## Management of Uncomplicated Skin and Skin Structure Infections

## PURULENT SKIN INFECTIONS

ABSCESSES<sup>1,2,3</sup>

**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

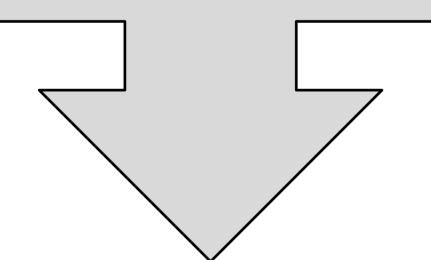
Purulent Abscess

#### INVESTIGATIONS

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

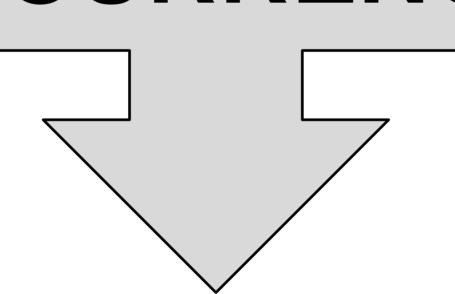
#### TREATMENT

## 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

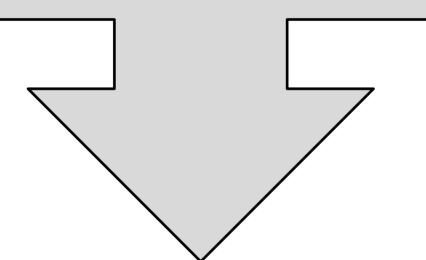
#### FIRST LINE THERAPY

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



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

### 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



**Toronto Central Local Health** Integration Network

#### DURATION

# Management of Skin and Skin Structure Infections 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

- 1. Hankin A, Everett WW. Are antibiotics necessary after incision and drainage of a cutaneous abscess? Ann Emerg Med 2007; 50:49-51.
- 2. Korowyk C, Allan GM. Evidence-based approach to abscess management. Can Fam Physician 2007; 53:1680-3.
- 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 <a href="http://cid.oxfordjuornals.org/">http://cid.oxfordjuornals.org/</a> June 2014

