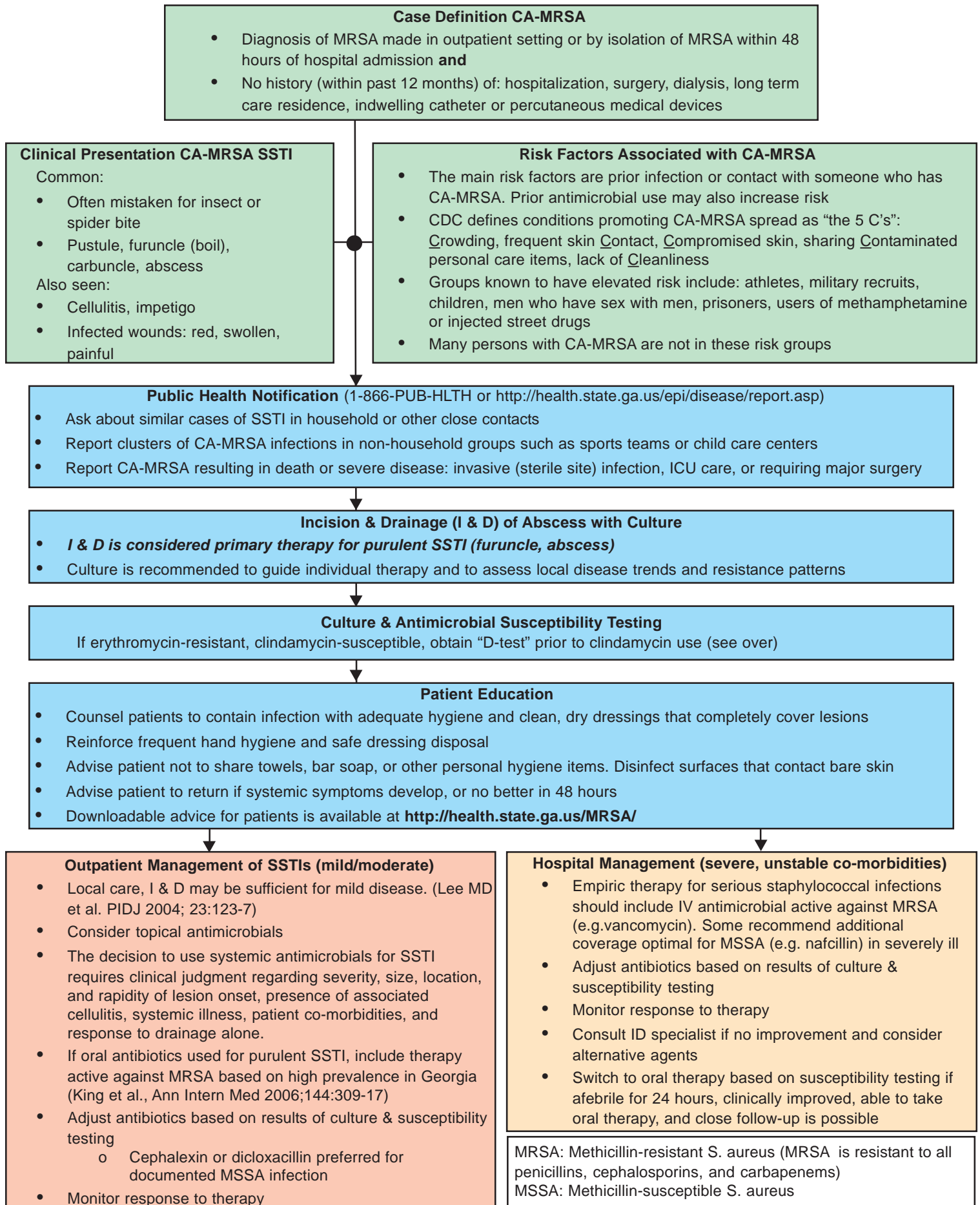


2006 Georgia Guidelines for Management of Suspected Community-Acquired Methicillin-Resistant *Staphylococcus aureus* (CA-MRSA) Skin and Soft Tissue Infections (SSTIs)



2006 Georgia Guideline for Empiric Oral Antimicrobial Treatment of Outpatients with Suspected CA-MRSA Skin and Soft Tissue Infections (SSTIs)

Selection of empiric therapy should be guided by local *S. aureus* susceptibility and modified based on results of culture and susceptibility testing. The duration of therapy for most SSTI is 7-10 days, but may vary depending on severity of infection and clinical response. **NOTE: Before treating, clinicians should consult complete drug prescribing information in the manufacturer's package insert or the PDR.**

Antimicrobials Recommended for CA-MRSA*

Antimicrobial	Adult Dose	Pediatric Dose
Trimethoprim-sulfamethoxazole* (TMP-SMX)	1-2 DS tablets (160 mg TMP/800 mg SMX) PO q 8-12h	Base dose on TMP: 8-12 mg TMP (& 40-60 mg SMX) per kg/day in 2 doses; not to exceed adult dose
Doxycycline or minocycline*	100 mg PO bid	Not recommended for pediatric use or in pregnancy-suggest consultation with infectious disease specialist before use.

*** If Group A streptococcal (GAS) infection is suspected, (e.g. rapid onset, lymphangitic streaking, regional lymphadenopathy) 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.**

Clindamycin	300-450 mg PO qid	10-20 mg/kg/day in 3-4 doses; not to exceed adult dose
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If considering clindamycin, isolates resistant to erythromycin and sensitive to clindamycin should be evaluated for inducible clindamycin resistance (MLSb 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, especially when treating severe or deep infection.

Other Therapeutic Considerations

Rifampin may be used in combination with TMP-SMX, doxycycline, OR clindamycin, 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.**

Rifampin (with other agents)	300 mg PO bid x 5 days	10-12 mg/kg/day in 2 doses not to exceed 600 mg mg/d x 5 days)
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Topical mupirocin may be used tid for 7-10 days with or without systemic antimicrobial therapy.

Skin antiseptics with chlorhexidine or other agents may be used in addition any of the above regimens.

Antimicrobials Not Routinely Recommended for CA-MRSA

Outpatient use of fluoroquinolones (e.g., ciprofloxacin, levofloxacin, moxifloxacin, gatifloxacin) or macrolides (e.g., erythromycin, clarithromycin, azithromycin, and telithromycin) is **NOT RECOMMENDED** for treatment of MRSA. Resistance to fluoroquinolones can develop on therapy, so these agents should not be routinely used even if the isolate is reported to be susceptible.

Outpatient use of linezolid in SSTI: Linezolid is costly, has great potential for inappropriate use, and has significant toxicity. Although it is 100% bioavailable and effective in SSTI, it is not recommended for empiric treatment or routine use because of these concerns. In addition, overuse of this valuable drug could lead to resistance and diminished effectiveness. 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.

Eradication of CA-MRSA Colonization

Efficacy of decolonization in preventing 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. For multiple recurrences or household transmission, reinforce infection control and (though data are lacking) consider short course regimen of skin antiseptics and nasal mupirocin.

This algorithm and more information available online at <http://health.state.ga.us/MRSA>

General information is available at www.cdc.gov/ncidod/dhqp/ar_mrsa_ca.html

CDC guidance for clinicians is available at www.cdc.gov/ncidod/dhqp/pdf/ar/CAMRSA_ExpMtgStrategies.pdf

Modified from "Interim Guidelines for Management of Suspected *Staphylococcus aureus* Skin and Soft Tissue Infections" from Infectious Diseases Society of Washington, Tacoma/Pierce County Health Department, Public Health-Seattle and King County, and Washington State Department of Health, September 2004, "Strategies for Clinical Management of MRSA in the Community: Summary of an Experts' Meeting Convened by the Centers for Disease Control and Prevention" March 2006, and NC Consensus Guidelines.

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