Cellulitis

General points

- Common pathogens are S. aureus including MRSA & pyogenic streptococci (Groups A, C & G streptococci).
- Consider other pathogens if trauma, water or other exposures - Contact microbiology for advice.
- Review previous microbiology test results for MRSA and susceptibility profiles of other potential pathogens particularly if allergic to penicillin.
- Swab culture is not recommended as principle for identifying the causative bacteria in cellulitis patients. However, in immunosuppressed patients or those with neutropenia or in severe forms associated with systemic signs of inflammation or that do not respond to first-line therapy, culture may be helpful to identify the causative bacteria and define a targeted therapy.

Antibiotics (Empiric therapy)

First Line:

Flucloxacillin 2g QDS IV.

Oral switch/mild cellulitis: **Flucloxacillin** 500mg-1g QDS PO.

Penicillin allergy:

NOT IgE mediated reaction/anaphylaxis:

Cefuroxime 750mg- 1.5g TDS IV.

Oral switch/mild cellulitis: **Cefalexin** 500mg-1g TDS PO

Severe IgE mediated reaction/anaphylaxis to penicillin:

Clindamycin 300-450mg QDS PO OR 600mg- 1.2g QDS IV if oral administration not possible.

If known or suspected **MRSA** add **Vancomycin** or **Teicoplanin** to the all of the above regimes whilst awaiting culture results. For oral switch for proven MRSA infection contact microbiology to discuss. (Please see Vancomycin / Teicoplanin dosing schedule).

Severe cellulitis: as above

AND add **Vancomycin** or **Teicoplanin** as some strains of S. aureus and streptococci can be resistant to clindamycin. (Please see Vancomycin / Teicoplanin dosing schedule).

Consider the addition of Clindamycin 450mg QDS PO for 3-5 days. IV route may be indicated. Discuss these patients with the microbiology. As clindamycin is associated with a risk of C. difficile infection, short treatment courses are usually advised.

Comments

Duration : 5 days, may extend to 7-10 days if lack of symptom resolution at 5 days.

- Incision and drainage may be required in purulent cellulitis.
- Consider potential for deep seated infection such as underlying osteomyelitis if cellulitis related to ulcer or wound.
- Severe cellulitis should not be treated with a macrolide (erythromycin/clarithromycin).
- In confirmed Group A streptococcal infection discuss with microbiology and change to Benzylpenicillin IV + Clindamycin.