**STOP AND THINK BEFORE YOU PRESCRIBE ANTIBIOTICS** Does your patient actually have an infection, and require treatment?
- Ensure optimal management of co-existing conditions, particularly diabetes mellitus, peripheral vascular disease or rheumatoid arthritis
- If appearance is atypical or if there is failure to progress after 12 weeks appropriate management consider referral
- Optimal wound care must be maintained throughout treatment – See NHS Tayside wound management formulary (WMF)
- Consider differential diagnosis of venous eczema in suspected bilateral lower limb cellulitis
- Wounds less than 4 weeks old are not considered chronic and should be managed according to the NHS Tayside Wound Management Formulary (WMF)
- Recommendations are for non-pregnant adults and doses stated assume normal renal and hepatic function

**Management of Suspected Infection in Chronic Wounds and Ulcers**

**NEWS≥5 and infection: THINK SEPSIS**
If 2 or more of the following AND clinical suspicion of infection
- Temp >38°C or <36°C
- Pulse >90 bpm
- WCC <4 or >12
- Altered mental state
- Known or suspected neutropenia

**NO sepsis**

If the patient has diabetes click [here](#) for guidance on wound care and [here](#) for antibiotic selection and seek advice

**Localised infection likely**
DO NOT SWAB
Use antimicrobial dressings (honey, iodine, Cutimed Sorbact® or Flaminal®) for 2 weeks. If partial response is achieved, continue use for a maximum of 4 weeks. ([see WMF](#)).

**Wound infection unlikely**
DO NOT SWAB
Normal wound care

**Systemic infection likely**
- Consider admission if sepsis (see information above), spreading cellulitis despite oral antibiotics, lymphangitis, at high risk of complications or unable to take oral medication and refer to [Management of Cellulitis](#)
- Cleanse with saline or tap water and swab the edge of the wound
- Send any aspirate, pus or loose tissue for culture
- Include wound duration and site, and any recent antibiotics on microbiology request
- Use antimicrobial dressings as for localised infection

**AND**
Commence systemic antibiotics for 7 days – consider severity of symptoms, risk of complications and previous antibiotic use.
- Flucloxacillin 1g four times daily OR
- Doxycycline 100mg twice daily (in penicillin allergy)

If history or risk of MRSA use
- Doxycycline 100mg twice daily
- If not sensitive to doxycycline seek advice from microbiology

Reassess if symptoms worsen rapidly or significantly at any time, if no improvement within 2 to 3 days or the person becomes systemically very unwell. Seek specialist advice or consider referral if concerns of more serious illness eg. sepsis/ necrotising fasciitis/ osteomyelitis.

**Significant organisms**
- **Staph aureus**
- Group A, B, C or G streptococcus
- Milleri group

**Likely colonisers**
- Pseudomonas aeruginosa
- Escherichia coli
- Proteus
- Klebsiella
- Enterobacter
- Coagulase-negative staphylococci
- Bacillus sp
- Anaerobes
- Corynebacterium

**Adjust antibiotic treatment in line with sensitivities, but be aware of likely colonisers that should not alter management**

**References**
- [Public Health England, SIGN CG 120](#)
- [Potassium permanganate should be used as a soak for weeping wounds. See Wound Management Formulary](#)
- [If further advice required after use of above protocol please contact the on call doctor for the relevant specialty; or microbiology on bleep 4039.](#)
- [References: PHE, SIGN CG120, BNF 78](#)