SKIN AND SOFT TISSUE INFECTIONS

Eczema - treatment of suspected secondary bacterial infection

Background:

- Symptoms and signs of bacterial secondary infection can include – weeping, pustules, crusts, no treatment response, rapidly worsening eczema, fever and malaise.
- **Not all eczema flares are caused by bacterial infection, even if crusts and weeping are present.**
- Eczema is often colonised with bacteria but may not be clinically infected.
- Eczema can also be infected with herpes simplex virus (eczema herpeticum).

Continue to manage underlying eczema and flare-ups with treatments including emollients and corticosteroids, whether antibiotics are given or not.

Consider prescribing new supplies of topical products (emollients and corticosteroids) for use after the infection has cleared and advise the person to discard the old products. **This is only necessary if the topical products are likely to be contaminated** e.g., Tub preparations where hands are put into the tub.

For people who are not systemically ill and where infection is mild, do not routinely offer either a topical or oral antibiotic:

- Evidence suggests a limited benefit with antibiotics.
- Consider the risk of antimicrobial resistance.
- Consider the extent and severity of signs and symptoms and risk of complications.
- Mild infection may clear with treatment of underlying eczema

If antibiotic offered to people who are not systemically unwell take into account:

- Extent and severity (topical may be more appropriate for localised infection), and adverse effects.
- Previous use of topical antibiotics as antimicrobial resistance can develop rapidly with repeated use.

For systemically unwell people, offer an oral antibiotic.

Refer to the hospital if symptoms/signs of more serious illness such as necrotising fasciitis or sepsis.

Treatment	Antibiotic[1]	Dosage	Duration
First-choice if a topical antibiotic appropriate (localised areas of infection).	Fusidic acid 2%	Apply three times a day Extended or recurrent use may increase the risk of developing antimicrobial resistance.	5 to 7 days
First-choice oral if an oral antibiotic is appropriate	Flucloxacillin	**Child 1mth-1yr:** 62.5mg to 125mg four times a day **Child 2-9yrs:** 125mg to 250mg four times a day **Child 10-17yrs**: 250mg to 500mg four times a day **Adult:** 500mg four times a day	5 to 7 days
Alternative first choice if penicillin allergy/intolerance			
	Clarithromycin[2]	**Child 1mth-11yrs:** • Under 8kg: 7.5mg/kg twice a day • 8 to 11kg: 62.5mg twice a day • 12 to 19kg: 125mg twice a day • 20 to 29kg 187.5mg twice a day • 30 to 40kg: 250mg twice a day **Child 12-17yrs:** 250mg twice a day (increased to 500mg twice a day for severe infection) **Adult:** 250mg twice a day (increased to 500mg twice a day for severe infection)	5 to 7 days
Preferred in pregnancy	Erythromycin[2,]	**Child 8-17yrs:** 250mg to 500mg four times a day **Adult:** 250mg to 500mg four times a day	5 to 7 days

[1]See BNF and BNFC for appropriate use and dosing in specific populations, e.g., hepatic, or renal impairment, pregnancy, breastfeeding.
[2]Withhold statins whilst on erythromycin/clarithromycin course.

If methicillin-resistant Staphylococcus aureus is suspected or confirmed - Consult local microbiologist.

If there are signs and symptoms of cellulitis, see APC cellulitis guideline.

Further information: Management of lower limb inflammation (Nottingham CityCare IPC and Tissue Viability Teams)