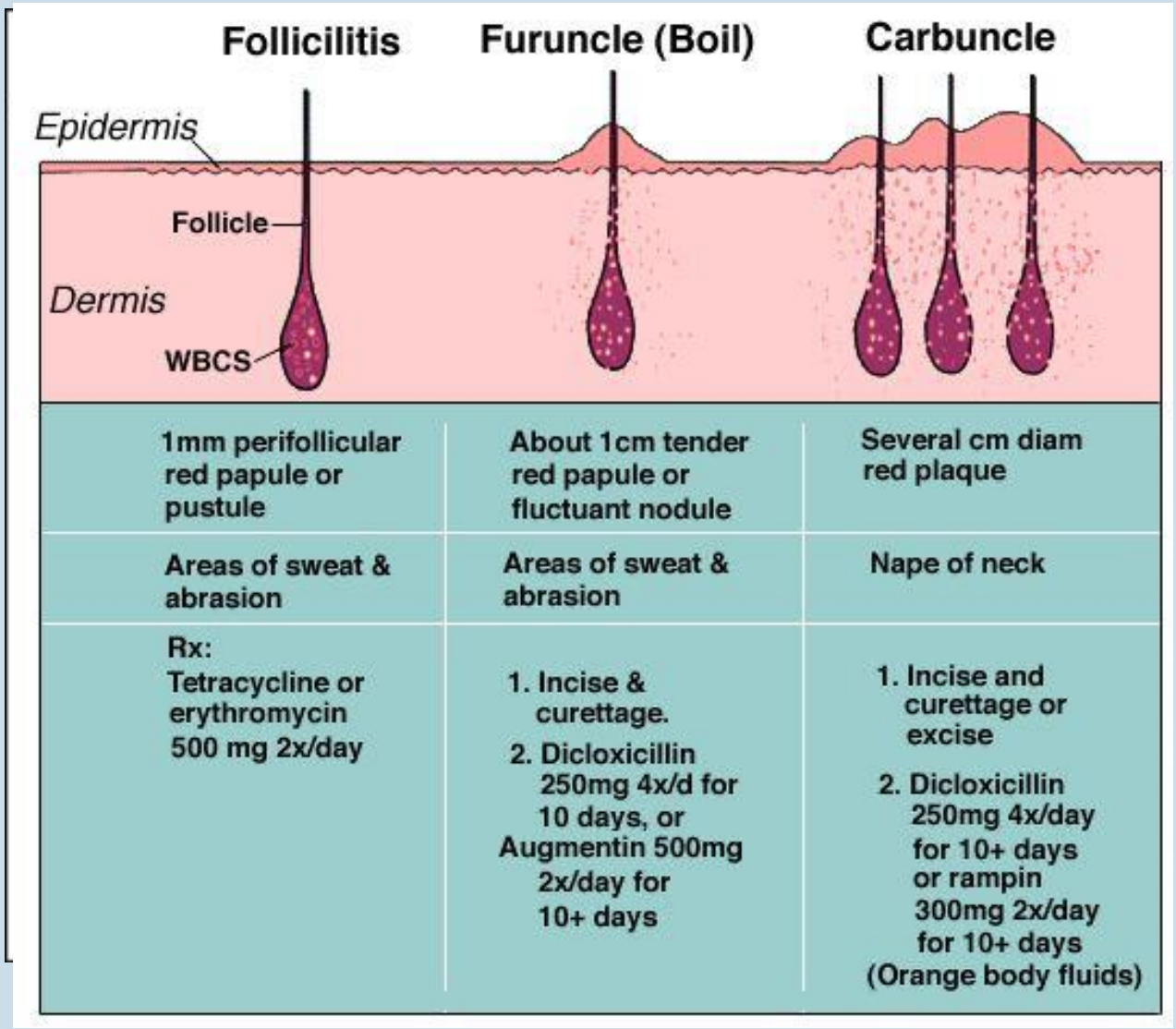
“I HAVE A RASH…”

TREATING CELLULITIS AND OTHER SSTIS IN THE OUTPATIENT SETTING

OBJECTIVES

- Distinguish and define the difference between common types of SSTIs: impetigo, ecthyma, cellulitis, erysipelas, abscesses, carbuncles, furuncles
- Review IDSA guidelines on the outpatient management of SSTIs
- Review diagnosis and treatment of purulent vs non-purulent SSTIs
- Provide recommendations for initiation of IV antibiotics



SSTI REVIEW

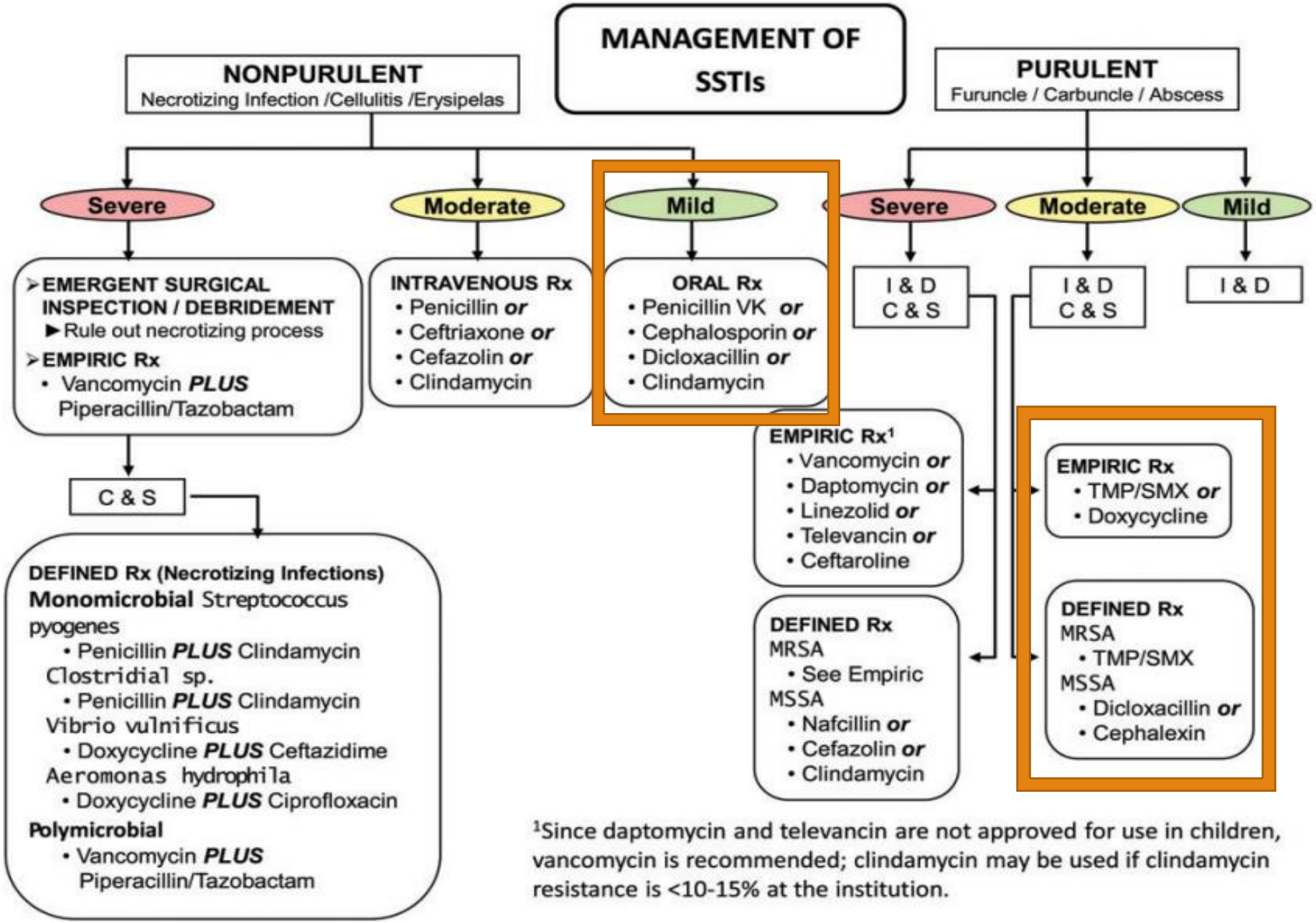
Carbuncles, furuncles, folliculitis: all involve follicles

Not seen here: ecthyma

Abscess: Dermis and subcutaneous fat

Erysipelas and cellulitis often overlap and are treated identically

Most common organism: streptococcus (Grps A, B, C, G, F), strep pyogenes. S aureus less common but important



[1]Since daptomycin and televancin are not approved for use in children, vancomycin is recommended; clindamycin may be used if clindamycin resistance is <10-15% at the institution.

	Culture?	I&D?	Empirically treat for S aureus?	Duration	Use
Impetigo/ Ecthyma	Yes, +Gram stain	N/A	No. Focu son strep unless with risk factors or +cx	5-7 days	Mupirocin BID or Retapamulin x5days MSSA- Keflex x7days MRSA: doxy, clinda, Bactrim x7 days
Purulent SSTIs (abscesses, furuncles, carbuncles)	Yes +Gram stain	Yes	Initial empiric txt should cover MRSA AND if fulfills SIRS	7 days or longer	Empiric: Bactrim or Doxy MRSA: Bactrim MSSA: Keflex, Dicloxacillin
Non-purulent (cellulitis, erysipelas)	Blood cx (bx or swabs NOT recommended)	N/A	No. Focus on strep unless pt has MRSA risk factors	5 days or longer	Keflex, Dicloxacillin, Clindamycin
Recurrent cellulitis	No	No	No	Weeks (see regimens)	PO penicillin or erythromycin BID 4-52 weeks IM benzathine penicillin Q2-4 weeks if 3-4 eps/yr despite txt or risk control

WHEN TO START IV ANTIBIOTICS

- Presence of hemodynamic instability
- Fulfills SIRS criteria
- Neutropenic
- Suspicion or diagnosis of necrotizing fasciitis or pyomyositis

TAKE-AWAY POINTS:

- IV antibiotics is for those with or at risk of having moderate/severe infection and ALWAYS for those with systemic symptoms
- Purulent cellulitis: I&D if possible, cover for MRSA
- Non-purulent cellulitis: cover for strep and MSSA, MRSA coverage is only for those at-risk
- Duration should be based on clinical response

BIBLIOGRAPHY

- Stevens et al. Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. July 2014:10-52.
- Raff AB, Kroshinsky D. Cellulitis: A Review. JAMA. 2016 Jul;316(3):325-37.