



Background

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VUMC Antibigrams
 UpToDate

Cellulitis Mimics

- Venous Stasis
- Lymphedema
- Vasculitis
- Shingles
- Gout

Presentation consistent with bacterial skin and soft tissue infection and/or abscess

Signs of cellulitis: Classically erythema, pain, swelling, warmth, often with smooth borders and unilateral presentation

Non-infectious causes to consider: Venous hyperstasis, DVT, Lymphedema

Symptoms suggesting need for admission: Systemic signs of toxicity* (eg, T >100.5°F, SBP <90 mmHg, sustained HR > 100 bpm) Rapid progression of erythema Progression of clinical findings after 48-72 hours oral antibiotics Inability to tolerate oral therapy Proximity of lesion to an indwelling medical device (e.g., prosthetic joint or vascular graft)

*In stable, otherwise healthy patient with mild systemic signs eg fever, can consider ED discharge with an injectable antibiotic followed by oral antibiotics.

Need for Admission? evaluation?

Mark erythema with marker or take a picture for the chart

If febrile: 2 sets of blood cultures

Discharge from ED Please see Cellulitis and Skin Abscess Pathway

Seek consultation with Surgery immediately Consider consulting Infectious Disease, if needed Concern for Necrotizing Soft Tissue Infection?

Symptoms suggesting Surgical/Medical Emergency: Rapidly spreading infection Pain out of proportion Crepitus Hemorrhagic bullae

Surgical or Medical Emergency?

Empiric Treatment for Dog/Cat/Human Bites Unasyn 3g IV q6h Oral option: Augmentin 875-125mg BID x5 days

Dog/Cat/Human Bite?

Nonpurulent infection, purulent infection, or drainable abscess?

Empiric oral antibiotic covering beta-hemolytic Streptococcus? Ceftriaxone 2g q24h or Cefazolin 2g q8h If requires empiric MRSA coverage, add: Vancomycin or for oral: Cephalixin 500mg PO QID Amoxiclav 875-125 PO BID

Have ED or ortho drain abscess Additional Imaging Superficial: US Deep: CT w/ contrast Osteo: MRI w/wo

Discharge Recommendations for presumed beta-hemolytic Streptococcus Amoxicillin 500mg TID x5 days or Cephalixin 500mg QID x5 days or Cefadroxil 1g BID If contraindications to other listed drugs, please consider: Linezolid 600mg PO BID

Consider MRSA coverage for (not comprehensive): Failure of other antibiotics Purulent drainage Known MRSA colonization or past infection Recent healthcare exposure IV drug abuse Hemodialysis Spider Bite

Nonpurulent

Purulent (non-drainable)

Culture purulent material

Empiric antibiotic coverage for MRSA*

Vancomycin Alternative: TMP-SMX 1 DS BID (2 DS BID if larger patient) Linezolid 600mg PO BID Doxycycline 100mg PO BID If patient is immunocompromised or having symptoms of severe sepsis, add: Cefepime 2g q8hrs Or if allergic to B-Lactam: Levofloxacin 750mg q24h If confident MRSA: Cefazolin 2g q8h Note: For perioral or perirectal, add Unasyn

Frequent causes of immunocompromise (not comprehensive): 1. Solid organ transplant in previous 12 months 2. Solid organ transplant AND treated for rejection in previous 6 months 3. Hematopoietic stem cell transplant in previous 12 months 4. Chronic GVHD 5. HIV with CD4 <200 6. Neutropenia with ANC <1000 7. Autoimmune disorders on biologic agents (e.g. TNFa inhibitors, rituximab, etc.) 8. Long-term corticosteroids (prednisone equivalent 20mg/day for at least 2 weeks)

Discharge recommendations for MRSA SSTI

Doxycycline 100mg BID x5 days or Bactrim 1 DS PO BID x5 days Consider adding for strep coverage (above agents have unreliable strep coverage): Amoxicillin 500mg TID x5 days or Cephalixin 500mg QID x5 days or Cefadroxil 1g BID Coverage of staph and strep and contraindications to above regimen, please consider: Linezolid 600mg PO BID

Discharge considerations: Total 5-6 days of antibiotics is standard. Can extend up to 14 days for severe infection or slow clinical response.

Disclaimer: 5 days includes time antibiotics received as inpatient

When to consider longer duration: Complicated Minimal to slow improvement Immunocompromised