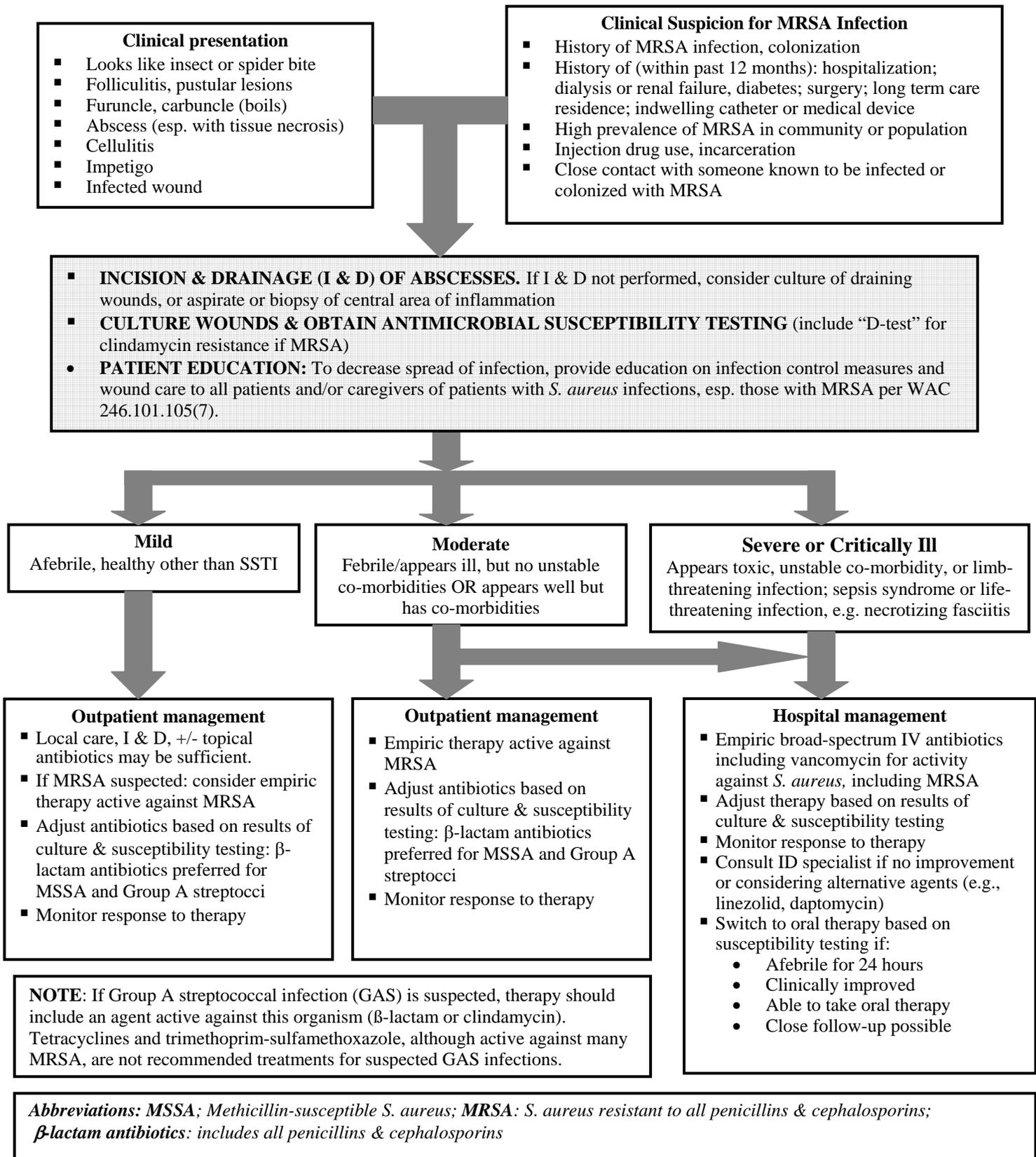


Guidelines for Management of *S. aureus* Skin & Soft Tissue Infection, December, 2007*

Infectious Diseases Society of Washington, Public Health – Seattle & King County, Tacoma-Pierce County Department of Health, and Washington State Department of Health



Adapted from: Guidelines for Evaluation & Management of Community-Associated Methicillin-Resistant *Staphylococcus aureus* Skin and Soft Tissue Infections in Outpatient Settings. Infectious Diseases Society of Washington, Public Health – Seattle & King County, Tacoma-Pierce County Department of Health, and Washington State Department of Health. **See original document for full information.**
Available at: <http://www.metrokc.gov/health/providers/epidemiology/>; <http://www.doh.wa.gov/> and <http://www.tpchd.org/mrsa>

Table 1. Guidelines for Empiric Oral Antimicrobial Treatment of Outpatients with Suspected MRSA Skin and Soft Tissue Infections (SSTI)

<p>Selection of empiric therapy should be guided by local <i>S. aureus</i> susceptibility and modified based on results of culture and susceptibility testing. The duration of therapy for most SSTI is 7-10 days, but may vary depending on severity of infection and clinical response. NOTE: Before treating, clinicians should consult complete drug prescribing information in the manufacturer’s package insert or the PDR.</p>		
Antimicrobial	Adult Dose	Pediatric Dose
Trimethoprim-sulfamethoxazole (TMP-SMX) DS	1-2 tablets (160 mg TMP/800 mg SMX) PO bid	Base dose on TMP: 8-12 mg TMP (& 40-60 mg SMX) per kg/day in 2 doses; not to exceed adult dose
Minocycline or doxycycline	100 mg PO bid	<i>Not recommended for pediatric use – suggest consultation with infectious disease specialist before use</i>
Clindamycin	300-450 mg PO qid	10-20 mg/kg/day in 3-4 doses; not to exceed adult dose
<p>NOTE: If Group A streptococcal infection is suspected, oral therapy should include an agent active against this organism (β-lactam or clindamycin). Tetracyclines and trimethoprim-sulfamethoxazole, although active against many MRSA, are not recommended treatments for suspected GAS infections.</p> <p>NOTE: Outpatient use of quinolones or macrolides. Fluoroquinolones (e.g., ciprofloxacin, levofloxacin, moxifloxacin, gatifloxacin) and macrolides (e.g., erythromycin, clarithromycin, azithromycin) are NOT recommended for treatment of MRSA because of high resistance rates. If fluoroquinolones are being considered, consult with infectious disease specialist before use.</p> <p>NOTE: Outpatient use of Linezolid in SSTI. Linezolid is costly and has great potential for inappropriate use, inducing antimicrobial resistance, and toxicity. Although it is 100% bioavailable and effective in SSTI, it is not recommended for empiric treatment or routine use because of these concerns. It is strongly recommended that linezolid only be used after consultation with an infectious disease specialist to determine if alternative antimicrobials would be more appropriate.</p> <p>^aIf considering clindamycin, isolates resistant to erythromycin and sensitive to clindamycin should be evaluated for inducible clindamycin resistance (MLS_B phenotype) using the “D test.” Consult with your reference laboratory to determine if “D testing” is routine or must be specifically requested. If inducible resistance is present, an alternative agent to clindamycin should be considered.</p>		

Table 2: Eradication of MRSA Colonization

Efficacy of decolonization in preventing re-infection or transmission in the outpatient setting is not documented, and is NOT routinely recommended. Consultation with an infectious disease specialist is recommended before eradication of colonization is initiated. Possible regimens may include one or more of the following:

Topical intranasal 2% mupirocin may be used bid for 5 days.
Skin antiseptics (i.e. chlorhexidine or dilute baths)
Rifampin (Adult dose: 300mg PO bid x 5 days; pediatric dose: 10-20 mg/kg/day in 2 doses not to exceed 600 mg/d x 5 days) may be used in combination with TMP-SMX, OR with doxycycline, OR with minocycline, for recurrent MRSA infection despite appropriate therapy. <i>Never use rifampin monotherapy, due to the rapid emergence of resistance. Rifampin interacts with methadone, oral hypoglycemics, hormonal contraceptives, anticoagulants, protease inhibitors, phenytoin, theophylline, cardiac glycosides and other drugs.</i>