



CLINICAL GUIDELINE

OPAT pathway adults (≥ 16) with complicated SSTI affecting upper or lower limb(s) or face (erysipelas)

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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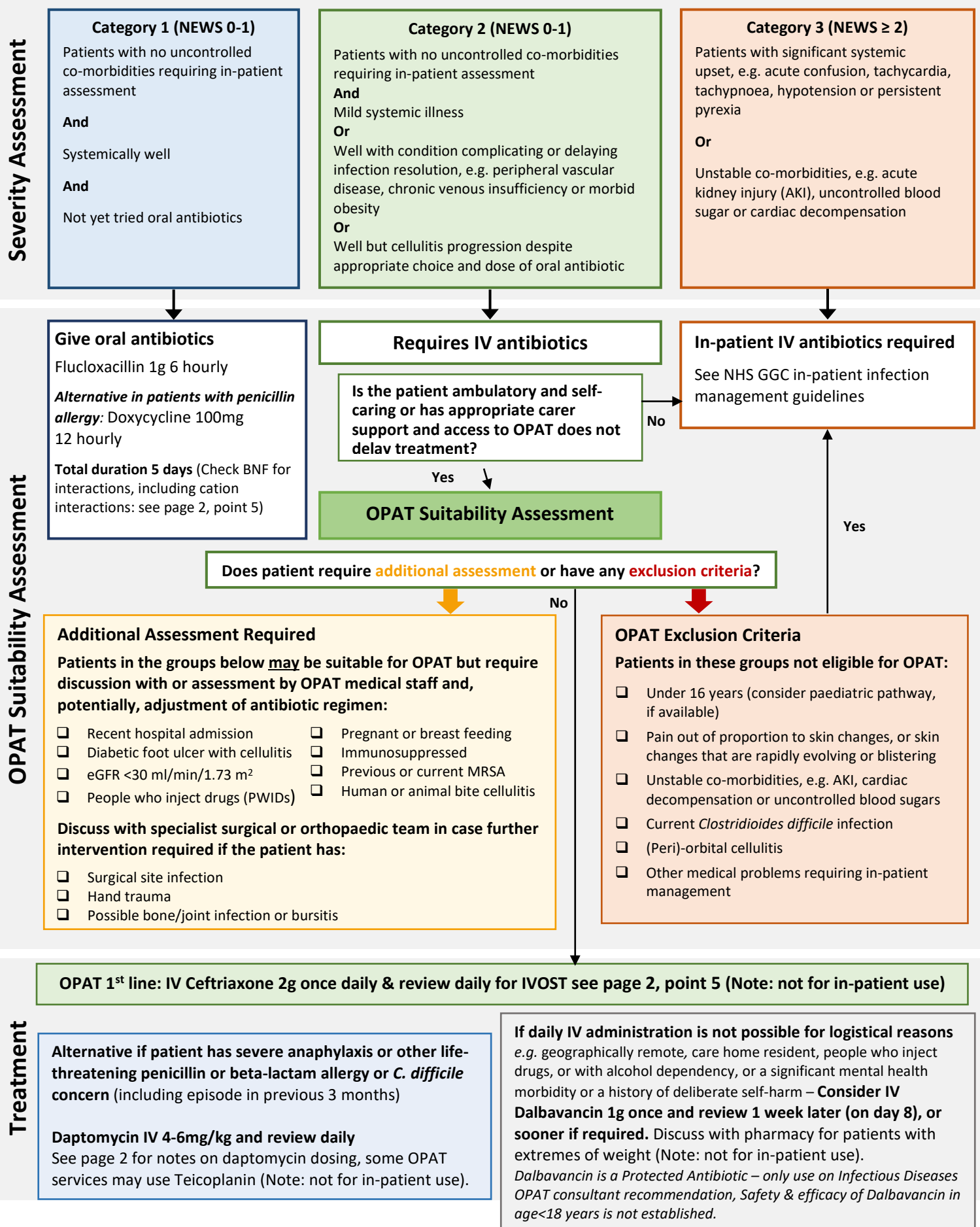
Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

GGC Out-patient parenteral antibiotic therapy (OPAT) pathway for the management of adults (≥ 16 years) with complicated skin and soft tissue infections (SSTI) affecting their upper or lower limb(s) or face (erysipelas)

For OPAT/ambulatory care/Hospital at Home clinicians, including advanced nurse practitioners or other non-medical prescribers (within competency framework) and non-prescribing OPAT specialist nurses (in accordance with local OPAT SSTI patient group direction)

Consider and exclude **SSTI mimics** (see page 2, point 1) and **assess severity and suitability for OPAT** (see below).



Guidance to support SAPG OPAT Pathway for management of adults with complicated SSTI

This guidance is for patients in an out-patient or OPAT setting only, refer to local antimicrobial policy for in-patient management.

1. Consider SSTI mimics/other dermatopathies

Note: Bilateral skin changes are usually **not** cellulitis.

- **Common:** Venous eczema, dependent rubor in venous insufficiency, superficial thrombophlebitis, irritant or allergic contact dermatitis, deep vein thrombosis, septic arthritis.
- **Less common:** Erythema nodosum, pyoderma gangrenosum, erythema multiforme, leukocytoclastic vasculitis.

2. Initial OPAT review (If patient is in hospital follow NHS GGC in-patient infection management guideline until OPAT review).

- Take baseline bloods including urea and electrolytes (U&Es), C-reactive protein (CRP), liver function tests (LFTs), full blood count (FBC), and blood cultures if possible.
- In patients with lower limb cellulitis examine both feet for, and treat, tinea pedis, if present. ADD Miconazole nitrate 2 % cream apply twice daily. Duration: Continue for 7 days after all signs and symptoms have disappeared.
- **IV ceftriaxone administration**
 - Administer IV ceftriaxone 2g daily via 30 minute infusion and observe for 30 minutes.
- **IV daptomycin administration** (if previous anaphylaxis or other life-threatening penicillin allergy or *C. difficile* concern)
 - Check baseline creatine kinase (CK) and highlight pulmonary eosinophilia risk.
 - Administer IV daptomycin 4-6 mg/kg (as per local guidance) daily via 3 minute injection or 30 minute infusion and observe for 30 minutes.
 - If Cr Cl <30ml/min, give IV daptomycin on alternate days.
 - Some OPAT services may prefer teicoplanin to daptomycin; refer to local guidance on dosing as, currently, there is no SAPG consensus on optimal dosing in the OPAT setting.

Table: Daptomycin 6mg/kg dosing regimen adapted from Greater Glasgow and Clyde OPAT

Body weight	6mg/kg dosing*
< 59kg	350mg
59 - 83kg	500mg
84 - 117kg	700mg
118 - 142kg	850mg
> 142kg	discuss with pharmacy

*Dose rounded to nearest vial

3. Daily assessment whilst on IV therapy

- Assess national early warning score (NEWS), including temperature, pulse, BP and respiratory rate, skin heat, erythema, pain and swelling.
- Continue IV therapy until there is significant reduction in heat, erythema, pain and normal temperature (<38°C), heart rate (<100 bpm) and respiratory rate (<20 breaths/ min).
- If clinical deterioration observed at any time, or no improvement at 72 hours, arrange for medical review.
- Average IV therapy length 48-96 hours (including any IV doses given prior to OPAT).

4. If unable to review patient daily due to logistical reason(s): consider single dose of dalbavancin (on Infectious diseases OPAT approval)

- **Dalbavancin administration (avoid if known hypersensitivity to other glycopeptides)**
 - Administer IV dalbavancin 1g infusion over 30 minutes via peripheral cannula and observe for 30 minutes.
 - Review at one week to assess whether further antibiotic therapy is required, or sooner if any concern
 - The majority of patients require a single dalbavancin infusion only.
 - Discuss with pharmacy if caring for patients with extremes of weight or for repeat dosing advice.

5. Switch to oral when patient shows significant clinical improvement in local signs of infection

Oral flucloxacillin 1g 6 hourly for 5 days duration **OR** (if previous anaphylaxis or other life-threatening penicillin allergy concern) oral doxycycline 100 mg 12 hourly for 5 days duration.

Note:

Doxycycline: Do not co-administer with iron. Stop/withhold other cation-containing products (including calcium, calcium containing nutritional supplements, magnesium, aluminium, zinc or sucralfate) until doxycycline course is complete. If concomitant administration necessary then give the cation-containing product at least 2 hours before or after doxycycline. See British National Formulary (BNF) for other interactions.

6. Advice for patients

- Importance of good skincare, e.g. application of non-perfumed emollient or soap substitute to affected area(s).
- Benefits of elevating the affected limb as much as possible until infection resolves.

7. Follow up and communication

- Provide all patients opportunity for telephone/remote review during OPAT and ensure communication with GP.
- Include admission plan in case a patient experiences deterioration out-of-hours and offer follow up/advice following completion of oral therapy.