Exclusions:

SSTI Location:
- Underlying hardware, bone/joint infection, surgical site infection, orbital/periorbital cellulitis, perianal/perineal/perirectal infection

Injury Context:
- Bite-associated infection, infection associated with immersion or penetrating trauma

Patient Factors:
- Neutropenia (ANC < 500)

Bilateral cellulitis is rare

For non-necrotizing cellulitis, imaging is only necessary in the case of poor response to antibiotic therapy

In the absence of systemic signs of infection, routine blood cultures are not recommended

Separate oral antibiotic coverage for MRSA and *Strep* spp is not recommended for non-purulent SSTI

Management of Non-Purulent SSTI (cellulitis/erysipelas)

*For ulcerative SSTI, refer to separate Ulcerative SSTI guideline

Concern for necrotizing infection?

STOP! Call appropriate surgical service and consult ID

Start IV vancomycin
+
Piperacillin-tazobactam (UCSF/SFVA) OR ertapenem (ZSFG)
+
Clindamycin

Outpatient Treatment[1]

PO cephalexin

If beta-lactam allergy (BLA): Clindamycin

Responding?[2]

Yes → Continue to complete 5 days

No → Image for abscess

Abscess present?

Yes → Refer to Purulent SSTI guideline

No → Evaluate adherence
Adjunctive therapies (see below)
Consider alternative diagnosis
Consider admission

CDU Treatment[1]

*Refer to CDU guideline for triage decisions

IV cefazolin[3]

Improvement within 24 hours?

Yes → Switch to PO cephalexin
Duration: 5 days from start of cefazolin

No → Inpatient Treatment[1]

Inpatient Treatment[1]

IV cefazolin[3]

Responding?[2]

Yes → Switch to PO cephalexin
Duration: 5 days from start of cefazolin

No → **Switch to IV vancomycin**
Image for abscess
Adjuctive therapies (see below left)
Consider alternative diagnosis

Responding?[2]

No → ID/Derm consultation

Yes → Switch to PO TMP-SMX[4]
If sulfa allergy: Clindamycin
Duration: 5 days from start of vancomycin

[1] MRSA is rarely implicated in non-purulent cellulitis. Cases for which MRSA coverage might be considered include cellulitis associated with penetrating trauma, injection drug use, and MRSA nasal colonization.

[2] Response to antibiotic therapy may not be immediate, and erythema may progress in the first 24-48 hours. Failure to improve within the first 72 hours is not necessarily indicative of clinical failure.

[3] If beta-lactam allergy present, refer to UCSF Inpatient Beta-lactam Allergy Guideline

[4] In patients with baseline elevations in serum potassium or creatinine, consider using clindamycin rather than TMP-SMX.

Adjunctive Therapys for Non-Purulent SSTI:

- Leg elevation
- Treatment of tinea pedis
- Adequate foot care/toenail clipping