<table>
<thead>
<tr>
<th>Cellulitis/Erysipelas Severity</th>
<th>Preferred Empiric Regimens</th>
<th>Duration of Therapy</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Mild</strong> (no signs of systemic toxicity) - Assess for risk factors or clinical evidence of MRSA (e.g. purulent boil with spreading cellulitis, previous MRSA infections or colonization)</td>
<td>cephalaxin 500 - 1000 mg PO q6h&lt;sup&gt;2&lt;/sup&gt;  OR  cefadroxil 500 - 1000 mg PO q12h&lt;sup&gt;2,3&lt;/sup&gt;  <strong>True immediate allergy</strong> to a beta-lactam at risk of cross-reactivity with cephalaxin or cefadroxil: cefuroxime 500 mg PO q8-12h&lt;sup&gt;2&lt;/sup&gt;  <strong>Severe delayed reaction</strong> to a beta-lactam where their future use is not recommended: clindamycin 300 - 450 mg PO q6h MRSA Suspected: sulfamethoxazole/trimethoprim 800/160 mg to 1600/320 mg (1 or 2 DS tablets) PO q12h&lt;sup&gt;2,6&lt;/sup&gt;  OR  doxycycline 100 mg PO q12h&lt;sup&gt;6&lt;/sup&gt;</td>
<td>5 days (may extend duration if not improved)</td>
<td>Work-up: None, unless there is an associated fluctuant pustule that can be drained and sent for culture</td>
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<td><strong>Moderate</strong> (signs of systemic toxicity) OR Progression on oral therapy</td>
<td>ceFAZolin 2 g IV q8h&lt;sup&gt;2&lt;/sup&gt;  <strong>Alternative for outpatient management:</strong> probenecid 1 g PO followed 30 - 60 min later by ceFAZolin 2 g IV, repeated q24h&lt;sup&gt;2&lt;/sup&gt;  OR  cefTRIAXone 2 g IV q24h  <strong>Severe delayed reaction</strong> where future use of beta-lactams not recommended: clindamycin 600-900 mg IV q8h MRSA suspected, add: vancomycin 25 to 30 mg/kg IV x 1 dose then 15 mg/kg IV q8-12h&lt;sup&gt;2&lt;/sup&gt; (adjust based on levels to a trough target of 15 - 20 mg/L)</td>
<td>5 days (may extend duration if not improved)</td>
<td>Work-up: As above plus: Consider blood cultures (2 sets)</td>
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<td><strong>Severe</strong> (sepsis syndrome, Necrotizing Fasciitis [clinical features of NF include systemic toxicity, deep severe pain – more severe than expected for skin findings, violaceous bullae, rapid spread along fascial planes, gas in soft tissues])</td>
<td>ceFAZolin 2 g IV q8h <strong>with or without</strong> clindamycin 900 mg IV q8h  <strong>Risk of mixed bacterial infection:</strong> piperacillin-tazobactam 3.375 g IV q6h&lt;sup&gt;2&lt;/sup&gt; <strong>with or without</strong> clindamycin 900 mg IV q8h MRSA suspected, add: vancomycin 25 to 30 mg/kg IV x 1 dose then 15 mg/kg IV q8-12h&lt;sup&gt;2&lt;/sup&gt; (adjust based on levels to a trough target of 15 - 20 mg/L)</td>
<td>Consult with specialists</td>
<td>Work-up: As above plus: urgent surgical assessment for diagnostic biopsy and/or debridement</td>
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**Clinical pearls:**
- These guidelines are for basic skin infections only, any complicating features on history may require alternative management (Specific but not exclusive examples include: immunocompromised patients, diabetic foot infections, cellulitis associated with a surgical site, trauma or animal/human bites)
- Consider looking for predisposing feature (e.g. Tinea pedis) as source of cellulitis
1 MRSA risk factors: history of MRSA infection or colonization, household contact with a MRSA colonized individual, IV drug use, homelessness, incarcerated persons, recent travel to or residing in an MRSA endemic region or community
2 Dose adjustment required in renal impairment
3 Non-formulary agent not available within hospital
4 True, immediate IgE-mediated allergies include, but are not limited to: anaphylaxis, urticaria, angioedema, hypotension, bronchospasm, stridor, and pruritis.
5 Stevens-Johnson syndrome, toxic epidermal necrolysis, immune hepatitis, DRESS, serum sickness, hemolytic anemia or interstitial nephritis
6 Poor coverage for beta-hemolytic streptococci, consider combining with cephalaxin or cefadroxil
7 Assessment of clinical response within 48 hours should be based on pain and fever; **mild progression of erythema expected during this timeframe**
8 IV to PO conversion appropriate when patient: afebrile, hemodynamically stable, clinically improving, and able to tolerate oral intake (see IV to PO conversion policy for more details)
References:


