Diagnosis

Cellulitis

* Relatively sudden onset of redness, warmth, tenderness, and swelling of the skin1-3
	+ **Nonpurulent**: no evidence of abscess/phlegmon; most cases caused by beta-hemolytic streptococci (usually group A strep but also B, C, G) that are suceptible to penicillin; ~10% of cases caused by methicillin-susceptible *Staphylococcus aureus* (MSSA)
	+ **Purulent:** evidence of abscess/phlegmon; caused by *S. aureus*, often methicillin-resistant (MRSA)
* Almost always unilateral4,5
* Fever in 22–71%; elevated white blood cell count in 35–50%1
* Usually associated with skin surface disruption due to recent trauma, tinea pedis, cutaneous ulcer, past saphenous venectomy, or impaired venous or lymphatic drainage2
* Obtain wound culture if purulence is present2,3
* Obtain ultrasound if concern for abscess/phlegmon and physical exam is equivocal2,3

*Note: Several noninfectious conditions can mimic cellulitis. The most common is venous stasis dermatitis, which is often bilateral and associated with skin hyperpigmentation, pitting edema, serous drainage, and itching. Venous stasis dermatitis presents with minimal pain and without fevers.*6

Treatment

* Elevate the affected extremity and treat underlying predisposing conditions1,2
* Erythema may initially persist, worsen, or extend despite appropriate therapy, but overall improvement (e.g., reduction of pain, erythema, and local inflammation and resolution of fevers) generally occurs by day 37
* Narrow and tailor antbiotics based on available culture results when available2,3
* **Nonpurulent cellulitis**1,2
	+ Cover beta-hemolytic strep and MSSA; MRSA coverage is not routinely indicated
	+ [Place local treatment recommendations here]
	+ [Place local treatment recommendations here]
* **Purulent cellulitis2,3**
	+ Incision and drainage of abscess is essential
	+ For an uncomplicated skin abscess with minimal cellulitis, antibiotics are of modest benefit once the abscess is drained
	+ Antibiotics are recommended for residents with—
		- Associated systemic illness
		- Diabetes or immunocompromise
		- An abscess that has more than minimal cellulitis or
		- An abscess in an area where drainage is difficult
	+ Cover *S. aureus*, including MRSA
	+ [Place local treatment recommendations here]
	+ [Place local treatment recommendations here]

*Note: Residents who are critically ill, neutropenic, severely immunocompromised, or with suspected necrotizing fasciitis should receive care in an acute care setting where they can receive empiric broad-spectrum antibiotics. Patients with cellulitis associated with longstanding diabetic foot ulcers or pressure ulcers may require alternative antibiotics. Consider transferring these residents to an acute care setting if consistent with goals of care.*2,3

Duration

* 5–7 days if clincial response by day 31-3,8,9

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