


- Fusidic acid may be considered for children with three or less localised areas of impetigo, an oral antibiotic, however, is likely to be more appropriate<sup>10</sup>

Topical antibiotics continue to have a role in patients requiring nasal decolonisation of *S. aureus*, and in these cases substitution with a topical antiseptic is not appropriate. The choice of topical antibiotic should be made according to culture results.<sup>11</sup>

 For further information, see: "Should I prescribe a topical antiseptic cream instead of a topical antibiotic for minor skin infections?", BPJ 68 (Jun, 2015).


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## Cellulitis: skin deep and spreading across New Zealand

Cellulitis is an acute, spreading infection of the lower dermis and subcutaneous tissue that is frequently caused by *Streptococcus pyogenes* and related streptococci or *Staphylococcus aureus*. Most cases can be diagnosed clinically, without investigation, by the presence of localised pain, swelling, erythema and heat. Furuncles (boils) and carbuncles (multiple-headed lesions) are easily misdiagnosed as cellulitis due to a tender rim of erythema surrounding the central infection. However, this is inflammatory change and not extension of the infection into the surrounding tissue. Patients with these focal staphylococcal infections should not be treated as if they have cellulitis, i.e. antibiotics are not usually required.


Patients with uncomplicated cellulitis can usually be managed in the community; a lower threshold for referral to hospital is appropriate for young children and frail older people or people with bite or puncture wounds.

 Red flags for hospital referral include:

- Features of systemic involvement or haemodynamic instability
- Progressing infection despite antibiotic treatment
- Severe pain suggestive of necrotising fasciitis

- Unstable co-morbidities
- Orbital involvement

All patients with cellulitis should rest and elevate any affected limb. Oral flucloxacillin is the first-line treatment for children and adults with mild to moderate cellulitis. Oral erythromycin is a second-line alternative. An increase in erythema and swelling within the first 48 hours of treatment may represent the natural progression of the infection, rather than a failure of treatment. A reduction in pain in the affected skin and an improvement in appetite and energy are clear signs that the infection is being controlled in most patients. Treatment adherence should be assessed in patients who are not responding as well as expected. Intravenous cefazolin with oral probenecid is the recommended community-based treatment for patients who have not responded to oral flucloxacillin or for patients with more widespread cellulitis. Oral co-trimoxazole is the preferred antibiotic for cellulitis caused by MRSA unless susceptibility testing indicates otherwise.

 For further information, see: "Cellulitis: skin deep and spreading across New Zealand", BPJ 68 (Jun, 2015).