North Carolina Department Of Correction
Division Of Prisons

SECTION: Clinical Practice Guidelines

POLICY # CP-20

SUBJECT: Soft Tissue Infection/MRSA

EFFECTIVE DATE: June 2006
SUPERCEDES DATE: None

PURPOSE

To assure that DOP inmates with Soft Tissue Infections are receiving high quality Primary Care for their infections and that the risk of infecting other inmates or staff is minimized.

POLICY

All DOP Primary Care Providers are expected to follow this guideline and/or will document in the medical record any deviations from this guideline and the reasoning behind the need for deviation.

PROCEDURE

THE MANAGEMENT OF SOFT TISSUE INFECTION/MRSA
(See Table 1 for algorithm)

I. **Initial Assessment**:
   - A. **Whenever possible obtain material for culture and sensitivity**
   - B. **Minor infection**: treat with incision and drainage and warm compresses without antibiotics
   - C. **Serious or persistent infections** treat empirically with antibiotics pending results of culture

II. **Empiric Treatment**:
   - A. **Evaluate for MRSA** – Risk Factors:
     1. Known MRSA outbreak
     2. Recent hospitalization
     3. Previous anti-staphylococcal antibiotic usage
     4. Indwelling catheter
     5. Chronic wound drainage
     6. Repeated soft tissue infections
   - B. **No Risk Factors** treat with **standard anti-staphylococcal antibiotics**:
     1. First generation cephalosporins
     2. Amoxicillin/clavulanate
     3. Erythromycin
   - C. **Risk Factors** present use:
     1. **TMP-SMX: 2 DS tab b.i.d. (1 b.i.d. if impaired renal function) +/- Rifampin* 300 mg b.i.d.**
     2. Sulfa allergic or intolerant - Use one of the following:
        a) Clindamycin 300-450 milligrams q6h +/- rifampin* 300 b.i.d.
     3. Doxycycline 100 mg b.i.d. **+/-** Rifampin* 300 mg b.i.d**.**
     4. *Rifampin may be used in combination for recurrent MRSA infection despite appropriate therapy

III. **Hospitalize** if any of the following is clinically evident:
- A. Sepsis
- B. Fasciitis
- C. Evolving skin or soft tissue infection despite oral antibiotics
- D. Toxic shock syndrome

IV. **Culture positive** for staphylococcal infection:
- A. **Sensitive to first-line antibiotics:**
  1. If treating with MRSA agents change to first-line antibiotic
  2. If treating with first-line antibiotic and is sensitive continue until clinically cured
  3. If not sensitive and not clinically responding change to first-line antibiotic which is sensitive
- B. Positive for **Community Associated MRSA (CA-MRSA)** (outpatient setting, no prior medical history of MRSA, no history of the past year of hospitalization, nursing home, dialysis, for surgery, no permanent indwelling catheters or medical devices that passed through the skin, usually sensitive to several p.o. antibiotics)
  1. If susceptible: treat with TMP-SMX **2 DS tab b.i.d. (1 b.i.d. if impaired renal function)**. +/- rifampin* 300 mg b.i.d.
  2. If not, use one of the following based on susceptibility results:
     a) Clindamycin (if resistant to erythromycin and sensitive to clindamycin must evaluate for inducible resistance using "D test") 300 – 450 mg q6h +/- rifampin* 300 mg b.i.d. or
     b) Doxycycline 100 b.i.d. +/- rifampin* 300 mg b.i.d.
     Topical mupirocin +/- systemic therapy
  3. **DO NOT USE CIPRO OR OTHER FLUOROQUINOLONES EVEN IF SENSTIVE**
  4. If Group A streptococcus also present
     a) Add therapy (beta-lactam, macrolide, or clindamycin) to cover it also
     b) Tetracyclines and TMP-SMX are not adequate therapy for GAS
  5. Consider directly observed therapy
  6. Monitor closely for clinical improvement
  7. *Rifampin may be used in combination for recurrent MRSA infection despite appropriate therapy.
- C. Positive for **Highly Resistant MRSA**** (does not meet one or more of the above criteria, usually resistant to all p.o. antibiotics)
  1. If susceptible: treat with IV Vancomycin
  2. If not use another IV antibiotic based on susceptibility results
  3. Follow closely clinically for response to therapy

V. **Infection control**
- A. Inmates with potentially contagious infections: wound with uncontained drainage, weeping cellulitis, purulent catheter site infections, nonhealing abscesses, draining skin sinuses,

infected surgical wounds, multiple furuncles, infected burn sites, and MRSA pneumonia should be assigned to single cell housing and a separate toilet & shower or if not feasible shower/toilet must be decontaminated prior to use by others

B. Inmates with non draining MRSA skin infections or easily contained draining skin lesions may be housed with other inmates if the infected inmate adheres to infection control instructions and cellmates are not at increased risk of acquiring a MRSA infection.
C. The patient should be rechecked for reoccurrence one week after completing therapy
D. The patient should be on medical hold until he completes treatment and recheck

VI. **Surveillance For MRSA Outbreaks**

A. Interview all MRSA positive patients for potential sources of infection and close contacts; recent hospitalizations; sharing a personal hygiene items; recent injection drug use, tattooing or sexual contact; close contact sports; and exposures to other inmates with draining wounds or skin infections.
B. Examine all identified contacts for signs/symptoms of infection
C. Have all MRSA positive cultures held for at least 30 days by laboratory
D. Compare susceptibility of all positive MRSA cultures, similar susceptibilities among two or more MRSA isolates from epidemiological-linked patients suggest the possibility of an outbreak and should be reported immediately to Health Services

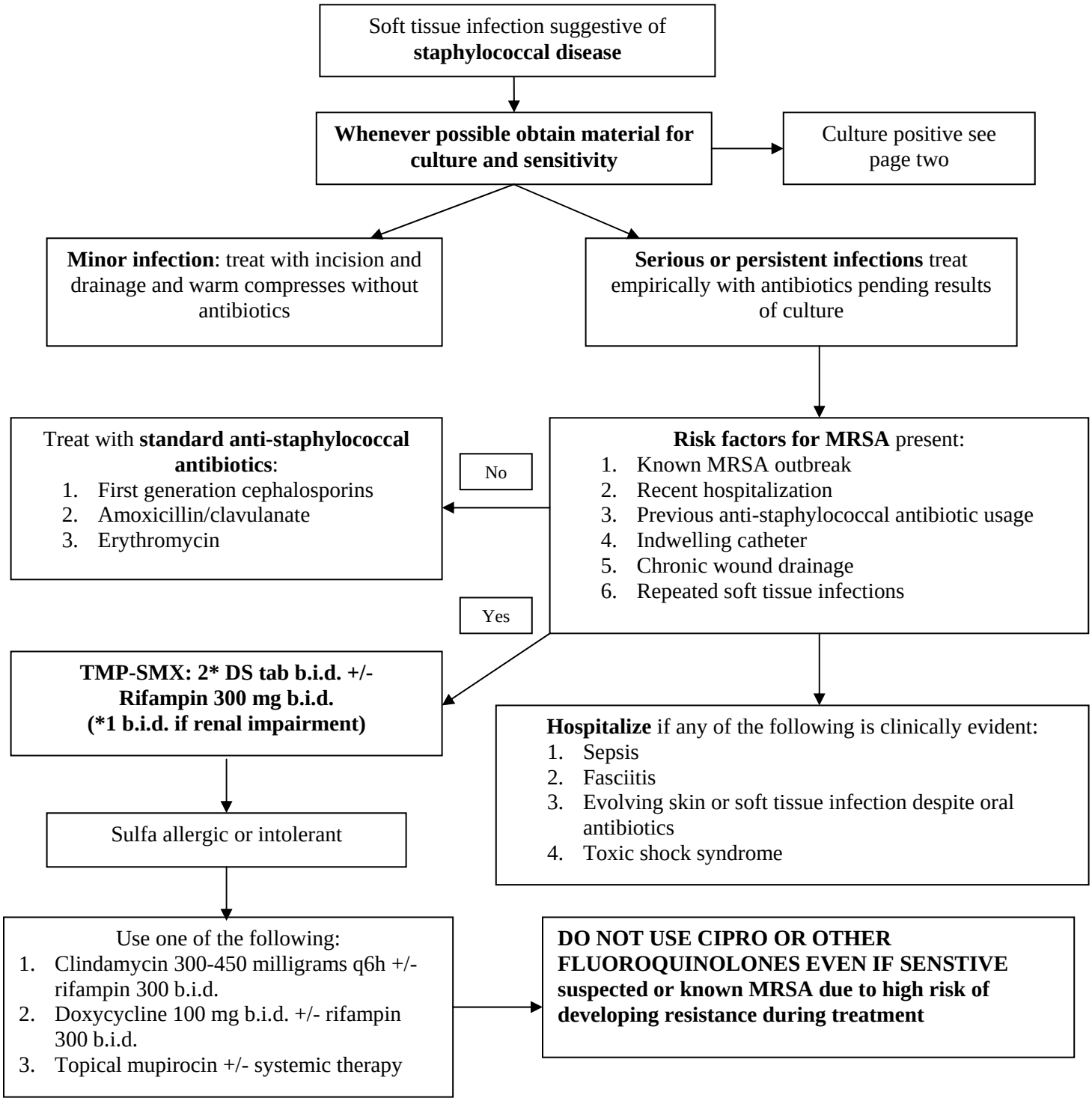
6/5/06

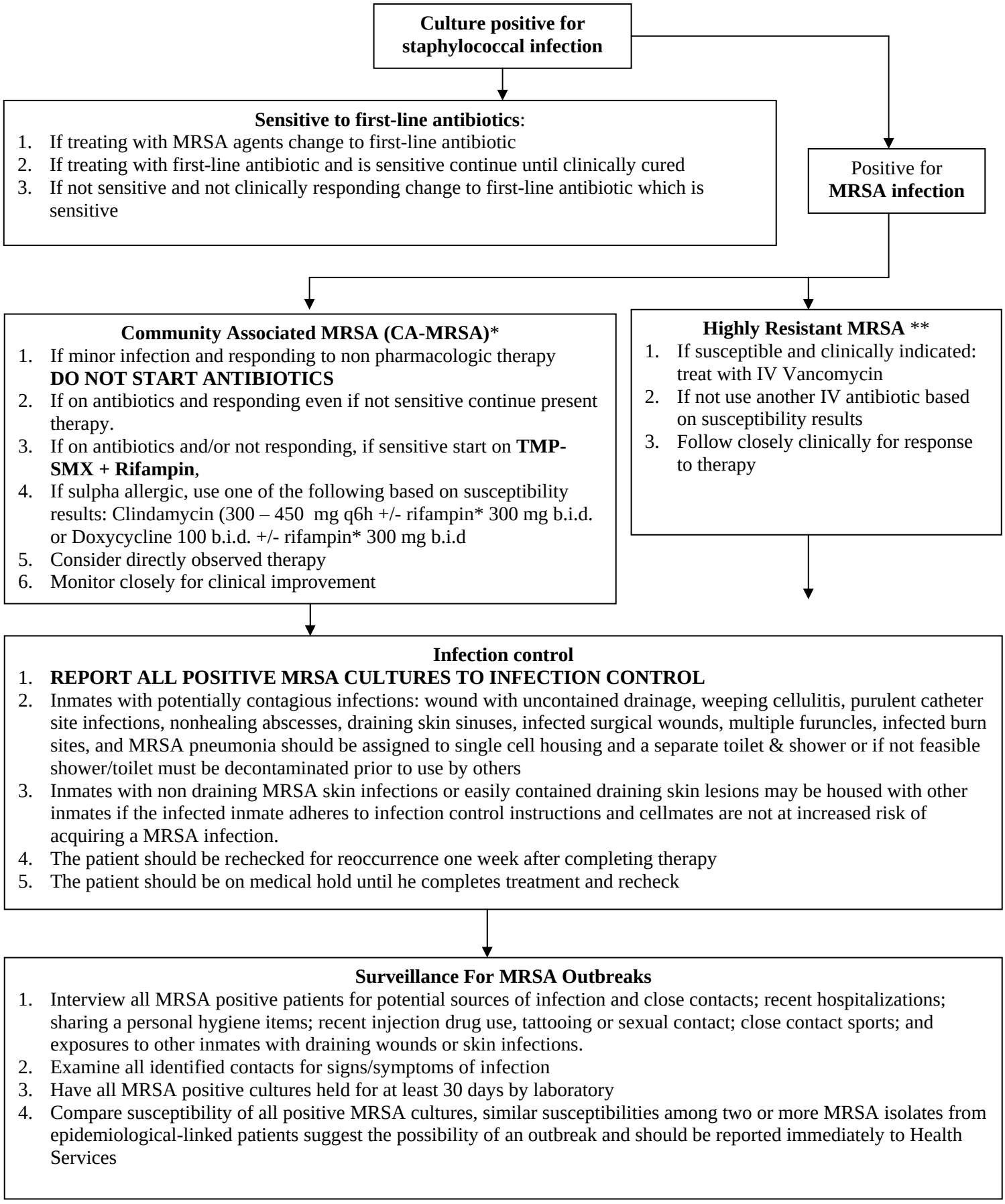
Paula Y. Smith, MD, Director of Health Services Date

SOR: Deputy Medical Director

TABLE 1

SOFT TISSUE INFECTION/MRSA





* **CA-MRSA**: outpatient setting, no prior medical history of MRSA, no history of the past year of hospitalization, nursing home, dialysis, for surgery, no permanent indwelling catheters or medical devices that passed through the skin, usually sensitive to several p.o. antibiotics

** **Highly Resistant MRSA**: does not meet one or more of the above criteria, usually resistant to all p.o. antibiotics