**Cellulitis/SSTI mimics**

<table>
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<th>Deep vein thrombosis is</th>
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<td>Pain &amp; swelling with less significant erythema</td>
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<td>● Follow local/national guidelines for investigation</td>
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<th>Overlying a joint?</th>
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<tr>
<td>Consider septic arthritis, bursitis or gout</td>
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<td>● Joint aspirate for Microscopy (inc. for crystals), culture and sensitivity (if prostatic joint refer to ortho)</td>
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<th>Other common:</th>
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<tr>
<td>Venous or other cezema, intertrigo, lipodermatosclerosis, dependent rubor in venous insufficiency, thrombophlebitis, irritant or allergic contact dermatitis</td>
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<th>Less common:</th>
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<tr>
<td>Erythema nodosum, erythema multiforme, erythema, erythema gangrenosum, pyoderma gangreosum, drug/chemo or radiation-induced, cutaneous infiltration of malignancy</td>
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<th>Rare:</th>
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<td>Sweet's syndrome, leukocytoclastic vasculitis</td>
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**Necrotising skin & soft tissue infections** are often fatal. Presentation can be varied and visible clinical signs can underestimate the severity of illness.

**Suspect if:** Severe pain, sepsis, tenderness beyond apparent skin involvement. **Late signs:** crepitus, blisters/bullae, dusky skin discoloration or rapidly progressing cellulitis.

**Investigations & antimicrobial therapy may require broadening if:**

- Diabetes mellitus with ulcers, travel abroad, unusual exposures (animals, water, vegetation), injecting drug use or immunosuppression (see special patient groups*). Cover MRSA if current or previous history.

- For those with underlying comorbidities: consider MRSA - Isolation, decolonisation & further public health measures may be required

**Clinical assessment**

1. **First line tests**
   - Blood
   - C&S if intraosseous catheter then pair with peripheral set
   - Blood borne virus screen (HIV, hepatitis B and C)

2. **Second line tests Required in specific cases**
   - MRSA screen
   - MC&S
   - Viral PCT (Fluid from wound if present)
   - OPAT

**Infection Prevention and Control**

- Discuss if necrotizing SSTI, GAS, PVL-associated Staphylococcus aureus or MRSA - Isolation, decolonisation & further public health measures may be required

**OPAT**

Consider for patients with no evidence of sepsis or uncontrolled comorbidities

**Special patient groups**

- Recurrent boils/abscesses
  - search for local causes such as a pilonidal cyst, hidradenitis suppurativa or foreign material
  - discuss PVL testing with ID/micro

- Immunosuppression:
  - also consider mycobacterial, fungal and viral agents
  - more aggressive approach to determining aetiological agent (e.g. aspiration, skin biopsy)

- Injecting drug use
  - infected thromboses
  - wider range of pathogens inc. an aerobes MRSA, Bacillus anthracis, and fungi

- Water-exposure (non-cholera Vibrio species, Aeromonas, Pseudomonas aeruginosa, fungi/algae)

- Contact with animals or animal products (Bacillus anthracis, cutaneous diphtheria, erysipelas)

- Contamination with soil or plant matter (sporotrichosis, plus other fungi)

- Travel history (e.g. mycetoma, endemic fungi, chromoblastomycosis)

- Jaw, thoracic or abdominal site/pelvic, especially if intrauterine coil present (actinomycosis)

**References**


- Clinical Resource Efficiency Support Team. Guidelines on the care of adults with SSTIs. It should be used in conjunction with current guidance on the management of SSTIs, which it does not replace (see references). NOT for use in diabetic foot infection – see NICE guideline [NG19].

**Abbreviations**

- MRSA Methicillin resistant Staphylococcus aureus
- OPAT Outpatient Parenteral Antibiotic Therapy
- IPC Infection Prevention and Control
- MC&S Microscopy, culture and sensitivity
- SEVNS Standardised Early Warning Score
- PVL Pantone-Valentine Leukocidin
- GAS Group A streptococcus
- I&D Incision & drainage

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