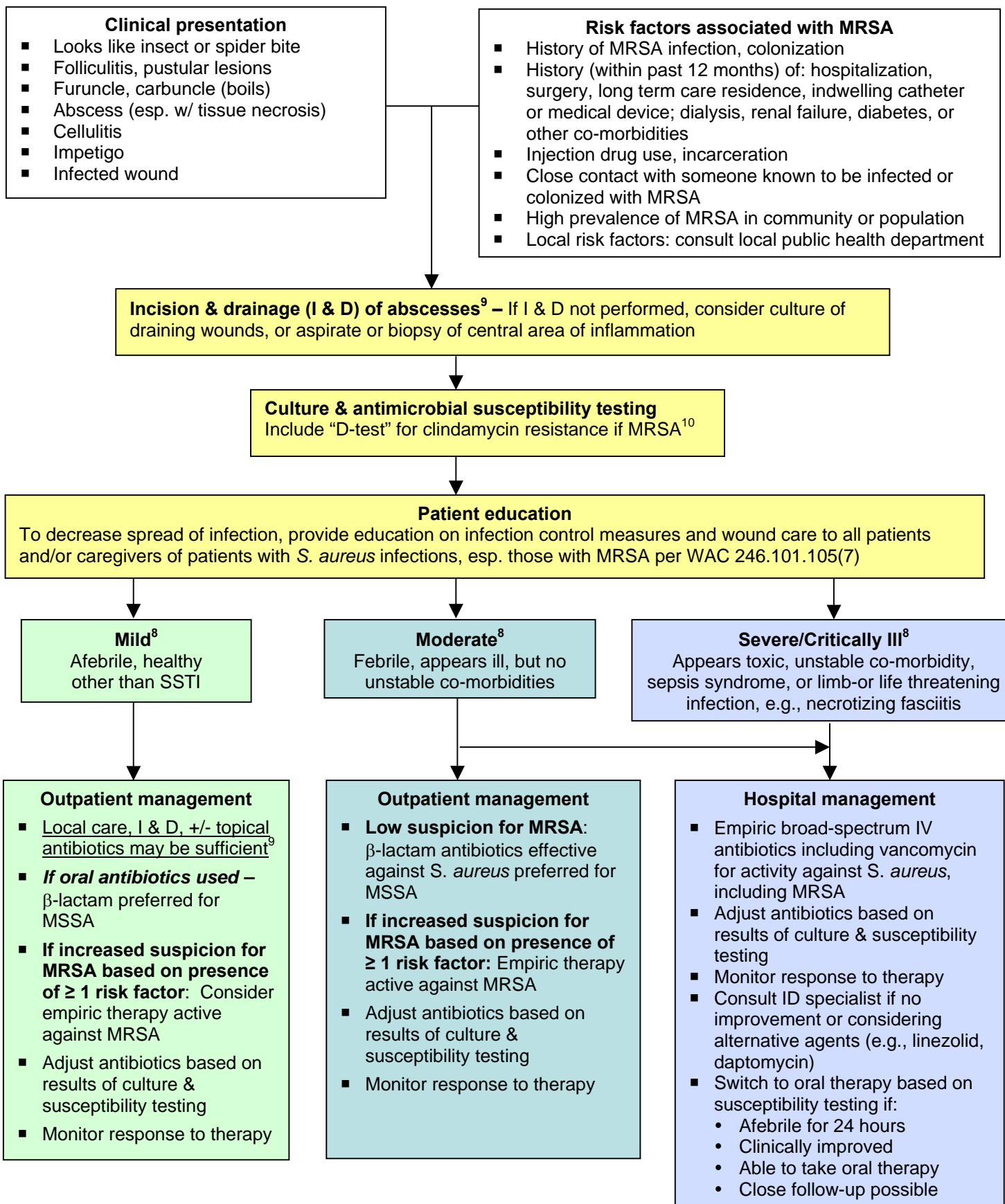


Interim Guidelines for Management of Suspected *Staphylococcus aureus* Skin and Soft Tissue Infections*



MSSA: Methicillin susceptible *S. aureus*
MRSA: *S. aureus* resistant to all penicillins & cephalosporins
β-lactam antibiotics: Includes all penicillins & cephalosporins

*For details, see full text of Interim Guidelines for Evaluation & Management of Community-Associated Methicillin Resistant *Staphylococcus aureus* Skin and Soft Tissue Infections in Outpatient Settings

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

Antimicrobial	Adult Dose	Pediatric Dose
Trimethoprim-sulfamethoxazole (TMP-SMX) DS ¹¹⁻¹³	1 tablet (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 ¹³⁻¹⁵ or doxycycline ¹³	100 mg PO bid	Not recommended for pediatric use – suggest consultation with infectious disease specialist before use
Clindamycin ^{a,13,16,17,21}	300-450 mg PO qid	10-20 mg/kg/day in 3-4 doses; not to exceed adult dose

^a **If 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.¹¹

- If Group A streptococcal infection is suspected, oral therapy should include an agent active against this organism (β-lactam, macrolide, clindamycin). Tetracyclines and Trimethoprim-sulfamethoxazole, although active against many MRSA, are not recommended treatments for suspected GAS infections.
- Outpatient use of quinolones or macrolides: Fluoroquinolones^{13, 21-23} (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.
- Outpatient use of linezolid in SSTI:^{24,25} 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.

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 eradication regimens include:
Rifampin (Adult dose: 300mg PO bid x 5 days; pediatric dose: 10-12 mg/kg/day in 2 doses not to exceed 600 mg/d x 5 days) may be used in combination with TMP-SMX, OR rifampin with doxycycline, OR rifampin with minocycline, for recurrent MRSA infection despite appropriate therapy. 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.
Topical intranasal mupirocin may be used bid for 5 days with or without systemic antimicrobial therapy.
Skin antiseptics with chlorhexidine or other agents may be used in addition to one or both of the above regimens.

