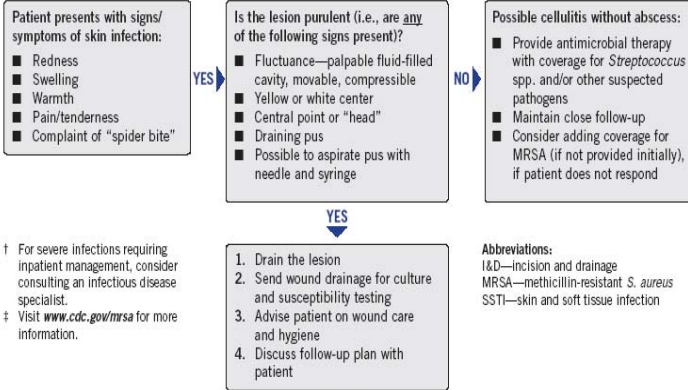


# Outpatient† management of skin and soft tissue infections in the era of community-associated MRSA‡



**IF SYSTEMIC SYMPTOMS, SEVERE LOCAL SYMPTOMS, IMMUNOSUPPRESSION, OR FAILURE TO RESPOND TO I&D, CONSIDER ANTIMICROBIAL THERAPY WITH COVERAGE FOR MRSA IN ADDITION TO I&D. (SEE BELOW FOR OPTIONS)**

## Options for empiric outpatient antimicrobial treatment of SSTIs when MRSA is a consideration\*

Drug name	Considerations	Precautions**
Clindamycin	<ul style="list-style-type: none"> <li>■ FDA-approved to treat serious infections due to <i>S. aureus</i></li> <li>■ D-zone test should be performed to identify inducible clindamycin resistance in erythromycin-resistant isolates</li> </ul>	<ul style="list-style-type: none"> <li>■ <i>Clostridium difficile</i>-associated disease, while uncommon, may occur more frequently in association with clindamycin compared to other agents.</li> </ul>
Tetracyclines ■ Doxycycline ■ Minocycline	<ul style="list-style-type: none"> <li>■ Doxycycline is FDA-approved to treat <i>S. aureus</i> skin infections.</li> </ul>	<ul style="list-style-type: none"> <li>■ Not recommended during pregnancy.</li> <li>■ Not recommended for children under the age of 8.</li> <li>■ Activity against group A streptococcus, a common cause of cellulitis, unknown.</li> </ul>
Trimethoprim-Sulfamethoxazole	<ul style="list-style-type: none"> <li>■ Not FDA-approved to treat any staphylococcal infection</li> </ul>	<ul style="list-style-type: none"> <li>■ May not provide coverage for group A streptococcus, a common cause of cellulitis</li> <li>■ Not recommended for women in the third trimester of pregnancy.</li> <li>■ Not recommended for infants less than 2 months.</li> </ul>
Rifampin	<ul style="list-style-type: none"> <li>■ Use only in combination with other agents.</li> </ul>	<ul style="list-style-type: none"> <li>■ Drug-drug interactions are common.</li> </ul>
Linezolid	<ul style="list-style-type: none"> <li>■ Consultation with an infectious disease specialist is suggested.</li> <li>■ FDA-approved to treat complicated skin infections in adults, including those caused by MRSA.</li> </ul>	<ul style="list-style-type: none"> <li>■ Has been associated with myelosuppression, neuropathy and lactic acidosis during prolonged therapy.</li> </ul>

■ MRSA is resistant to all currently available beta-lactam agents (penicillins and cephalosporins)  
■ Fluoroquinolones (e.g., ciprofloxacin, levofloxacin) and macrolides (erythromycin, clarithromycin, azithromycin) are not optimal for treatment of MRSA SSTIs because resistance is common or may develop rapidly.

\* Data from controlled clinical trials are needed to establish the comparative efficacy of these agents in treating MRSA SSTIs. Patients with signs and symptoms of severe illness should be treated as inpatients.

\*\* Consult product labeling for a complete list of potential adverse effects associated with each agent.

### Role of decolonization

Regimens intended to eliminate MRSA colonization should not be used in patients with active infections. Decolonization regimens may have a role in preventing recurrent infections, but more data are needed to establish their efficacy and to identify optimal regimens for use in community settings. After treating active infections and reinforcing hygiene and appropriate wound care, consider consultation with an infectious disease specialist regarding use of decolonization when there are recurrent infections in an individual patient or members of a household.

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