On the pathophysiology and management of cellulitis

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Chapter 2

Cellulitis: current insights into pathophysiology and clinical management

D.R. Cranendonk, A.P.M. Lavrijsen, J.M. Prins, W.J. Wiersinga

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ABSTRACT

Cellulitis is a bacterial skin and soft tissue infection which occurs when the physical skin barrier, the immune system and/or the circulatory system are impaired. Diabetes, obesity and old age are associated with defects in all of these areas and as a result are major predisposing factors for cellulitis. In this review, we summarise current insights into the pathophysiology of cellulitis and place the Dutch guidelines on the clinical management of cellulitis of the lower extremities in perspective. Recent evidence on diagnostic strategies is discussed, the importance of which is underscored by findings that venous insufficiency, eczema, deep vein thrombosis and gout are frequently mistaken for cellulitis. Empiric antibiotic choices are designed against the background of a low prevalence of multi-resistant Staphylococcus aureus. Novel antimicrobial agents registered for cellulitis are also discussed. Relapses occur frequently due to a high prevalence of risk factors associated with cellulitis in combination with the occurrence of persistent post-inflammatory lymphatic damage. Lastly, we identify knowledge gaps which, if addressed, will advance our understanding of the pathophysiology of cellulitis and improve its clinical management.
**INTRODUCTION**

Cellulitis (Latin: cellula (diminutive of cella: cell) + itis (suffix denoting inflammation)) and its subtype erysipelas (Greek: erythrós (red) + pella (skin)), are among the most frequent infections requiring hospitalisation. The historical distinction between cellulitis and erysipelas, based on different bacterial aetiologies and thus treatment options, is becoming obsolete as increasing evidence suggests a large overlap between these two entities (Textbox 1). In the Netherlands, the annual incidence is estimated to be 22 per 1000 inhabitants. Approximately 7% of all patients with cellulitis are hospitalised. The mortality rate of hospitalised patients has been reported to be around 2.5%. Recent epidemiology data on cellulitis in the Netherlands is lacking, but given the rise in the incidence of important risk factors (namely diabetes, obesity and old age), an increase in the incidence of cellulitis is expected. Dutch guidelines on the clinical management of cellulitis of the lower extremities are available since 2013 (Figure 1). Since their publication, numerous studies have provided novel insights and new antibiotics registered for skin and soft tissue infections have entered the market. This review discusses the current state of evidence regarding

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**Textbox 1. Erysipelas vs cellulitis**

Historically, physicians distinguish erysipelas, a streptococcal infection of the superficial dermis and superficially located lymphatic vessels, from cellulitis, an infection of all skin layers generally caused by staphylococci. Erysipelas is characterised by sharp demarcation, a palpable edge and salmon-red erythema and is accompanied by high fever. This distinction has therapeutical implications, as beta-lactamase sensitive penicillins would suffice for erysipelas.

Etiological evidence however contests the concept that erysipelas is solely caused by streptococci. For instance, a systematic review of bacteraemias in erysipelas and cellulitis patients found equal rates of *S. aureus* (14%) in both groups. In addition, in a retrospective study of 1142 patients with erysipelas more than half of the positive wound cultures yielded *S. aureus*. Lastly, streptococci were not more frequently found in patients with all classical erysipelas symptoms than in the general cellulitis population (68%), in a prospective etiological study.

In addition to being hard to distinguish from cellulitis based on clinical symptoms, the above suggests that diagnosing erysipelas does not help to differentiate between streptococcal and staphylococcal infections. In most studies the two conditions are already grouped together and US guidelines use the term ‘skin and soft tissue infections’, making management decisions based on presence of purulence instead.
pathogenesis, diagnostics, and treatment of cellulitis. The literature search strategy used is documented in textbox 2.

### CELLULITIS: A DIAGNOSTIC CHALLENGE

All that is red is not cellulitis. The classical symptoms of erythema, oedema, warmth and tenderness, are non-specific and vary in severity. The clinical presentation of cellulitis is mimicked by a whole range of diseases (Table 1 and Figure 2). One recent study revealed that 31% of patients hospitalised with
cellulitis were misdiagnosed, the most frequent mimickers being stasis dermatitis, stasis ulcers, gout, congestive heart failure, non-specific oedema and deep venous thrombosis (DVT). Another study in the primary care setting found a similar rate of misdiagnoses. Furthermore, when clinicians specifically consulted dermatologists because of uncertainty about a diagnosis of cellulitis, 74% of the patients turned out not to have cellulitis. Misdiagnosis results in unnecessary admissions and extra costs for perceived refractory cellulitis. Leucocytosis and elevated C-reactive protein (CRP) levels are present in 34-50% and 77-97% of patients, respectively. Stasis dermatitis can mimic all symptoms, including mild leucocytosis and/or CRP elevation. Its origin lies in chronic venous insufficiency, which causes proliferation and increased permeability of dermal capillaries. Leucocytes migrate, cause inflammation, stimulate collagen production, and thus induce dermal fibrosis. Erythrocyte extravasation causes brown skin pigmentation. Untreated, stasis dermatitis can progress to lipodermatosclerosis, which is characterised by a fibrotic tightening and sometimes ulceration of the skin above the ankles. Compression therapy can correct haemodynamic effects and cytokine levels.

Imaging is sometimes indicated. As DVT does not occur more often in patients with cellulitis than those without, routine DVT screening is not recommended.
When ultrasound was only utilised among uncertain ‘DVT vs cellulitis’ diagnoses, 17% turned out to have DVT. Ultrasound may detect occult abscesses, or disprove ‘abscesses’ mistakenly diagnosed during physical examination. Computed tomography is not warranted due to nonspecific findings. Magnetic resonance imaging and the Laboratory Risk Indicator for Necrotising Fasciitis score might help distinguish between necrotising fasciitis and cellulitis, but as yet neither have proven superior to clinical suspicion and subsequent surgical exploration.

Uncomplicated superficial abscesses with erythema can be difficult to distinguish from primary cellulitis with secondary abscesses. Uncomplicated abscesses are treated with incision and drainage, but two recent trials show cure rate increases from 69-74% to 81-83% with adjunctive antibiotics.

**RISK FACTORS**

Multiple physical barriers and active protective mechanisms prevent the invasion of skin commensals and thus the occurrence of infection (Figure 3a). An intact vasculature will help maintain the integrity and function of all these barriers.
Table 1. Mimickers of cellulitis and how to recognise them

<table>
<thead>
<tr>
<th>Mimicker</th>
<th>Signs suggestive for this diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stasis dermatitis(^{12})</td>
<td>Bilateral nature (is extremely rare for cellulitis), slow onset of symptoms, hyperpigmentation, superficial desquamation</td>
</tr>
</tbody>
</table>
| Lipodermatosclerosis\(^{12}\) | Acute: pain above the medial malleolus  
Chronic: Inverted champagne bottle effect (leg diameter narrows below the calf), history of venous insufficiency, bronze-brown skin |
| Stasis ulcers\(^{13}\)    | Ulcer in patient with long history of chronic venous insufficiency                                                                                                      |
| Gout\(^{14}\)             | Focal swelling and erythema limited to joints (f.e. knee or first metatarsalphalangeal joint), history of gout, tophi, increase in serum uric acid                             |
| Deep venous thrombosis\(^{15}\) | History of immobilization or cancer, thrombosis on duplex scan; no fever                                                                                               |
| Ecthyma\(^{16}\)          | Shallow ulcer with punched-out borders and adjacent erythema                                                                                                            |
| Erysipeloïd\(^{16}\)      | Red hands, people who work with animals                                                                                                                                   |
| Impetigo\(^{16}\)         | Crusted blisters, brown-yellow scabs erosions and erythema, mostly in children                                                                                          |
| Lyme disease\(^{16}\)     | Painless spreading sharply demarcated erythema with central pallor (erythema migrans)                                                                                     |
| Eosinophilic cellulitis\(^{12}\) | Eosinophilia, indurated plaques, itching and burning before plaque formation                                                                                           |
| Contact dermatitis\(^{12}\) | Erythema confined to areas in contact with irritant (soaps, detergents, hobby materials, etc)                                                                            |
| Necrotizing fasciitis\(^{17}\) | Pain disproportionate to clinical findings and outside of lesion margins, rapid onset, systemic toxicity, bullae, purple or blue discoloration of the skin, cutaneous crepitations |
**Chapter 2**

**Epidermis**
- Arid, salty, acidic (pH 5-6) surface with few nutrients
- Tightly linked corneocytes with high turnover (shedding)
- Commensal flora produces AMPs, prevents pathogen colonization
- Keratinocytes produce AMPs
- Resident immune cells

**Dermis**
- AMPs secreted by sweat glands
- Structural framework of elastin and collagen produced by fibroblasts
- Resident immune cells
- Lymphatics drain protein-rich fluid and APCs
- Adipocytes can increase and produce AMPs, cytokines and adipokines

**Subcutaneous tissue and systemic**
- Lymphoid tissue trains adaptive immunity
- Venous and lymphatic drainage of fluid
- Arterial supply of oxygen, nutrients, recruitable immune cells and warmth
- Protective genetic variants (e.g. in toll like receptors)

---

**a) Protective factors in healthy skin**

**Epidermis**
- Arid, salty, acidic (pH 5-6) surface with few nutrients
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- Lymphoid tissue trains adaptive immunity
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**b) Risk factors for cellulitis**

**Immunity defects**
- Impaired defense against invasion; slow pathogen clearance
- APCs unable to migrate

**Circulatory defects**
- Provide hospitable environment for bacteria; impede wound healing; facilitate ulcer development

**Skin integrity defects**
- Facilitate bacterial invasion of skin layers

**Cellulitis**
- Skin barrier disruption
- Skin tearing (separation of dermis and epidermis)
- Reduced dermal thickness
- Flattened dermal-epidermal junctions
- Loss of collagen, vessels, glands, fibres, nerves

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**Previous episode of cellulitis**

**Saphenectomy**
- Venous insufficiency
- Impaired microvascular blood flow
- Atherosclerosis

**Surgery**
- Decreased tissue channels
- Slower recruitment of neutrophils, macrophages
- Reduced vascular response to stimuli
- Lower skin temperature

**Skin cracks**
- Burns
- Pressure damage
- Ulcers
- Toe web intertrigo

**Medication (e.g. corticosteroids, immunosuppressants)**
- Fewer LH cells, with decreased functionality

**Diseases (e.g. HIV)**
- Defective AMP production
- Genetics susceptibility
- Mild chronic inflammation, weak acute response
- APCs unable to migrate

**Behaviour (e.g. smoking, alcohol, malnourishment)**
- Fewer naive T and B cells, weaker response to new pathogens
- Inability to induce fever

**Increased bacterial survival on skin**
- Skin integrity defects

**Humidity**
- Higher skin pH
- Increased epidermal turnover time (20 -> 30 days)

**Edema**
- Increased tissue channels
- Slower recruitment of neutrophils, macrophages
- Reduced vascular response to stimuli

**Reduced epidermal thickness**
- Skin tearing (separation of dermis and epidermis)
- Flattened dermal-epidermal junctions
- Loss of collagen, vessels, glands, fibres, nerves

---

**Toe web intertrigo**
- Dermatitis
- Animal bites
- Lacerations
- Burns
- Pressure damage
- Ulcers

**Medication (e.g. corticosteroids, immunosuppressants)**
- Fewer LH cells, with decreased functionality

**Diseases (e.g. HIV)**
- Defective AMP production
- Genetics susceptibility
- Mild chronic inflammation, weak acute response
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**Behaviour (e.g. smoking, alcohol, malnourishment)**
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**Humidity**
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**Edema**
- Increased tissue channels
- Slower recruitment of neutrophils, macrophages
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endocarditis) and hospitalisation rates are all higher in diabetic patients. Most cases of cellulitis in diabetic patients will be attributable to diabetic foot associated skin defects, but more than a quarter of the cases of culture-positive diabetic cellulitis occur on non-foot locations. In morbid obesity, the skin is more susceptible to damage and takes longer to repair.

Some seasonal variability has been observed. Streptococcal skin infections occur more frequently in the winter in cold countries, while warmer regions see a higher erysipelas incidence during the summer.

Skin microbiome alterations have been observed in diseases such as atopic dermatitis, where more staphylococci and fewer streptococci are present, but also in acne. S. aureus is shown to be overrepresented in the peri-abscess skin microbiome. Pioneering studies have revealed that commensals can influence the composition of the local microbiome and alter local immunity, but future studies will have to reveal relationships between the microbiome and cellulitis.

**TO ADMIT OR NOT TO ADMIT**

The 7% of patients who are hospitalised cause 83% of the total healthcare expenditure associated with cellulitis. Unfortunately, as yet there are no validated, prospectively evaluated admission guidelines. One system distinguishes classes with supposedly increasing mortality and therapy failure rates based on systemic symptoms, comorbidity and the Standardised Early Warning Scores. Two cohort studies compared this system with current clinical practice: one retrospectively, one prospectively. Overtreatment of infections that the system classified as mild (class I and II) was very common, while most of the severest infections (class IV) were undertreated. In one of the two studies, only 5 of 6 (83%) class IV patients had achieved complete resolution of symptoms at the end of therapy, compared with 100%, 98% and 96% in classes I-III. One explanation for this is that factors not incorporated in this system currently have a substantial effect on admission and...
treatment practices.

Pragmatically, one could consider admission for patients with (1) poor disease perception, (2) intake problems, (3) an altered mental status, or (4) disease progression despite adequately dosed oral antibiotics. Severity or dysregulation of comorbidity (e.g. diabetes, immunodeficiency, obesity, or cardiac, renal or venous insufficiencies) and severity of infection (e.g. systemic symptoms, organ failure) should also be taken into account.11,64

Factors predicting oral therapy failure may also be indications for admission for intravenous antibiotics. Retrospectively identified factors associated with failure of oral antibiotic therapy include fever, chronic leg ulcers, chronic oedema and lymphoedema, prior cellulitis in the same area, and wound infections.65,66 Additionally, after treatment in an observation unit for 24 hours, patients with cellulitis of the hand, an elevated lactate, fever, history thereof, or multiple comorbidities were more likely to be admitted.67,68 However, this mainly reflects clinical practice rather than need for admission.

Alternatively, outpatient parenteral antibiotic therapy, where intravenous antibiotics are given at home or on outpatient basis, can avoid or shorten hospitalisation for selected patients and is usually preferred by patients.69

**ANTIBIOTIC TREATMENT**

One might wonder if a proportion of cases of cellulitis are self-limiting and do not require antimicrobial agents. It is noteworthy that in clinical trials performed in the pre-antibiotic era, in which the effects of horse serum and ultraviolet light were evaluated, cure rates of 70% were observed.70 On the other hand, it has also been demonstrated that inadequate empirical antibiotics are associated with prolonged treatment durations and length of hospital stay.71 Current treatment recommendations are summarised in Figure 1.

Streptococci and *S. aureus* are the most common pathogens identified in patients with cellulitis (Table 2), and accumulating evidence from prospective convalescent serology studies suggests that >70% are caused by streptococci.4,79 Atypical pathogens can be observed in patients with selected conditions (Table 3). In contrast to diabetic foot infections, diabetic non-foot infections are generally not caused by atypical pathogens.87 In the Netherlands, the preferred small
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A spectrum agent covering both methicillin-susceptible S. aureus and beta-haemolytic streptococci is flucloxacillin. Confirmed streptococcal infections can be treated with benzylpenicillin or feneticillin. Co-amoxiclav and clindamycin are alternative options.

Clindamycin is recommended in case of beta-lactam allergies, and inhibits streptococcal and staphylococcal toxin production. Clindamycin is also thought to have better tissue penetration than beta-lactams. However, clindamycin is highly concentrated intracellularly, and studies measuring tissue concentrations used homogenised tissues and thus also measured intracellular clindamycin. This overestimates relevant clindamycin levels in the extracellular fluid, while the primarily extracellular beta-lactam concentration is diluted by the released intracellular volume and thus underestimated. Of note, some S. aureus strains have inducible resistance for clindamycin, showing growth inhibition in vitro but resistance in vivo. In the Netherlands, around 10% of S. aureus from selected general practice patients and hospital patients show (inducible) resistance to clindamycin, compared with less than 3% for flucloxacillin. This makes clindamycin less preferable as an empirical choice. Evidence does not favour one agent over others, although there is a major lack of evidence in this area. One study found pristinamycin to be slightly more efficacious than penicillin in a non-blinded trial, but did not account for penicillin not covering S. aureus. Beta-lactams were as effective as non-beta-lactams in a cohort study. A recent meta-analysis comparing penicillins or cephalosporins with macrolides or lincosamides (such as clindamycin) found similar efficacy between the two groups.

If one needs to cover multi-resistant Staphylococcus aureus (MRSA), vancomycin remains the first choice of treatment, with linezolid as an alternative. Additionally, three novel antibiotics have recently been approved by the European Medicines Agency for treatment of skin infections: oritavancin and dalbavancin, two (lipo)glycopeptides, and tedizolid, an oxazolidinone, all showing potent activity against MRSA similar to vancomycin and linezolid (Table 4). Oritavancin and dalbavancin both have terminal half-lives of over two weeks and thus only require a single intravenous dose to reach cure rates non-inferior to a 2-week course of vancomycin. Whether this actually reduces the number of admissions or total treatment costs remains to be evaluated.
### Table 2. Causative agent of cellulitis depending on culture methodology. (continued on next page)

<table>
<thead>
<tr>
<th>Culture method</th>
<th>Cultured/total patients, % positive cultures</th>
<th>Pathogen distribution</th>
<th>Factors which increase yield</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood culture</td>
<td>2731/unknown, 4% (+3% contamination)(^3)*</td>
<td>GAS: 24-26%</td>
<td>Increased blood volume cultured, extensive infection, high CRP, fever, diabetes, chronic ulcer, alcoholism, impaired immunity, immersion injuries, animal bites.(^72) Age &gt;65, non-lower extremity involvement, cirrhosis, systemic inflammatory response syndrome.(^73)</td>
<td>Unknown if patients with Gram-negative bacteremia had risk factors.(^3) Blood cultures rarely elicit change of antibiotic class.(^74)</td>
</tr>
<tr>
<td></td>
<td>555/1142, 9% (+2%)(^2)</td>
<td>OS: 37-58%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>250/476, 4.8% (+1.6%)(^2)</td>
<td>SA: 8-25%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>GNB: 0-23%</td>
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<tr>
<td>(Wound) swab culture</td>
<td>343/1142, 72%(^2)</td>
<td>GAS: 21-23%</td>
<td>Debridement and irrigation of wound before swabbing, to avoid culturing colonizers(^75)</td>
<td>Role of S. aureus and Gram negatives unknown (colonizer vs pathogen), as BHS etiology was often confirmed or probable despite S. aureus growth in cultures(^4)</td>
</tr>
<tr>
<td></td>
<td>127/216, 75%(^4)</td>
<td>OS: 26-39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA: 62-74%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>GNB: 10-12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punch biopsy / needle aspiration culture</td>
<td>541/808, 24%(^76)*</td>
<td>GAS: 27%</td>
<td>Take from point of maximum inflammation, not leading edge(^27)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>OS: 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA: 51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others: 17%</td>
<td></td>
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</tr>
</tbody>
</table>
OPTIMISING ANTIBIOTIC USE

For oral flucloxacillin, proper timing of intake (before or long after meals) optimises the bioavailability to ~55%. Beta-lactams reach lower serum concentrations in obese patients due to altered distribution volumes and clearance, so these patients might benefit from higher oral dosing, or more frequent intravenous dosing. This is underscored by the fact that obese patients tend to have lower cure rates.

The optimal duration of antibiotic treatment of cellulitis is unknown. One study suggested that patients with cellulitis who are treated on an outpatient basis only require 5 days of therapy when signs of improvement are seen. However, this study used unconventional numbers for its power calculation, had a dropout rate of 30% before randomisation due to non-improvement, included relatively young and healthy subjects and made use of levofloxacin as study drug. Community-acquired pneumonia, pyelonephritis and intra-abdominal infections require shorter antibiotic treatments than we previously thought necessary. Whether cellulitis treatment can also be shortened is under investigation.

Some patients have an increased risk of a complicated infection. Obesity predisposes to local complications such as bullae, abscess formation, haemorrhagic lesions and necrosis. Smoking and delays in antibiotic treatment are also...
linked to abscess formation. Patients with congestive heart failure, neutropenia, hypoalbuminaemia, an altered mental status or discharge from the lesion have an increased risk of experiencing adverse outcomes, in terms of death, local complications (e.g. requiring surgical drainage) or systemic complications (e.g. multi-organ failure)."
NON-ANTIBIOTIC MANAGEMENT

Additional non-antibiotic management options can potentially improve outcomes. Compression therapy has long been, and still is, cause for debate. Advocates claim there is an accelerated reduction of oedema and pain, and shorter time to cure. Currently, no evidence supports this claim. Patients, however, often report side effects such as pain, dry skin, itching, constriction and slipping.\textsuperscript{115,116} It is unknown if the altered haemodynamics affect the time to microbiological cure. The adequacy of applied bandages varies in clinical practice, and inadequately applied bandages can cause pressure ulceration, thus unnecessary harm.\textsuperscript{117,118} An alternative to reduce oedema in the acute phase is passive leg elevation. To prevent persisting lymphoedema from causing recurrences, compression therapy is indicated when lymphoedema persists for several weeks after antibiotic treatment.\textsuperscript{11} Compression stockings should follow initial bandaging, provided the patient’s arterial disease status allows it.\textsuperscript{118}

The use of anti-inflammatory drugs in addition to antibiotic therapy might be beneficial. In a proof-of-concept study, adjunctive non-steroidal anti-inflammatory drugs (NSAIDs) led to faster regression and resolution of symptoms.\textsuperscript{119} Similarly, patients receiving adjunctive oral prednisone (2 days 30 mg, 2 days 15 mg, 2 days 10 mg, 2 days 5 mg) had earlier resolution of symptoms and intravenous to oral antibiotic switches.\textsuperscript{120,121} Whether these drugs also affect microbial eradication is as yet unknown.

RECURRENT CELLULITIS

Almost 30% of admissions for cellulitis are for recurrent cellulitis.\textsuperscript{122} Two, three and five year recurrence rates are 17%, 29-47% and 47%, respectively.\textsuperscript{38,123-125} Five-year recurrence rate is 57% in patients with a history of recurrence.\textsuperscript{125} For HIV-infected patients, one- and three-year recurrence rates are 29% and 47%.\textsuperscript{126} Independent of persisting risk factors that might explain recurrences, the first episode’s inflammation has also likely damaged local lymphatic channels. Drainage is then insufficient, antigen presenting cells cannot migrate, and accumulating protein-rich fluid accommodates invading bacteria.\textsuperscript{127}

Lymphoedema is the most important risk factor for recurring cellulitis,
### Table 4. New antibiotics for skin and soft tissue infections. (continued on next page)

<table>
<thead>
<tr>
<th>Agent</th>
<th>Dosing</th>
<th>Early clinical response (mITT)*</th>
<th>Investigator assessed clinical cure post-therapy (mITT)*</th>
<th>Cellulitis specific*</th>
<th>Inclusion criteria for study population</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalbavancin</td>
<td>1500mg i.v. 1 or 2 once-weekly doses of 1000mg i.v. and 500mg i.v. (75% of dose in creatinin clearance &lt;30 ml/min)</td>
<td>80% vs 80%</td>
<td>96% vs 97%</td>
<td>79% vs 77% ECR; 91% vs 92% CSEOT</td>
<td>- 85 ≥ age ≥ 18</td>
<td>Comparator is vancomycin. CSEOT = decrease in lesion size from baseline, temp &lt;37.6, no fluctuance or heat/warmth, tenderness/induration no worse than mild, at end of therapy. Increased ALT/AST levels, 12% of patients have reduced platelets.</td>
</tr>
</tbody>
</table>
### Current insights into pathophysiology and management

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Treatment Duration</th>
<th>Cure Rate</th>
<th>Comparator</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oritavancin</td>
<td>1200mg i.v.</td>
<td>once</td>
<td>80-82%</td>
<td>80-83%</td>
<td>vs 79-83%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Age ≥ 18</td>
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<td></td>
<td>- Wound infection, cellulitis/erysipelas (onset within 7 days prior) or major cutaneous abscess, each with a minimum surface area of 75 cm²</td>
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<td></td>
<td></td>
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<td></td>
<td>- Suspected or confirmed gram-positive bacteria</td>
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<td></td>
<td>- Hospitalized for at least 7 days of intravenous antibiotics</td>
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<td></td>
<td>- At least two local and one systemic signs of infection</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comparator is vancomycin. Serious hypersensitivity reactions reported. Caution warranted in case of allergy to other glycopeptides, including vancomycin. Falsely elevated PT and PTT, increases bleeding risk of warfarin. Relatively healthy study population in registration trials.</td>
<td></td>
</tr>
<tr>
<td>Tedizolid</td>
<td>100-102</td>
<td>Once daily 200mg i.v. or p.o., 6 days</td>
<td>82% vs 79%</td>
<td>87% vs 87%</td>
<td>78% vs 76% ECR; 88% vs 82% IACPT</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>- Age ≥ 12</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Wound infection, cellulitis/erysipelas or major cutaneous abscess, each with a minimum surface area of 75 cm² and onset within 7 days prior</td>
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<td></td>
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<td></td>
<td>- Suspected or confirmed gram-positive bacteria</td>
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<td></td>
<td></td>
<td></td>
<td>- Minimum of local and systemic signs of infection depend on infection type</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comparator is linezolid. Cellulitis-specific investigator-assessed post-treatment cure rate only available from ESTABLISH-I</td>
<td></td>
</tr>
</tbody>
</table>

**Legend:** mITT modified Intention To Treat; IV intravenous; * all percentages are listed as success chance in investigational treatment group vs comparator group, no differences were statistically significant; ECR early clinical response; CSEOT clinical status at end of therapy; WBC white blood cell; IACPT investigator-assessed cure post treatment; PTE post-treatment evaluation.
and 25-60% of recurrent cellulitis patients suffer from chronic oedema.\textsuperscript{122,124} Obese patients have more recurrences and CRP and leucocyte counts are higher in these recurrences.\textsuperscript{39} For HIV-infected patients specifically, non-hepatitis liver disease, intravenous catheters or intravenous drug use increase the recurrence risk.\textsuperscript{126} All persisting risk factors are also likely to increase the chance of recurrences, and should be treated vigorously when possible. Lymphoedema warrants treatment with compression therapy. Tinea pedis should be treated with topical azoles in order to decrease the chance of recurrence. Frequent and meticulous interdigital web space cleansing prevents skin damage, bacterial overgrowth and bacterial invasion.\textsuperscript{127} 

\textit{S. pyogenes} is able to survive and replicate within macrophages.\textsuperscript{128} Theoretically this might elicit recurrences. However, recurrence rates are similar between patients receiving antibiotics with or without intracellular activity.\textsuperscript{129} When infections recur despite adequately treating risk factors, prophylactic antibiotics prevent recurrences.\textsuperscript{130} In the PATCH I trial, which randomised 274 patients with two or more episodes to either twice daily low-dose oral penicillin or placebo, recurrence rates were significantly lower in the penicillin group (22\% vs 37\%) after one year, although this effect wore off after cessation of treatment.\textsuperscript{131} For recurring \textit{S. aureus} infections, on-demand therapy can be considered. \textit{S. aureus} eradication or hygiene measures do not prevent recurrent \textit{S. aureus} skin infections.\textsuperscript{132,133}

\textbf{FUTURE PERSPECTIVES}

An overview of knowledge gaps which, if addressed, could advance our understanding of the pathophysiology of cellulitis and improve its clinical management is given in textbox 3. A major challenge is the high rate of misdiagnoses which can bias clinical trials towards non-inferiority.\textsuperscript{70} To determine applicability and reliability of trial results, it is imperative to document results from abscesses and cellulites separately, to accurately describe criteria and definitions, to extensively document clinical and microbiological characteristics, and to report information on additional procedures such as surgical drainage or limb immobilisation.\textsuperscript{134} For this relatively simple infection which has plagued humanity for so long, there still is a lot to discover.
Textbox 3. Questions for future research

What is the best way to...
... distinguish cellulitis from its mimickers?
... obtain a representative microbiological diagnosis?
... effectively reduce recurrences?
What is the role of...
... the skin microbiota in the etiology of cellulitis?
... compression therapy in its management?
... anti-inflammatory agents in disease management?
... pathogen reservoirs in recurrences?
Which patients are likely to...
... not require antibiotics at all?
... succeed with a shortened treatment duration?
... fail on outpatient therapy?
... require higher doses of antibiotics?
... require extended treatments?
REFERENCES


15. Sunderkotter C, Becker K. Frequent bacterial


33. Talan DA, Mower WR, Krishnadasan A,


130. Oh CC, Ko HC, Lee HY, Safdar N, Maki DG,


