Skin Infections: Cellulitis & Abscess (Non-Toxic Patient)

Non-Toxic
Labs not routinely indicated

Suppurative
fluctuant/drain ing; abscess suspected

I & D with gram stain and culture

• Clindamycin 40 mg/kg/day divided every 8 hours IV/PO
• Alternative therapy
  Trimethoprim-sulfamethoxazole
  8-12 mg/kg/day divided in 2 doses (PO).

When culture results return narrow or change antimicrobial therapy if needed

Non-suppurative
indurated but not fluctuant/drain ing

Family or personal history of MRSA (+)

YES

Cefazolin 100 mg/kg/day every 6-8 hours. Or
Cephalexin 50 mg/kg/day divided into 3 doses
*If cephalosporin allergy treat with Clindamycin

NO

Exclusion Criteria
• Foreign body suspected
• Immunocompromised
• Near recent surgical site
• Facial including orbital, periorbital, dental
• Bite wounds
• Symptoms overlying a joint
• Adenitis

If cellulitis is overlying a joint consider MSK pathway

Consider admission for:
• Failure of outpatient therapy
• Accessibility to care
• Extensive involvement (consider: hands, feet, face, groin, overlying joints)
• Not tolerating PO
• Rapid progression
• Inadequate pain control

Antibiotic Max Dose
• Cefazolin 1000mg every 8 hours
• Cephalexin 500mg every 6 hours (or 750mg every 8 hours)
• Clindamycin 600mg IV every 8 hours
• Clindamycin 450mg orally every 8 hours
• Bactrim DS 2 tab every 12 hours

If not improved in 48-72 hours
• CBC
• CRP
• Blood culture
• Consider ultrasound and/or Pediatric Surgery consult
• Consider alternate therapy or consultation with Infectious Disease at 402-955-4005 with any questions
• Consider admission

Disclaimer: Pathways are intended as a guide for practitioners and do not indicate an exclusive course of treatment nor serve as a standard of medical care. These pathways should be adapted by medical providers, when indicated, based on their professional judgement and taking into account individual patient and family circumstances.