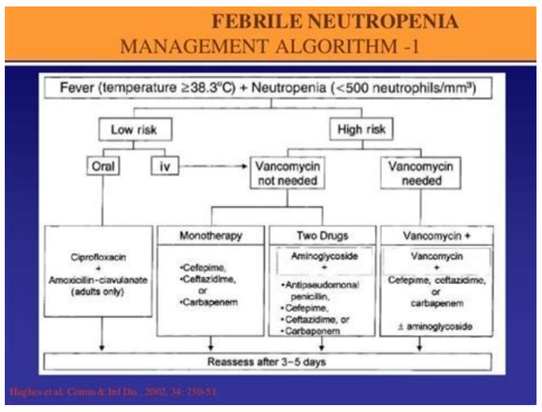
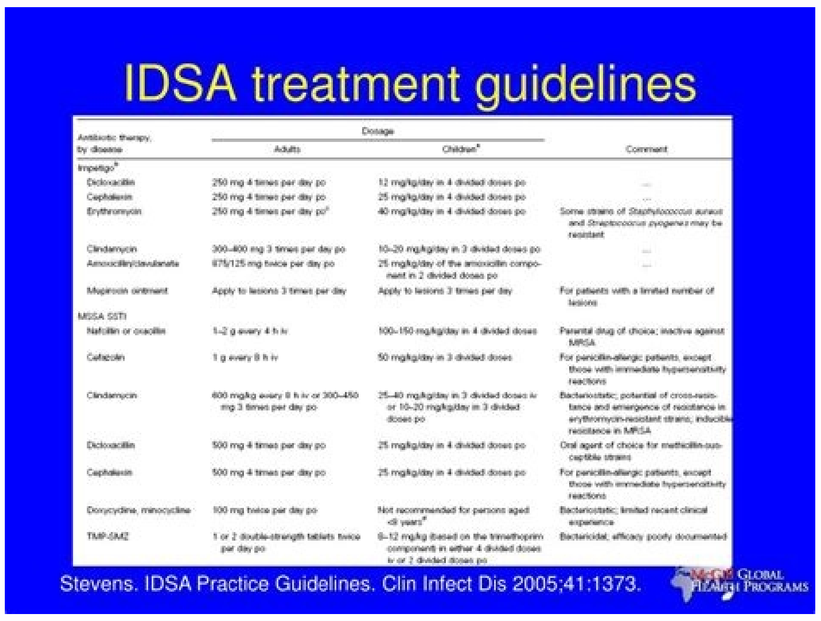
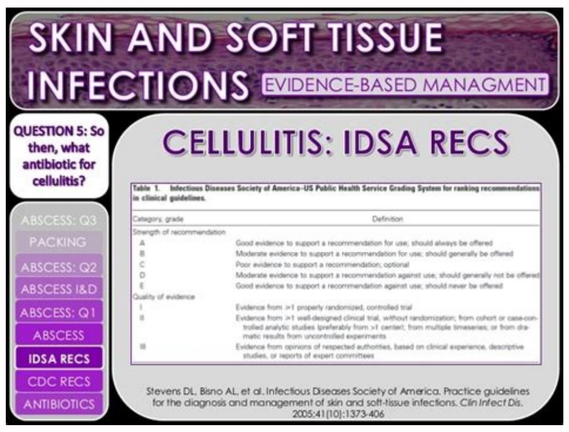
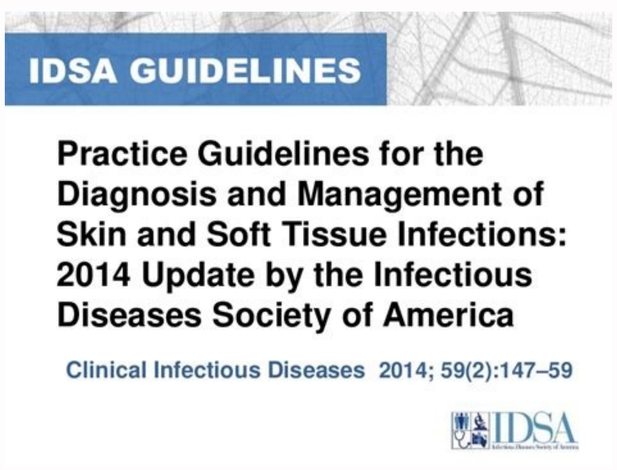
Idsa cellulitis guidelines 2014









Idsa guidelines for antibiotics. Cellulitis idsa guidelines.

1. IDSA GUIDELINES Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Diseases Society of America Clinical Infectious Diseases 2014; 59(2):147–59 2. What Is the Appropriate Evaluation and Treatment for Purulent SSTIs (Cutaneous Abscesses, Furuncles, Carbuncles, and Inflamed Epidermoid Cysts)? 3. Gram stain and culture of pus from carbuncles and abscesses are recommended, but treatment without these studies is reasonable in typical cases (strong, moderate). 4. Gram stain and culture of pus from inflamed epidermoid cysts are not recommended (strong, moderate). 5. Incision and drainage is the recommended treatment for inflamed epidermoid cysts, carbuncles, abscesses, and large furuncles, mild (strong, high). 6. The decision to administer antibiotics directed against S. aureus as an adjunct to incision and drainage should be made based upon presence or absence of systemic inflammatory response syndrome (SIRS), such as temperature >38ºC or 24 bpm, tachycardia >90 bpm, or WBC >12000 or < 400 cells/µL (moderate) (strong, low). An antibiotic active against MRSA is recommended for patients with carbuncles or abscesses who have failed initial antibiotic treatment or have markedly impaired host defenses or in patients with SIRS and hypotension (severe) (strong, low). 7. What Is Appropriate for the Evaluation and Treatment of Erysipelas and Cellulitis? 8. Cultures of blood or cutaneous aspirates, biopsies, or swabs are not routinely recommended (strong, moderate). 9. Cultures of blood are recommended (strong, moderate), and cultures and microscopic examination of cutaneous aspirates, biopsies, or swabs should be considered in patients with malignancy on chemotherapy, neutropenia, severe cell-mediated immunodeficiency, immersion injuries, and animal bites (weak, moderate). 10. Typical cases of cellulitis without systemic signs of infection should receive an antimicrobial agent that is active against streptococci (mild) (strong, moderate). For cellulitis with systemic signs of infection (moderate nonpurulent), systemic antibiotics are indicated. Many clinicians could include coverage against MSSA (weak, low). For patients whose cellulitis is associated with penetrating trauma, evidence of MRSA infection elsewhere, nasal colonization with MRSA, injection drug use, or SIRS (severe nonpurulent), vancomycin or another antimicrobial effective against both MRSA and streptococci is recommended (strong, moderate). In severely compromised patients (severe nonpurulent), broad-spectrum antimicrobial coverage may be considered (weak, moderate). Vancomycin plus either piperacillin-tazobactam or imipenem/meropenem is recommended as a reasonable empiric regimen for severe infections (strong, moderate). 11. The recommended duration of antimicrobial therapy is 5 days, but treatment should be extended if the infection has not improved within this time period (strong, high). 12. In lower-extremity cellulitis, clinicians should carefully examine the interdigital toe spaces because treating fissuring, scaling, or maceration may eradicate colonization with pathogens and reduce the incidence of recurrent infection (strong, moderate). 13. Outpatient therapy is recommended for patients who do not have SIRS, altered mental status, or hemodynamic instability (mild nonpurulent) (strong, moderate). Hospitalization is recommended if there is concern for a deeper or necrotizing infection, for patients with poor adherence to therapy, for infection in a severely immunocompromised patient, or if outpatient treatment is failing (moderate or severe nonpurulent) (strong, moderate). 14. Should Anti-inflammatory Agents Be Used to Complement Antibiotic Treatment of Cellulitis? 15. Systemic corticosteroids (eg, prednisone 40 mg daily for 7 days) could be considered in nondiabetic adult patients with cellulitis (weak, moderate). 16. What Is the Preferred Evaluation and Management of Patients With Recurrent Cellulitis? 17. Identify and treat predisposing conditions such as edema, obesity, eczema, venous insufficiency, and toe web abnormalities (strong, moderate). These practices should be performed as part of routine patient care and certainly during the acute stage of cellulitis (strong, moderate). 18. Administration of prophylactic antibiotics, such as oral penicillin or erythromycin bid for 4–52 weeks, or intramuscular benzathine penicillin every 2–4 weeks, should be considered in patients who have 3–4 episodes of cellulitis per year despite attempts to treat or control predisposing factors (weak, moderate). This program should be continued so long as the predisposing factors persist (strong, moderate). 19. What Is the Preferred Management of Surgical Site Infections? 20. Suture removal plus I&D should be performed for surgical site infections (strong, low). 21. Adjunctive systemic antimicrobial therapy is not routinely indicated, but in conjunction with I&D may be beneficial for surgical site infections associated with a significant systemic response, such as erythema and induration extending >5 cm from the wound edge, temperature>38.5ºC, heart rate >110 bpm, or WBC >12 000/µL (weak, low). 22. A brief course of systemic antimicrobial therapy is indicated in patients with surgical site infections following clean operations on the trunk, head and neck, or extremities that also have systemic signs of infection (strong, low). 23. A first-generation cephalosporin or an anti-staphylococcal penicillin for MSSA, or vancomycin, linezolid, daptomycin, telavancin, or ceftaroline where risk factors for MRSA are high (nasal colonization, prior MRSA infection, recent hospitalization, recent antibiotics), is recommended (strong, low). 24. Agents active against gram-negative bacteria and anaerobes, such as a cephalosporin or fluoroquinolone in combination with metronidazole, are recommended for infections following operations on the axilla, GI tract, perineum, or female genital tract (strong, low). 25. What Is the Preferred Evaluation and Treatment of Necrotizing Fasciitis, Including Fournier Gangrene? 26. Prompt surgical consultation is recommended for patients with aggressive infections associated with signs of systemic toxicity or suspicion of necrotizing fasciitis or gas gangrene (severe nonpurulent) (strong, low). 27. Empiric antibiotic treatment should be broad (eg, vancomycin or linezolid plus piperacillin-tazobactam or a carbapenem; or plus ceftriaxone and metronidazole), as the etiology can be poly-microbial (mixed aerobic–anaerobic microbes) or mono-microbial (group A streptococci, community-acquired MRSA) (strong, low). 28. Penicillin plus clindamycin is recommended for treatment of documented group A streptococcal necrotizing fasciitis (strong, low). 29. What Is the Appropriate Approach to the Management of Pyomyositis? 30. MRI is the recommended imaging modality for establishing the diagnosis of pyomyositis. CT and ultrasound studies are also useful (strong, moderate). 31. Cultures of blood and abscess material should be obtained (strong, moderate). 32. Vancomycin is recommended for initial empirical therapy. An agent active against enteric gram-negative bacilli should be added for infection in immunocompromised patients or following open trauma to the muscles (strong, moderate). 33. Cefazolin or anti-staphylococcal penicillin (eg, nafcillin or oxacillin) is recommended for treatment of pyomyositis caused by MSSA (strong, moderate). 34. Early drainage of purulent material should be performed (strong, high). 35. Repeat imaging studies should be performed in the patient with persistent bacteremia to identify undrained foci of infection (strong, low). 36. Antibiotics should be administered intravenously initially, but once the patient is clinically improved, oral antibiotics are appropriate for patients in whom bacteremia cleared promptly and there is no evidence of endocarditis or metastatic abscess. Two to 3 weeks of therapy is recommended (strong, low). 37. What Is the Appropriate Approach to the Evaluation and Treatment of Clostridial Gas Gangrene or Myonecrosis? 38. Urgent surgical exploration of the suspected gas gangrene site and surgical debridement of involved tissue should be performed (severe nonpurulent) (strong, moderate). 39. In the absence of a definitive etiologic diagnosis, broadspectrum treatment with vancomycin plus either piperacillin/tazobactam, ampicillin/sulbactam, or a carbapenem antimicrobial is recommended (strong, low). Definitive antimicrobial therapy with penicillin and clindamycin is recommended for treatment of clostridial myonecrosis (strong, low). 40. Hyperbaric oxygen (HBO) therapy is not recommended because it has not been proven as a benefit to the patient and may delay resuscitation and surgical debridement (strong, low). 41. What Is the Role of Preemptive Antimicrobial Therapy to Prevent Infection for Dog or Cat Bites? 42. Preemptive early antimicrobial therapy for 3–5 days is recommended for patients who a) are immunocompromised b) are asplenic c) have advanced liver disease d) have preexisting or resultant edema of the affected area e) have moderate to severe injuries, especially to the hand or face f) have injuries that may have penetrated the periosteum or joint capsule (strong, low). 43. Postexposure prophylaxis for rabies may be indicated;consultation with local health officials is recommended to determine if vaccination should be initiated (strong, low). 44. What Is the Treatment for Infected Animal Bite–Related Wounds? 45. An antimicrobial agent or agents active against both aerobic and anaerobic bacteria such as amoxicillin-clavulanate should be used (strong, moderate). 46. Should Tetanus Toxoid Be Administered for Animal Bite Wounds? 47. Tetanus toxoid should be administered to patients without toxoid vaccination within 10 years. Tetanus, diptheria, and tetanus (Tdap) is preferred over Tetanus and diptheria (Td) if the former has not been previously given (strong, low). 48. In Which Patients Is Primary Wound Closure Appropriate for Animal Bite Wounds? 49. Primary wound closure is not recommended for wounds, with the exception of those to the face, which should be managed with copious irrigation, cautious debridement, and preemptive antibiotics (strong, low). Other wounds may be approximated (weak, low).

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