

## Pearl of Knowledge

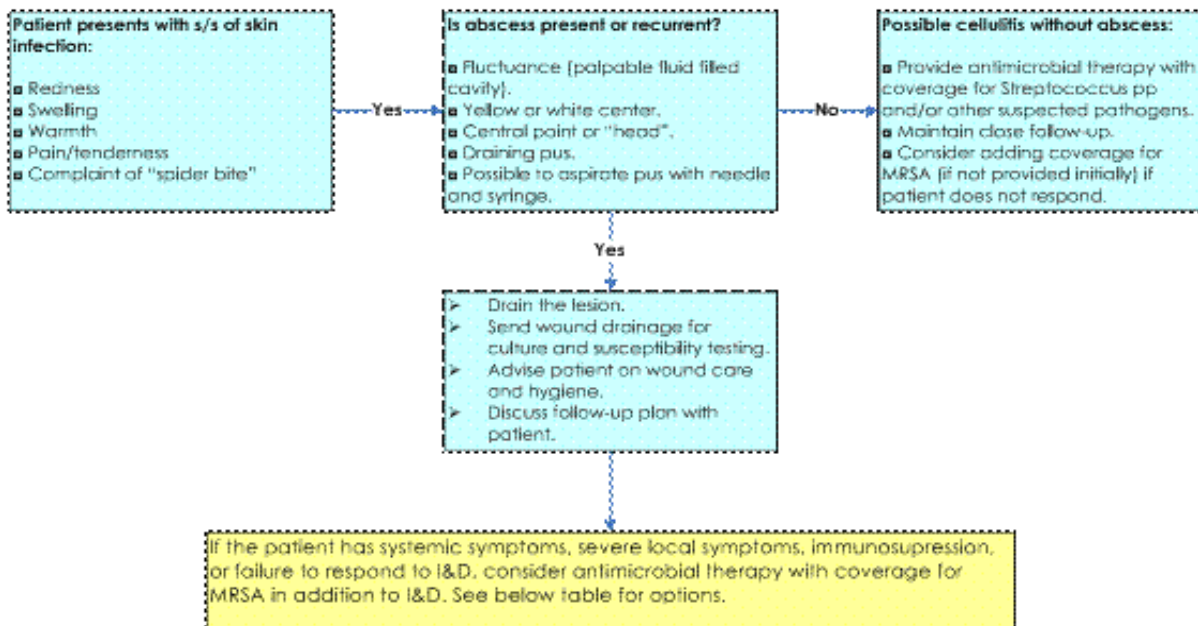
Evidence-based Summary Documents



### Summary Recommendations: Treatment of Skin Infections

1. Not all skin abscesses need antibiotic therapy. Often, unless there is a significant cellulitis or systemic symptoms, the abscess can be treated with incision and drainage alone.
2. Abscess formation should make one think about MRSA as the most likely organism, and treat accordingly. The best choices for empiric therapy are Trimethoprim-Sulfamethoxazole or Doxycycline. Because these are not reliable for treating streptococcal infections, an additional antibiotic may be needed until culture results are available.
3. Microbiology is reporting that Clindamycin has an effective rate of approximately 55%. Consequently, Clindamycin should not be used for empiric therapy. Clindamycin should be used when isolates indicate sensitivity and the patient is allergic to Bactrum and Doxycycline.

## Ambulatory Care Management of Skin and Soft Tissue Infection in the era of Community-Associated MRSA



Options for empiric outpatient antimicrobial treatment of SSTIs when MRSA is a consideration.		
Antimicrobial	Adult Dose	Pediatric dose
Trimethoprim-sulfamethoxazole (TMP-SMX) DS	(160mg TMP/800mg SMX) 1-2 tabs po bid x 10-14 days 3 tabs po bid id BMI ≥ 30	<i>Base dose:</i> 8-12mg TMP & 40-60mg SMX per kg per day in 2 doses. (Not to exceed adult dose).
Minocycline or Doxycycline	100mg po bid x 10-14 days	Not recommended for pediatric use or during pregnancy. Please consult with Infectious Disease.
Clindamycin (Not useful for empiric therapy. Useful if the MRSA isolate is known to be susceptible and if patient is allergic to betalactams or sulfa).	300-450mg po qid x 10-14 days	10-20mg/kg/day in 3-4 doses. (Not to exceed adult dose).
<ul style="list-style-type: none"> <li>➤ When using TMP-SMX or a tetracycline for empiric coverage, additional coverage for streptococci may be necessary. Consider adding amoxicillin or Cephalexin.</li> <li>➤ Fluoroquinolones are not recommended.</li> </ul>		

Role of Decolonization
<ul style="list-style-type: none"> <li>➤ Regimens intended to eliminate MRSA colonization should not be used in patients with active infections.</li> <li>➤ Decolonization regimens may have a role in preventing recurrent infections, but more data are needed to establish their efficacy and to identify optimal regimens for use in community settings.</li> <li>➤ <u>After treating active infections and reinforcing hygiene and appropriate wound care</u>, please consult with an Infectious Disease Specialist regarding use of decolonization when there are recurrent infections in an individual patient or member of a household.</li> </ul>

**Resources:**

CDC: [www.cdc.gov/mrsa](http://www.cdc.gov/mrsa)

MDH: <http://www.health.state.mn.us/divs/idepc/diseases/mrsa/index.html>

**Questions:**

Please reply to this e-mail, and your questions(s) will be directed to the author of this Pearl.

**All Pearl recommendations are consistent with professional society guidelines, and reviewed by HealthPartners Physician Leadership.**