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Pharmacist's Letter
Hospital

Guide Empiric Treatment of Skin and Soft Tissue Infections

You'll see renewed focus on **appropriate use of antibiotics for patients hospitalized with skin and soft tissue infections (SSTIs)**.

The Joint Commission now requires hospitals to implement at least 2 guidelines to improve antibiotic use. Hospitals will likely include SSTI...it's one of the most common antibiotic indications.

Work with your antimicrobial stewardship team to guide empiric treatment.

When should you cover for MRSA? Consider empiric coverage for MRSA in PURULENT infections...or infections from penetrating trauma or injection drug use.

But continue to use a beta-lactam, such as cefazolin, for most NONPURULENT cellulitis...since the pathogen is often *Streptococcus*.

When MRSA coverage is needed, continue to lean toward vancomycin...due to its long track record and low cost.

Limit long-acting dalbavancin or oritavancin to specific situations. They're usually just one dose...but are expensive.

For example, consider these for ED patients who need IV but aren't sick enough to be admitted...or to facilitate discharge for inpatients with barriers to home IV meds (IV drug use, etc).

When should you add gram-negative or anaerobic coverage? Only for certain infections.

For example, consider polymicrobial coverage with ampicillin/sulbactam for foot infections in patients with diabetes...or infected wounds from human or animal bites.

Don't empirically cover for *Pseudomonas* unless there are additional risk factors...such as frequent exposure to water (hot tub, lake, pool, etc).

But empirically cover *Pseudomonas* in severe cases, such as immunocompromised patients...or those with systemic symptoms or signs of a deeper infection (hypotension, skin sloughing, etc).

In these cases, think about broad-spectrum coverage with piperacillin/tazobactam, cefepime, etc...plus MRSA coverage.

Be aware that redness around the infection may expand before it gets better. Consider waiting 48 hours before adjusting antibiotics if this is the only indication of treatment failure.

Reinforce de-escalation and IV-to-PO switches as patients improve or pathogens are known.

See our resource, Antibiotics for MRSA Skin Infections, for guidance on ceftaroline, daptomycin, or linezolid.

Explore our training program, *RxAdvanced: Antimicrobial Stewardship*, to sharpen your skills.

Key References:

-Clin Infect Dis. 2014 Jul 15;59(2):147-59
-https://www.jointcommission.org/standards/r3-report/r3-report-issue-35-new-and-revised-requirements-for-antibiotic-stewardship#.Y6N_G3bMK5c (12-22-22)

Hospital Pharmacist's Letter. January 2023, No. 390120