Royal United Hospital Bath NHS

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Guidelines for the management of
LYMPHOEDEMA RELATED CELLULITIS

Diagnosis & Assessment

- Assess vital signs (Temperature, Pulse Rate, Blood Pressure, Respiration Rate)
- Assess the cellulitis –severity, duration, deterioration, speed of onset , associated symptoms eg vomiting, diarrhoea, flu-like symptoms, route of entry for infection eg athlete's foot, dermatitis, abrasions
- If necrotising fasciitis suspected, refer to surgeons IMMEDIATELY, then discuss antibiotic management with Microbiologist.
- If animal bite suspected, or if cellulitis felt to be secondary to contamination with sea- or fresh- water discuss with a Microbiologist.
- Consider taking baseline bloods including Full Blood Count & C-Reactive Protein
- Consider sending off cultures for microbiology e.g. blood cultures, blister fluid, pus
- Outline and date the infected area with a permanent marker pen.

Management

- Treat promptly with antibiotics – see chart overleaf (ensure cultures sent prior to antibiotics where possible)
- Consider limb support/elevation, analgesia, and adequate fluid intake. Avoid compression garments and exercise during the acute episode.
- Refer the patient to the Lymphoedema Specialist Nurse Practitioner.
- Treat conditions facilitating bacterial invasion e.g. athlete's foot, dermatitis, minor skin abrasions
- Follow up patients closely, particularly if in the community – if the cellulitis is failing to resolve at 48hrs patient may require a change in antibiotics or hospitalisation.
- Cellulitis frequently takes a long time to resolve in patients with lymphoedema (sometimes up to 2 months), but distinction needs to be made between residual pigmentation and persisting cellulitis. Inflammatory markers may be helpful in guiding therapy.
- Prophylaxis may be required for patients with recurrent episodes of cellulitis.

Kerry Sant & Paula Byrne (Lymphoedema Specialist Nurse Practitioners) and Dr Sarah Meisner (Consultant Microbiologist) May 2008

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	No history of penicillin intolerance	Patients intolerant to penicillin (not anaphylaxis)	Comments
1st line oral therapy	Oral **Flucloxacillin** 500mg qds	Oral **Clindamycin** 300-450mg qds	Warn patient to contact a doctor immediately if diarrhoea develops (may be Clostridium difficile). Do not use cefuroxime if patient has a history of anaphylaxis to penicillin or cephalosporins. Once daily alternatives are available if home IV therapy is possible – please discuss with Microbiologist/ MAU
2nd line oral therapy (i.e. if poor or no response to 1st line by 48hours but well enough for oral Rx)	Oral **Clindamycin** 300-450mg qds	IV **Cefuroxime** 1.5g tds (do NOT use this if there is a history of anaphylaxis with penicillins or cephalosporins)	
IV Therapy – if systemically unwell or worsening/ failing to respond to oral therapy	IV **Flucloxacillin** 1g qds +/- gentamicin 4mg/kg stat. If severe consider adding **Clindamycin** 300mg-460mg qds PO/IV	IV **Cefuroxime** 1.5g tds +/- gentamicin 4mg/kg stat. If severe consider adding **Clindamycin** 300mg-450mg qds PO/IV	Do not use cefuroxime if patient has a history of anaphylaxis to penicillin or cephalosporins. Once daily alternatives are available if home IV therapy is possible – please discuss with Microbiologist/ MAU If necrotising fasciitis suspected, get urgent surgical opinion
Prophylaxis (consider a trial for 1-2 years in patients with ≥2 episodes at the same site **)**	Oral **Penicillin V** 250mg bd (500mg bd if weight is above 75kg)	Oral **Erythromycin 2**50mg bd (or **Clarithromycin** 250mg od if erythromycin poorly tolerated)	For patients who have had recurrent episodes of cellulitis (2 or more episodes in 6 months).

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If the patient has diabetes, is immunosuppressed, or has significant ulceration, please see RUH Empiric Antibiotic Guidelines or discuss with a Microbiologist.

If the patient wants therapy to take “just in case” cellulitis develops e.g. on holiday, a supply of first line therapy is appropriate in most cases and should be taken at the first hint of infection. The patient must be asked to present to a doctor as soon as possible after the onset.

For further information regarding lymphoedema related cellulitis please contact the lymphoedema specialist nurse practitioner who can advise regarding conservative management strategies.

Kerry Sant & Paula Byrne (Lymphoedema Specialist Nurse Practitioners) and Dr Sarah Meisner (Consultant Microbiologist) May 2008