Lymphoedema - Cellulitis - Summary Clinical Guideline

Reference no.: CG-LYMPH/2018/001

Prompt treatment of cellulitis is essential to prevent further damage to the lymphatics which can predispose to recurrent and worsening attacks. Flu like symptoms are often recognised by the patient before changes in the affected limb / area are evident. Bed rest and elevation of the affected part is essential.

Patients are advised to remove the compression garment whilst the limb is painful, but to reintroduce it as soon as it becomes comfortable.

It is believed that most cellulitis in Lymphoedema is due to β-haemolytic streptococcal infection (Mortimer 2000, Cox 2009). However, microbiologists consider staphylococcus aureus to be the cause in some patients (Chira and Miller, 2010). The British Lymphology Society consensus group favours the use of Amoxicillin (effective against streptococci). Flucloxacillin is effective against staphylococcal and less effective than Amoxicillin against streptococcal. Flucloxacillin is considered to be an acceptable alternative to Amoxicillin.
Always review response to first-line antibiotics after 48 hours.

Home Treatment
If possible, mark and date the edge of the erythema and record the level of systemic upset.

First-Line Antibiotics:
- Amoxicillin 500mg TDS
- If Penicillin allergic, Erythromycin 500mg QDS or Clarithromycin 500mg BD

If there is any evidence of *staphylococcal aureus* infection, (folliculitis, crusted dermatitis or pus formation) then Flucloxacillin 500mg QDS should be prescribed in addition or as an alternative, if the patient is not penicillin allergic.

Microbiologists suggest that the use of single agent flucloxacillin for all cellulitis covers both Strep. and Staph. infections. This is, therefore, an acceptable alternative.

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The recommended antibiotics for patients with a penicillin allergy will treat infections of streptococcal or staphylococcal origin.

Antibiotics should be continued for at least 14 days or until all signs of acute inflammation have resolved.

Second-Line Antibiotics:
If there is no or a poor response to first-line antibiotics after 48 hours, second-line antibiotics should be commenced. Clindamycin 300mg QDS is recommended as the second-line antibiotic.

Hospital Admission:
Hospital admission for IV antibiotics should be considered if:
- The patient's condition deteriorates at any time
- The cellulitis fails to resolve despite second-line antibiotics
- The patient has signs of septicaemia at the time of presentation

Further detailed guidance including antibiotic prophylaxis, the indications for patients having an "in case" course of antibiotics and a detailed discussion of the relative merits of Amoxicillin and Flucloxacillin are available at https://thebls.com/public/uploads/documents/document-49911513340766.pdf or www.lymphoedema.org/lsn/index