Management of Uncomplicated Skin and Skin Structure Infections

PURULENT SKIN INFECTIONS

ABSCESSES[1,2,3]

EXCLUSIONS

The following infections are not addressed in the guidelines: Dental abscesses, deep neck abscesses, abscesses due to bites, diabetic feet or orbital infections, ischiorectal, perirectal, and pilonidal abscesses

DIFFERENTIAL DIAGNOSIS

- epidermoid cyst
- hematoma
- bursitis

Purulent Abscess

INVESTIGATIONS

For uncertain diagnosis consider Ultrasound or large bore (16-18G) needle aspirate

TREATMENT

FIRST OCCURRENCE

- Incision and drainage
- Culture not routinely recommended
- There is no consensus on the clinical value of packing the wound

TREATMENT FAILURE OR SPONTANEOUS RECURRENCE

WITHIN 30 DAYS

- Incision and drainage
- Send specimen for microbiological diagnosis
- Start empiric antimicrobial therapy

FIRST LINE THERAPY

- co-trimoxazole** 1 DS tablet orally twice a day
- doxycycline *** 100 mg orally twice a day

SUBSEQUENT RECURRENCES

WITHIN 6 MONTHS

- Incision and drainage
- Send specimen for microbiological diagnosis
- Start empiric antimicrobial therapy
- Ensure that the pathogen identified during the previous incident is susceptible to the antibiotic chosen
- Consider referring patient to an Infectious Disease Clinic for follow-up

Empiric antimicrobial therapy should cover *Staphylococcus aureus* including community-acquired methicillin-resistant *Staphylococcus aureus* (CA-MRSA). If the organism cultured is NOT MRSA consider switching to cephalexin

DURATION

When antibiotic therapy is necessary it should be prescribed for a duration of **7 days**

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Additional Tools

Antibiotic	Daily Cost*
co-trimoxazole** 1 DS tablet orally twice a day	<$5
doxycycline*** 100 mg orally twice a day	<$5

* Daily cost refers to drug cost only and does not include dispensing fees
** Should not be given to patients taking warfarin, sulfonylureas, and drugs that raise serum potassium levels or patients with renal dysfunction (especially the elderly).
*** Currently not a benefit under the Ontario Drug Benefit Formulary

REFERENCES

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3. Schmitz GR, Brunder D, Pitotti R, Olderog C, Livengood T, et al. Randomized controlled trial of trimethoprim-sulfmethoxazole for uncomplicated skin abscessese in patients at risk for community-associated methicillin-resistant Staphylococcus aureus infection. Ann Emerg Med 2010; 56:283-7.

4. Stevens DL, Bisno AL, Chambers HF, et al. Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Disease Society of America. IDSA Guidelines http://cid.oxfordjuornals.org/ June 2014

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