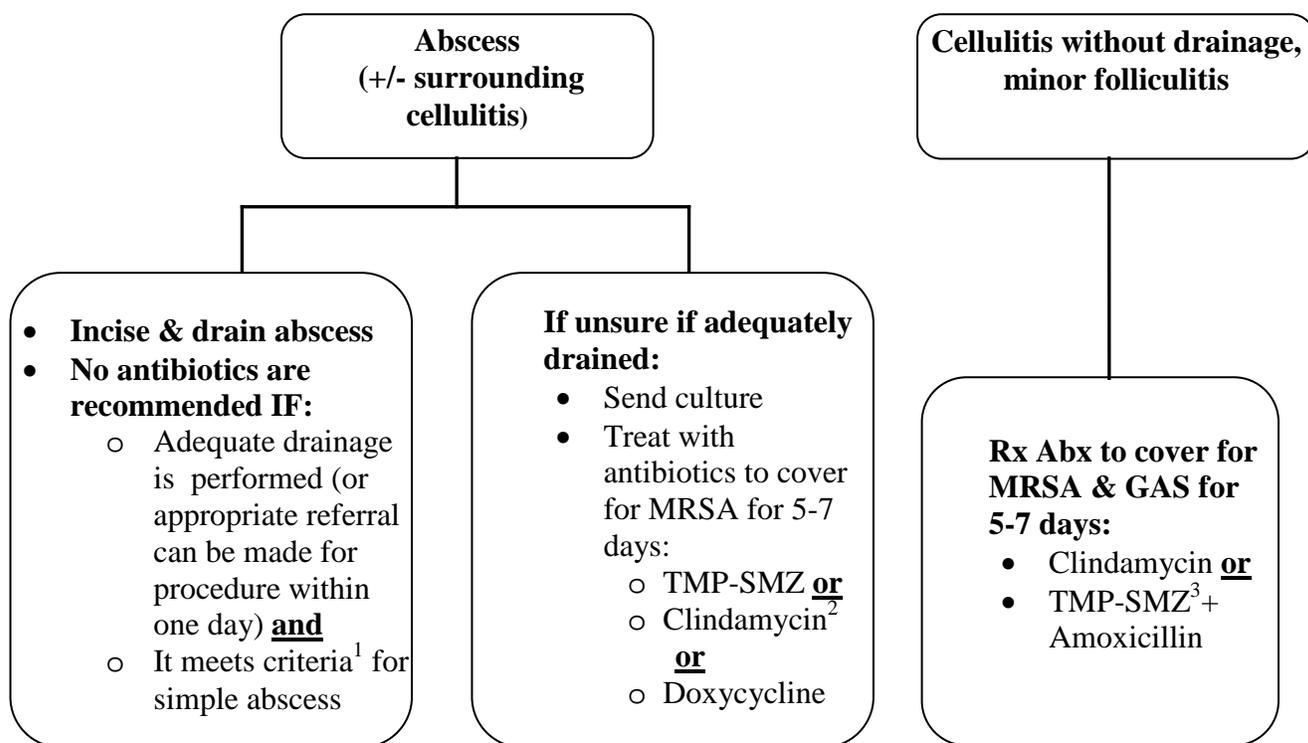


Outpatient Treatment Guidelines for Skin & Soft Tissue Infections in the era of increasing Community-Associated MRSA

1. For simple, drainable abscess(es) not involving deeper structures, incision & drainage (I&D) is the treatment of choice alone. Antibiotics are not necessary or recommended if the following criteria are met:
 - i. Adequate I & D can be performed, or appropriate referral can be made for procedure within one day
 - ii. No systemic signs (afebrile, otherwise stable and a candidate for outpatient therapy)
 - iii. No abscess is present on the face

If these criteria are met, I & D is preferable to antibiotics.
2. There is no evidence that mildly immunosuppressive underlying conditions such as diabetes mellitus or HIV would change this recommendation.
3. Send wound culture (ideally obtained from I & D) **if**:
 - i. Patient doesn't meet the criteria above and will need antibiotics
 - ii. Patient has recurrent skin and soft tissue infections

See following algorithm for additional guidance:



MRSA sensitivities in Kings County do not support the empiric use of Clindamycin.

¹Criteria for simple abscess:

- No systemic signs (afebrile, otherwise stable and a candidate for outpatient therapy)
- No abscess is present on the face

²If patient has risk factors for healthcare-associated MRSA (hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, or an indwelling catheter or percutaneous medical device at the time of culture), clindamycin is NOT recommended.

³Doxycycline is an acceptable alternative to TMP-SMZ if patient has allergy or contraindications to TMP-SMZ

Other miscellaneous guidance:

- Impetigo may still be treated empirically with antibiotics to cover Group A Streptococcus (GAS) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) such as cephalexin or dicloxacillin.
- Once culture results are available, if MSSA is recovered, a beta-lactam antibiotic such as cephalexin or dicloxacillin is preferable.
- These infections can be extremely painful and recommendation or prescription of pain relief medication may be appropriate.
- Criteria to consider hospital admission:
 - Systemically ill (fevers, chills)
 - Failed outpatient therapy
 - Parenteral therapy indicated secondary to severely immunosuppressive conditions (e.g. AIDS, chemotherapy, etc.)
- Decolonization/Eradiation:
 - There is insufficient data to recommend the routine use of intranasal mupirocin or any specific decolonization or eradication regimens. Various studied regimens have not been proven effective in preventing re-infection or primary or secondary transmission in the community. Consider consultation with an Infectious Disease specialist for recommendations for specific circumstances such as patients with recurrent SSTIs.

ANTIBIOTICS

Drug	Adult Dose	Pediatric Dose	Advantages	Disadvantages
Clindamycin	300mg po TID	30mg/kg/day divided TID	<ul style="list-style-type: none"> • GAS, MRSA & MSSA activity • Excellent tissue & abscess penetration 	<ul style="list-style-type: none"> • Potential for resistance • Taste (suspension) • <i>C. difficile</i> risk
Trimethoprim-Sulfamethoxazole (TMP/SMZ)	2 DS po BID (<50 kg: 1 DS TID)	Trimethoprim 8-12mg/kg/day Sulfamethoxazole 40-60mg/kg/day divided BID	<ul style="list-style-type: none"> • Extremely low resistance • MSSA & MRSA activity 	<ul style="list-style-type: none"> • Unreliable for GAS • Not recommended for women in 3rd trimester
Doxycycline	100 mg po BID	>8 years old only: 2-4mg/kg/day divided BID	<ul style="list-style-type: none"> • Low resistance • MSSA & MRSA activity 	<ul style="list-style-type: none"> • Unreliable for GAS • Not for use in <8 yo or pregnant women
Amoxicillin	500-875 mg po BID	25-45 mg/kg/day divided BID	Inexpensive, palatable	GAS activity only, doesn't cover <i>S. aureus</i>

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