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Cellulitis guidelines malaysia

What is cellulitis? How to distinguish cellulitis from erysipelas? Erysipelas and cellulitis are common bacterial skin infections. Cellulitis is a spreading infection of the skin that extends to the deeper tissue, with the subcutaneous tissue (fat and soft layer). Erysipelas is a specific superficial form of cellulitis that affects the upper layers of the skin (mainly dermis with significant lymphatic involvement). They can overlap, so it is not always possible to make a definitive diagnosis between the two. Fig. 1: Bacterial infections in the different skin layers What causes cellulitis and erysipelas? Germs (bacteria) are present on the skin and usually do no harm (normal flora). However, if they go deep into the skin layer, they can cause infections. You usually get through a break in the skin such as cuts, wound, scratches, willows, bites or injection or from another skin condition such as eczema, contact dermatitis, psoriasis, leg ulcer, intertrigo or tinea pedis (athlete's foot). The immune system of our body will try to prevent the spread of the bacteria. If it fails, an infection will develop. Both erysipelas and cellulitis are usually caused by bacteria called group A ß -hemolytic streptococcus (GABHS) and Staphylococcus aureus. Fig. 2: Pathophysiology of soft tissue and skin infections (SSTIs) Who is at risk of developing cellulitis or erysipelas? Anyone can get cellulitis or erysipelas. Once you've had it, you're more likely to get it back into the same part of the body. There are some conditions that make cellulitis and erysipelas more likely: fracture in the skin barrier lazerations, bites, wounds instrumentation (needles) / surgery wounds (chicken pox, Being ulcers) Burn spread from an adjacent infection (OM) Eczema / Dermatitis Underlying skin diseases such as intertrigo / Tinea infections (secondary infection) Host factors Poorly controlled diabetes mellitus age (child / older) Weakened immune system due to disease (AIDS, cancer) or medications such as corticosteroid, chemotherapy or radiation obesity Vascular insufficiency Intravenous drug use and alcoholism What are the symptoms of cellulitis and erysipelas? You will feel uncomfortable with fever and showers. The fever can start a few hours or a day before the skin changes become visible. The affected skin (usually occurs on one side of the body) becomes red, painful / sore, swollen and warm. In certain cases, bubbles may form. The nearest lymph glands can become swollen and painful. The area of the affected skin tends to expand in the next few hours to a few days. Cellulitis can only affect your skin. Or can also affect tissues that underlie your skin and can spread to your lymph nodes and bloodstream. It is important to seek immediate medical attention if cellulitis symptoms occur. What are the signs of cellulitis and erysipelas? Cellulitis often affects the lower limbs and erysipelas mainly affects the legs and face. All the websites of your may be affected. Erysipelas usually presents as rapidly progressive fiery red, hot, thickened and painful plaque with sharp demarcation from normal surrounding skin. On the other hand, cellulitis often presents itself as a painful, warm erythema with poorly defined edges and intangible edges. It is often preceded by systemic symptoms. It can be associated with ascending lymphangitis (red stripes on the skin above the affected area) ± regional lymphadenopathy. Swelling and blisters can develop through the erythemaatus area. In severe cases, skin areas can become purple or black (necrotic). Fig. 3: Erysipelas Fig. 4: Cellulitis Fig. 5: Bullous erysipelas Fig. 6: Cellulitis with ascending lymphangitis How can cellulitis / erysipelas diagnose? Cellulitis and erysipelas are clinically diagnosed. A smear or blood tests can be taken to identify the bacteria; however, it is not always possible to identify the bacteria. Is Cellulitis / Erysipelas Serious? The severity can range from light to heavy. This depends on the size of the affected area, which part of the body is affected (face is heavier) and whether there is an underlying disease. If left untreated, the spreading infection can be life-threatening. Cellulitis and erysipelas can also lead to complications: septicaemia (bloodstream bacterial infection) abscess (a buildup of pus in the affected area) infection that spreads to deeper tissues such as the muscle or bone. Necrotizing fasciitis is an example of deep-layer infection. It is an extreme emergency. Long-term swelling of the affected site due to lymphatic vascular damage Increased the likelihood of further cellulitis or erysipelas kidney damage after streptococcal infection meningitis according to facial erysipelas Is cellulitis / erysipelas contagious? No. They are different from Impetigo, which is a superficial infection that can easily be transmitted to other people. Cellulitis / Erysipelas affect the deeper layers of the skin. Can cellulitis be cured? Yes. Early treatment with systemic antibiotics is important to prevent the spread of infections and the associated complications. What are the treatment and prevention of cellulitis? An oral antibiotic must be administered as early as possible and continued for 7-14 days. If the condition does not improve, higher doses and longer courses may be required. For a more severe infection, they must be hospitalized for intravenous antibiotic injections. Most people are treated with a form of penicillin, so it is extremely important that you tell your doctor if you are allergic to penicillin. As long as the area is red, swollen and hot, it should be rested and raised. The foot should be rested higher than the hip, so that gravity reduces swelling. Any leg swelling after the solution of the infection should be treated with compression stockings. It is important that skin-crushed or concomitant skin diseases such as foot, intertrigo or eczema are treated. Be. repeated episodes of cellulitis. You should follow the advice on skin care to reduce skin fractures. If there are repeated episodes of cellulitis, the doctor may suggest long-term prophylactic antibiotic treatment. References Stevens DL et al. Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Disease Society of America. Clin Infect Dis.2014; 59(2): e10-52. Swartz MN. Clinical practice. Cellulitis. 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White Blood Cells (WBC) <15,000], then= may= typically= treat= patient= with= oral= antibiotics= on= an= outpatient= base= given= for= uncomplicated= cellulitis= if= symptoms= do= not= improve= or= if= disease= progresses= significant= within= the= first= 24-48= hours,= parenteral= therapy= may= be= needed= parenteral= antibiotics= should= be= considered= in= the= presence= of= the= following:= presence= of= signs of= toxicity= (fever=>100,5°F/38°C, Tachycardia, hypotension) Rapid progression of erythemunnot responsive/intolerant to oral antibiotic therapy with significant disease progression after 2 days of indwelling medical device (e.g. prosthesis, stents) Considered in patients with complicated cellulitis and comorbidities [e.g. vascular diseases] Change to oral therapy after 48 hours , if possible, choice of antibiotic tailored according to known pathogens, Comorbidity (e.B. DM), and special situations such as water (salt or freshwater) exposure or animal bite treatment should also address underlying predisposing conditions Empirical therapy may be started up to culture results for patients with purulent cellulitis, treatment is directed to methicillin-resistant S aureus (MRSA) as it is the dominant pathogen in this type of cellulitis; Therapy for beta-hemolytic streptococcus is probably not required For patients with non-runtercellulitis, Treatment may be required for methicillin-sensitive S aureus (MSSA) and beta-hemolytic streptococcal emfiric therapy for MRSA if the patient has signs of systemic infection, does not respond to initial therapy, has a recurrent infection, has an earlier episode of or is at high risk for MRSA infection, or with in-house Device in close proximity to the place of lesion penicillin (beta-lactamase resistant) Eg dicloxacillin, flucloxacillin, nafcillin, oxacillin Recommended therapy for patients with erysipelas, moderate </15,000],> </15,000],> Cellulitis and MRSA infection Recommended antibiotics for mild non-repurculent cellulitis caused by group A Streptococcus or S aureus Some authorities recommend antistaphylococcus penicillin alone, while other antistaphylococci advocate penicillin + penicillin or amoxicillin combination, may increase side effects that are recommended for the initial treatment of neonates with moderate to severe cellulitis. recurrent cellulitis penicillin G [Intravenous (IV)] Is indicated for erysipelas and moderate non-ritar uncomplicated cellulitis treatment option for patients with recurrent cellulitis Generally sufficient for uncomplicated cellulitis of an extremity caused by streptococcal aminopenicillin/beta-lactamase inhibitors eg amoxicillin/clavuline Ampicillin Recommended 1st-line therapy for patients with cellulitis or erysipelas near the eyes or nose as a 2nd-line alternative for patients with severe infection Effective and particularly useful in the presence of bone or joint infection cephalosporine - 1st generation Eg Cefadroxil, cefalexin, Cefazolin As a rule sufficient for mild non-overarching uncomplicated cellulitis and treatment option for erysipelas active against streptococcus and methicillin-sensitive S aureus (MSSA) cefalexin may be used in patients with erysipelas with beta-lactam allergy cephalosporins - 2nd and 3rd generation (Parenteral) Ceftriaxon are used Cefuroxime treatment alternative for patients with moderate non-ritarian cellulitis As a rule empirical in diabetes mellitus (DM) patients with formerly mild cellulitis active against streptococcus and MSSA aminoglycosides may, if necessary, cephalosporins - Other generations eg ceftaroline , Ceftobiprole may be considered for patients with methicillin-resistant S aureus (MRSA) infections Macrolides Eg Clarithromycin, Erythromycin, Roxithromycin may be used when patient is allergic to penicillin macrolide resistance in group A Streptococci and has become a problem in some countries erythromycin is the main macrolide used unless: Erythromycin resistance is widely used in community alternative therapy for patients with cellulitis or erysipelas near the eyes or nose Also for prophylactic treatment against recurrent cellulitis studies shown that the efficacy of roxithromycin for erysipelas was comparable with benzylpenicillin oxazolidinones Eg linezolid, tidezolid may be allergic to penicillin and to complicated cellulitis and erysipelas, or MRSA infections Quinolones Eg ciprofloxacin, delafloxacin , Levofloxacin, Moxifloxacin, Ofloxacin Those who have improved activity against Gram-positive bacteria have been shown to be effective for cellulitis caused by Vibrio vulnificus, which is used in combination with other antibiotics for MRSA and other or Gram-negative organisms and anaerobic tetracyclines Such as doxycycline, minocycline, omadacycline, tigecycline may be used for moderate purulent cellulitis, MSSA and and Infections Tigecycline can be used to treat complicated skin infections Clinical efficacy is comparable to standard treatment Other antibiotics Clindamycin Used in patients allergic to penicillin and cephalosporin alternative therapy for patients with non-riitor or purulent cellulitis by MSSA or MRSA infection Co-trimox causes azole For the treatment of patients with erysipelas with beta-lactam allergy in non-nullating cellulitis and moderate purulent cellulitis has a very good activity against Community-acquired MRSA, but not against streptococcus dalbavancin, Oritavancin, Telavancin lipoglycopeptides antibacterials with similar properties as vancomycin, which can be caused for complicated cellulitis by gram-positive organisms, including MRSA vancomycin treatment option for patients allergic to penicillin combination with ampicillin/sulbactam, piperacillin/tazobactam, ticarcillin/clavulate or ceftriaxone/ciprofloxacin/levofloxacin plus metronidazole is recommended for patients with purulent cellulitis That is recommended by MRSA infection and other gram-positive or gram-negative organisms and anaerobic combination with cefotaxim or gentamicin is recommended as 1st line parenteral treatment for neonates with MRSA infections Also in patients with penetrating trauma, wet-green co-settlement with MRSA, and intravenous drug use daptomycin is an alternative option when vancomycin is not available teicoplanin alternative to vancomycin for patients with cellulitis caused by gram-positive organisms including MRS A length of therapy uncomplicated/eitrig/non-ritent cellulitis and erysipelas patient may be treated with antibiotics for 5 to 14 days depending on clinical response. erythema, heat and edema have decreased significantly, patients can be treated with oral antibiotics for another 10 days patients with peripheral vascular diseases, chronic venous stase , diabetes mellitus or alcoholic cirrhosis may take 1-2 weeks to improve and often require 3-4 weeks of treatment Adjunct Therapy corticosteroids Eg Prednisolum, prednisone studies have shown that used in combination with antibiotics, cure time of lesions should be considered in non-diabetic patients immobilization and increase of affected limb effects: To reduce swelling and pain, especially if used early in the course of treatment, and can also shorten the time to recovery dressings Cool sterile saline dressing effects: Removes purulent exuthek from ulcers or infected abrasions, can help to reduce local compression stockings stockings

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