Cellulitis/Skin Abscess Care Guideline

**Inclusion Criteria:** Previously healthy children hospitalized with skin and soft tissue infection (cutaneous abscess, furuncle, carbuncle, cellulitis) due to either severity or failure to respond to outpatient treatment

**Exclusion Criteria:** PICU status, infants < 90 days of age, immune-compromised host, complicated infection (e.g., necrotizing fasciitis, toxic shock syndrome), infections involving other sites (e.g., eye, face, neck, peri-rectal region, bone, joint, etc.), bite wounds

**Assessment**
- Thorough history & physical including trauma, insect bites, previous skin infection, similar infection in close contacts, recent antimicrobial therapy
- Cardiorespiratory status, hemodynamic stability, severity of infection
- Wound assessment (description, size, depth); outline wound if possible

**Treatment**
- CBC, CRP, blood culture (if not done previously)
- Obtain wound culture when possible
- Consider MRSA surveillance culture if wound culture not possible
- Surgical drainage when indicated
- Contact precautions

**Antibiotics**
- Cefazolin 33.3 mg/kg IV q 8 hr (<60 kg); 2,000 mg IV q 8 hr (>60 kg or severe infection) (Max: 6 gm/day)
- Clindamycin 10 mg/kg/dose IV q 6 hr (<60 kg); 600 mg IV q 6 hr (>60 kg) (Max: 4.8 gm/day)
  *Monotherapy is preferred. Use clindamycin if history of/or + MRSA, recurrent boils, or more complex abscess.*

**Continued Considerations**
- Adjust antibiotics based on culture results and clinical course
- Re-evaluate if worsening symptoms or persistent fever
- If no clinical improvement, consider alternative MRSA coverage and ID Consult
- Wound care teaching (if applicable)

**Discharge Criteria**
- Significant clinical improvement
- Diet tolerated & adequately hydrated
- Vital signs stable
- Teaching completed
- Follow up care coordinated

**Recommendations/Considerations**
- The most common pathogens seen are *Staphylococcus aureus* (including MRSA) & *Streptococcus pyogenes*.
- Cellulitis associated with furuncles, carbuncles, or abscesses is usually caused by *S. aureus*.
- Cellulitis that is diffuse or without a defined portal is most commonly caused by *S. pyogenes*.
- Risk factors for community-acquired MRSA in children include: previous history of boils/abscesses in patient or close contact, underlying medical conditions, crowded conditions/daycare centers, contact sports
- Treatment is based on clinical factors, local susceptibility patterns, & severity of infection
- Consider elevation of affected part and/or warm compresses on a case-by-case basis
- Antibiotic duration is usually 7-14 days – depending on severity or clinical response

**Patient/Family Education**
- Handouts:
  - Cellulitis/Skin Abscess (located on PAWS)
  - A Parent’s Guide to MRSA in California – if MRSA confirmed (located on PAWS)

Reassess the appropriateness of Care Guidelines as condition changes and 24 hrs after admission. This guideline is a tool to aid clinical decision making. It is not a standard of care. The physician should deviate from the guideline when clinical judgment so indicates.


Cellulitis Care Guideline Contributors:
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Updated 7/15/15; Reviewed 11/21/18