pain and/or tenderness
   - Less warmth
   - Less erythema, or skin turning from red to brown
5. Antibiotic therapy is expected to end prior to complete wound healing

When to Consider Transfer to ED

1. Rapidly progressing erythema with altered mental status
2. Pain out of proportion to physical examination
3. Pain to palpation outside of areas of erythema
4. Numbness over painful area
5. Hemodynamic instability
6. Limb-threatening cellulitis in a patient with diabetes mellitus or peripheral arterial disease
7. Concern for need for surgical evaluation

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ADSP Northwestern Medicine Antimicrobial and Diagnostic Stewardship Program