SHC Clinical Guideline: Outpatient Management of Skin and Soft Tissue Infections

Noted Guideline Exclusions
These Guidelines <u>DO NOT</u> include recommendations for the following: • Head & Neck SSTI • GU & GI SSTI • Animal Bite SSTI • Diabetic Foot Infection • Surgical site infections Alternative therapy may be considered

Table 1. Stanford Outpatient Empiric Antibiotic Guidelines for Acute Bacterial Skin and Soft Tissue Infections (SSTI)

Clinical Syndrome	Most Common Organism	Treatment Options	Duration	Comments
<u>**NON-PURULENT INFECTIONS**</u> Acutely spreading, poorly demarcated skin changes: dolor (pain), calor (heat), rubor (erythema), and tumor (swelling) **Erysipelas** Superficial sharply demarcated infection of the upper dermis without focus of purulence (drainage, exudate, or abscess) **Cellulitis** Deeper infection of the dermis & subcutaneous fat without focus of purulence (drainage, exudate, or abscess)	***B-hemolytic Streptococci*** ▪ Group A (*S. pyogenes*) ▪ Other Streptococcus groups: B,C,G	**Preferred:** **Cephalexin** 500mg PO q6h **OR** 1g PO q8h **Alternative for β-lactam Allergy[#]:** **Clindamycin** 450mg PO q8h or **TMP-SMX** 1-2 DS tab PO BID *Combination therapy is not recommended*	**5 Days**	<u>**When to Consider Cellulitis Mimics[†]**</u> ▪ Inconsistent presentation (bilateral distribution, well demarcated chronic to subacute progression, etc.) ▪ Symptoms improved with leg elevation without use of antibiotics ▪ Symptoms not improved with antibiotics <u>**Patient Instructions**</u> ▪ Elevate infected area above the level of the heart to reduce redness & swelling ▪ Keep infected area clean & dry ▪ Call your doctor if symptoms have not improved after 72h OR if fever or other symptoms develop
<u>**PURULENT INFECTIONS**</u> **Furuncle** Infection of a hair follicle extending to dermis with small 'boil' **Carbuncle** Infection of several follicles leading to coalescing mass **Abscess** Cutaneous collection of pus within dermis and deeper skin layers	***Staphylococcus aureus*** ▪ MSSA & MRSA	I&D + Antibiotics **Preferred:** **TMP-SMX** 1-2 DS tab PO BID **OR** **Doxycycline** 100mg PO BID *Clindamycin is not preferred therapy due to decreased susceptibility rates*	**5 Days After I&D**	▪ Tailor antibiotic therapy to results of gram stain, culture and susceptibilities from I&D ▪ *S. aureus* susceptibility rates are 99% for TMP-SMX and 93% for doxycycline[**] <u>**When to Consider Admission**</u> ▪ ≥2 SIRS criteria* ▪ Hypotension ▪ Rapid disease progression ▪ Clinical signs of deeper infection (bullae, skin sloughing, organ dysfunction)

*fever ≥38 or <36 C, tachycardia >90 bpm, RR> 20 bpm leukocytosis >12k cells/µL

[**]Table 3. 2021 SHC S. Aureus Outpatient Antibiogram

[†]Consider Dermatology Consult for evaluation of cellulitis mimics such as stasis dermatitis, lipodermatosclerosis, contact dermatitis, lymphedema

[#] Clinically significant IgE or T lymphocyte mediated β-lactam allergies are extremely rare (<5%)

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Table 2. Antimicrobial Drug Dosing in Renal Impairment

Antimicrobial Drug	CrCl > 30 mL/min*	CrCl 15-30 mL/min*	CrCl < 15 mL/min*	Intermittent Hemodialysis (thrice weekly dialysis)
Cephalexin (PO)	500mg q6h OR 1g q8h	500mg q8-12h	500mg q24h	500mg q24h (dosed after HD on HD days)
Clindamycin (PO)	450mg q6h	450mg q6h	450mg q6h	450mg q6h
TMP-SMX (PO) SS = single strength (80mg of TMP) DS = double strength (160mg of TMP)	1-2 DS tablets BID	Administer 50% of recommended dose	Administer 25-50% of usual dose - *Use with caution and close monitoring*	Administer 25-50% of recommended dose
Doxycycline (PO)	100mg q12h	100mg q12h	100mg q12h	100mg q12h

*Creatinine clearance (CrCl) is calculated via the Cockcroft-Gault Method

Table 3. 2021 SHC Data for *S. aureus* Isolates- Outpatient Setting**

Species	Number of Isolates	TMP/SMX	Tetracycline (Doxycycline)	Clindamycin	Levofloxacin	Linezolid
S. aureus	823	99% (823)	93.2% (823)	70.4% (815)	76.3% (823)	100% (823)

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