## MANAGEMENT OF CELLULITIS IN ADULTS

### Diagnosis

- Flu-like symptoms, malaise, onset of UNILATERAL swelling, pain, redness

### Treatment

- Consider Tinea pedis as site of entry – treat with antifungal cream e.g. terbinafine 1% cream twice daily for 7 days

#### First line

<table>
<thead>
<tr>
<th>Mild</th>
<th>Penicillin allergy or at risk of MRSA</th>
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<tbody>
<tr>
<td>Flucloxacillin oral 1g QDS for 7 days</td>
<td>Doxycycline oral 100mg BD for 7 days</td>
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<tr>
<td>If not resolving: Doxycycline 100mg BD for 7 days</td>
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</tbody>
</table>

#### Sepsis

<table>
<thead>
<tr>
<th>Penicillin allergy:</th>
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<tr>
<td>Clindamycin 1.2g IV QDS + Gentamicin 7mg/kg IV (see gentamicin guideline)</td>
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</tbody>
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#### Septic Shock and/or Necrotising Fasciitis (NF)

- Flucloxacillin 2g IV QDS + Clindamycin 1.2g IV QDS + Gentamicin 7mg/kg IV (see gentamicin guideline)

  - Note: Fournier's Gangrene - piperacillin/tazobactam IV 4.5g tds + clindamycin IV 1.2g tds + gentamicin IV

#### At risk of MRSA:

- As above + Vancomycin IV (see vancomycin guideline)

### Suggested criteria for oral switch and/or discharge

- Pyrexia settling
- Less intense erythema
- Falling inflammatory markers
- 

### Suitable agents for oral switch therapy

- Penicillin allergy -
- Doxycycline 100mg bd or
- Clindamycin 300mg tds <50kg
- Clindamycin 450mg tds 50-90kg
- Clindamycin 600mg tds or 450mg qds >90kg or very severe

**MRSA and not doxycycline sensitive** - Seek ID/Micro advice

### Assess severity and MRSA risk.

- If patient is diabetic or has a chronic wound also refer to additional guidance.

### Investigations

- FBC
- CRP
- U+E
- Culture any exudate
- Blood Cultures (not for mild cases)
- Glucose
- Lactate (not for mild cases)

### OHPAT Service

For patients who may be suitable for IV outpatient therapy please follow referral process

**Developed by:** Antimicrobial Management Group  
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**Updated:** Nov 2017  
**Review:** Nov 2019