Cellulitis

If extensive involvement - cefazolin 1-2g IV Q8H
If limited involvement (or oral stepdown) - cephalexin 500 mg PO QID

Penicillin allergic
vancomycin 15 mg/kg IV Q12H
OR clindamycin 300 mg PO QID

YES

NO

Concern for necrotizing fasciitis?
- Hemodynamic instability
- Neurovascular compromise
- Pain out of proportion to exam
- Imaging with presence of gas
- Presence of hemorrhagic bullae

If shellfish exposure, water exposure or liver disease, consider adding doxycycline 100 mg PO BID or levofloxacin 750 mg PO daily and expert consultation

Purulent cellulitis
Staph>Strep

Non-purulent cellulitis
Strep>Staph

Risk factors for MRSA?
- MRSA colonization
- Prior MRSA
- Antibiotics last 30 days

Known Group A streptococcus
penicillin G 4 million units IV Q4H
PLUS clindamycin 900 mg IV Q8H

Penicillin allergic
vancomycin 25 mg/kg IV x1, then 15-20 mg/kg IV Q12H
PLUS clindamycin 900 mg IV Q8H
PLUS aztreonam 2g IV Q8H
PLUS metronidazole 500 mg IV Q6H

Pathogen unknown
piperacillin-tazobactam 4.5g IV Q6H
PLUS clindamycin 900 mg IV Q8H
PLUS vancomycin 25 mg/kg IV x1, then 15-20 mg/kg IV Q12H

All medication doses assume normal renal function (GFR>60)

Rapid initiation of antibiotics

STAT surgical consultation for consideration of debridement of infected soft tissue

This chart is a summary of the combined practice patterns of multiple members of the Division of Infectious Diseases faculty of the University of Pittsburgh School of Medicine. It draws from published studies, local and national guidelines, and hospital policies. As such, it is not recommendations for treatment of any specific condition or patient and should not be used as such. It does not replace local or regional guidelines, and do not represent the position of the University of Pittsburgh School of Medicine.