Table 1a. Summary Therapy Recommendations for Bacterial Skin and Soft Tissue Infections Treated in the Outpatient Setting

Condition	Common Pathogens	Empiric antibiotic	β- lactam Allergy or suspected MRSA	Duration	Comments
Non-purulent cellulitis and erysipelas	GAS	Cephalexin 25 mg/kg/dose PO TID (max 500 mg/dose)	Clindamycin 10 mg/kg/dose, PO TID (max 600 mg/dose)	5-7 days	If lack of improvement or worsening after 48 hours of initial antibiotic, consider adding or changing to an agent with MRSA activity.
Impetigo	*Staphylococcus aureus* and GAS	Cleanse with soap and water and use topical antibiotic. It is ok to soak the scab and pick it off. Mupirocin topically 3 times a day (underneath the scab). Consider extending duration of treatment if not improving. Oral Antibiotics for widespread or progressive infection - *clindamycin 10 mg/kg/dose PO TID (max 600 mg/dose) vs -TMP-SMX 4-6 mg/kg/dose TMP BID (max 160 mg TMP/dose)		5 days	Clindamycin is considered the first-line oral medication option because MRSA represents up to 30% of *S. aureus* isolates cultured at Cook Children's Bacitracin ointment is inferior to mupirocin TMP/SMX:. Watch for signs for allergic reaction Rare nephrogenic strains of *S. pyogenes* can cause acute glomerulonephritis.
Folliculitis	*Staphylococcus aureus* (including MRSA) or *Pseudomonas aeruginosa* (prolonged exposure to contaminated water-"hot tub folliculitis")	Topical antibiotic cleanser (chlorohexidine) or topical antibacterial ointment (Mupirocin) Severe cases: Incision and drainage. Systemic antibiotics with anti-staphylococcal coverage; consider MRSA coverage with *Clindamycin 10 mg/kg/dose PO TID (max 600 mg/dose) vs *Pseudomonas aeruginosa* Ciprofloxacin 15 mg/kg/dose PO BID (max 500 mg/dose)		5 days	
Cellulitis with abscess	*Staphylococcus aureus* (including MRSA) >> GAS other *Streptococcus sp.*, gram negative rods and anaerobes.	Incision and drainage alone (< 2 cm) and **low risk criteria - No antibiotic needed Incision and drainage + antibiotics (> 2 cm, incomplete drainage, surrounding cellulitis, severe infection) Oral antibiotics: -*Clindamycin 10 mg/kg/dose PO, TID (max 600 mg/dose) or -TMP-SMX 4-6 mg/kg/dose TMP BID (max 160 mg TMP/dose) or -***Doxycycline 2 mg/kg/dose PO BID (Max 100 mg/dose) if you suspect clindamycin resistant MRSA		5-7 days	Strongly consider sending a wound culture so that antibiotic therapy can be tailored based on results of the gram stain, culture and sensitivities.

*20% of *S. aureus* is resistant to clindamycin in CCMC (CCMC antibiogram 2023)
Low risk criteria: ≥6 months, simple abscess, complete I&D, No fever, well appearing, no significant comorbidities, follow-up assured.
**No activity against GAS infections

Table 1b. Summary of Therapy Recommendations for wound bite in the outpatient setting

Condition	Pathogens	Empiric antibiotic	β-lactam Allergy or suspected MRSA	Duration	Comments
Human bites	*Eikenella corrodens* Oral anaerobes Polymicrobial *Streptococci sp*. MSSA or MRSA	Copious irrigation Cautious debridement Prophylaxis/mild infection: Amoxicillin-clavulanate 45 mg/kg/day PO divided every 12 hours (max amoxicillin component 875 mg/dose)	cefdinir 14mg/kg daily (max 600 mg/dose) monotherapy OR TMP/SMX 4-6 mg/kg/dose TMP (Max 160 TMP/dose) + Clindamycin 10 mg/kg dose PO TID (max 600 mg/dose) dual therapy.	Prophylaxis 3 days Treatment 10 days	Post exposure prophylaxis for rabies may be indicated. Tetanus-toxoid should be administered to patient without vaccination within 10 years. Tdap is preferred if not previously administered. Primary wound closure is not recommended with exception to those involving the face
Animal bites	*Pasteurella multocida* Oral anaerobes *Eikenella corrodens* *Capnocytophaga sp.* *Streptococci sp*. MSSA or MRSA				