

16 – Skin and Soft Tissue Infections

Speaker: Helen Boucher, MD



Skin and Soft Tissue Infections

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Disclosures of Financial Relationships with Relevant Commercial Interests

- Editor
 - ID Clinics of North America
 - Antimicrobial Agents and Chemotherapy
 - Sanford Guide
- Treasurer, Infectious Diseases Society of America
- Member, ID Board, American Board of Internal Medicine
- Voting Member, Presidential Advisory Council on Combating Antibiotic Resistant Bacteria (PACCARB)

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Question #1

A 25 year old female suffers a cat bite on the forearm. She presents one hour later for care.

If no antibacterial is administered, the percentage of such patients that get infected is:

- A. 0-10 %
- B. 10-30 %
- C. 30-70 %
- D. 70-100 %

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Management of Animal Bites

- Wound care: irrigate, debridement
- Image for fracture or as baseline for osteo or to detect foreign body ?
- Wound closure: NO
- Anticipatory (prophylactic) antibiotics
- Vaccines (tetanus and rabies)

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Six pathogens that can cause infection after cat bites?

1. *Pasteurella species*
2. Anaerobic bacteria: e.g., *Fusobacteria*
3. *Bartonella henselae* (Cat Scratch disease)
4. Rabies virus
5. *S. aureus*
6. *Streptococcal species*

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Question #2

A 50 year old female alcoholic suffered a provoked dog bite.

- Bite was cleansed, tetanus toxoid given, and the dog placed under observation
- Patient is post-elective splenectomy for ITP; she received pneumococcal vaccine one year ago
- One day later, the patient is admitted to the ICU in septic shock with severe DIC and peripheral symmetric gangrene of the tips of her fingers/toes

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Question #2 Continued

Which one of the following is the most likely etiologic bacteria?

- A. *Pasteurella canis*
- B. *Capnocytophaga canimorsus*
- C. *Fusobacterium sp.*
- D. *Bartonella henselae*

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Question #3

A 45 year old USA homeless male presents with fever and severe polymyalgia. On physical exam, animal bite marks found around his left ankle. A faint rash is visible on his extremities. Within 24 hours, blood cultures are positive for pleomorphic gram-negative bacilli.

Which one of the following is the most likely diagnosis?

- A. *Pasteurella multocida*?
- B. *Haemophilus parainfluenza*?
- C. *Spirillum minus*?
- D. *Streptobacillus moniliformis*?

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Question #4

A 35 year old male suffers a clenched fist injury in a barroom brawl. He presents 18 hours later with fever and a tender, red, warm fist wound. Gram stain of bloody exudate shows a small gram-negative rod with some coccobacillary forms. The aerobic culture is positive for viridans streptococci.

Which one of the following organisms is the likely etiologic agent?

- A. *Viridans streptococci*?
- B. *Eikenella corrodens*?
- C. *Peptostreptococcus*?
- D. *Fusobacterium species*?

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Question #5 (Extra Credit)

Medicinal leeches are applied to a non-healing leg ulcer.

Which one of the following pathogens is found in the "mouth" of the leech ?

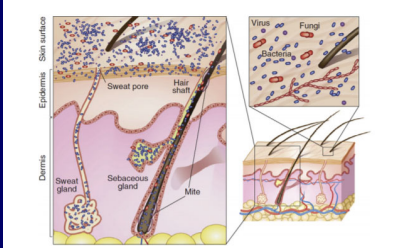
- A. *Alcaligenes xylosoxidans*
- B. *Aeromonas hydrophila*
- C. *Acinetobacter baumannii*
- D. *Arcanobacterium haemolyticum*

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The Skin: Local Invasion by Structure



[https://www.id.theclinics.com/article/S0891-5520\(20\)30090-8/pdf](https://www.id.theclinics.com/article/S0891-5520(20)30090-8/pdf)

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Skin Infections: Predisposing Factors

- Trauma to normal skin
- Immune deficiency
- Disrupted venous or lymphatic drainage
- Local inflammatory disorder
- Presence of foreign body
- Vascular insufficiency
- Obesity; poor hygiene

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What is this?



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Superficial Folliculitis

- **Purulence (sometimes mixed with blood) where hair follicles exit skin**
- Etiology:
 1. *S. aureus*
 2. *P. aeruginosa* (hot tub)
 3. *C. albicans* (esp. in obese patient)
 4. *Malassezia furfur* - lipophilic yeast (former *Pityrosporum* sp)
 5. Idiopathic eosinophilic pustular folliculitis in AIDS patients

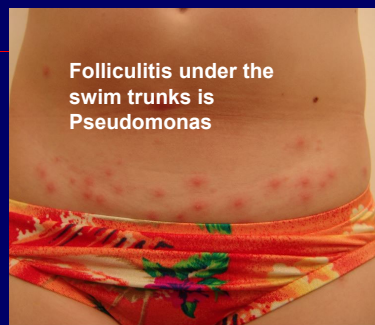
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Folliculitis under the swim trunks is ?



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Folliculitis under the swim trunks is *Pseudomonas*



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"Honey Crust"

Microbial Etiology?

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Streptococcal Infection of the Epidermis Name of the Clinical Syndrome?

Infection of outer layers of epidermis with production of "honey-crust" scales

Prevalent in warm, humid environments – esp. in children.

Microbial etiology

- Streptococci: Grps A, B, C, G

Name?

- Streptococcal impetigo

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Fragile superficial bullae

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Fragile Bullae in Epidermis

Diagnosis?

- Bullous impetigo

Etiology?

- *S. aureus*

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Impetigo ("to attack")

- Bullous impetigo: *S. aureus*
- Non-bullous impetigo: *S. pyogenes*, group A
- So, empiric therapy aimed at *S. aureus* as could be MRSA
- Topical: topical antibiotic ointment (TAO), mupirocin, retapamulin
- Oral rarely needed
 - e.g. Clindamycin, doxycycline

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Complications of *S. pyogenes*, *S. dysgalactiae* (Gps C&G) impetigo

- Post-streptococcal glomerulonephritis due to nephritogenic strains
- Rheumatic fever has "never" occurred after streptococcal impetigo

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Acute onset of painful, rapidly spreading red plaque of inflammation involving epidermis, dermis, and subcutaneous fat
NO PURULENCE

Diagnosis?

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Acute onset of painful, rapidly spreading red plaque of inflammation involving epidermis, dermis, and subcutaneous fat
NO PURULENCE

Diagnosis:

Erysipelas: Non-purulent cellulitis

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Acute onset of painful, rapidly spreading red plaque of inflammation involving epidermis, dermis, and subcutaneous fat.

NO PURULENCE

Diagnosis:

- Erysipelas: Non-purulent cellulitis

Etiology?

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Acute onset of painful, rapidly spreading red plaque of inflammation involving epidermis, dermis, and subcutaneous fat. NO PURULENCE

Diagnosis?

- Erysipelas: Non-purulent cellulitis

Etiology?

- Hemolytic Streptococci: Grp A now less common than groups C and G
- If on the face, could be *S. aureus*

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Erysipelas (“Red Skin”)

- Acute onset of painful skin, rapid progression +/- lymphangitis
- Inflamed skin elevated, red, and demarcated
- Etiology: Streptococci—Gps. A,B,C, & G (*S.pyogenes*, *S. agalactiae*, *S.dysgalactiae* subsp. *equisimilis*)
- Predisposition:
 - Lymphatic disruption, venous stasis

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Erysipelas and Cultures

- Usually no culture necessary
- Can isolate *S. pyogenes* from fungal-infected skin between toes
- Low density of organisms
 - Punch biopsy positive in only 20-30%
- Blood cultures positive in $\leq 5\%$
- Confused with stasis dermatitis

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Stasis Dermatitis



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Stasis Dermatitis

- Looks like erysipelas; Patient often obese
- No fever
- Chronic, often **bilateral**, dependent edema
- Goes away with elevation
- Does not respond to antimicrobials
- Cadexomer iodine (IODOSORB) response rate 21% vs 5% for usual care

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Treatment of Erysipelas (Non-purulent “cellulitis”)

- Elevation
- Topical antifungals between toes if tinea pedis present
- Penicillin, cephalosporins, clindamycin
- Avoid macrolides and TMP/SMX due to frequency of resistance

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Cellulitis



- Without localization or preceding macro or micro trauma: usually Beta strep. (usually GAS), extremities > face, elsewhere
- With localization (cut, pustule, etc.) or preceding trauma: *S. aureus*

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Severe Cellulitis



Microbiology: Streptococci (grp A>B,C,G); less often *S. aureus*; rarely GNR

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Recurrent Cellulitis

- Frequently non-group A streptococci (esp. B,G)
- Relapse > recurrence
- Prophylaxis:
 - benzathine penicillin IM
 - oral penicillin; other systemic antibiotics
 - decolonization (nasal, elsewhere)

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Risk factors for recurrent Cellulitis

- Lower Extremity
 - Post-bypass venectomy
 - Chronic lymphedema
 - Pelvic surgery
 - Lymphadenectomy
 - Pelvic irradiation
 - Chronic dermatophytosis
- Upper Extremity
 - Post-mastectomy/node dissection
- Breast
 - Post-breast conservation surgery, biopsy

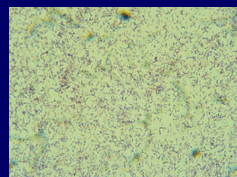
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Erysipelothrix (Gram + rod)

- On finger after cut/abrasion exposure to infected animal (swine) or fish
- Subacute erysipelas (erysipeloid)
- Severe throbbing pain
- Diagnosis: Culture of deep dermis (aspirate or biopsy)
- Treatment: Penicillin, cephalosporins, clindamycin, fluoroquinolone

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Erysipelothrix rhusiopathiae Infection



Gram stain of the organism (G+ rod) identified on culture



Resolving cellulitis caused by *Erysipelothrix rhusiopathiae*

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Question #6

A 53 year old male construction worker has sudden onset of pain in his left calf. Within hours the skin and subcutaneous tissue of the calf are red, edematous and tender. Red "streaks" are seen spreading proximally

A short time later, patient is brought to the ER

Confused, vomiting, and hypotensive

- Temp 40C, diffuse erythema of the skin. Oxygen sat. 88% RA
- WBC 3000 with 25% polys and 50% band forms. Platelet count is 60,000

(Continued#3

Question #6 Continued

Which one of the following is the most likely complication of the erysipelas?

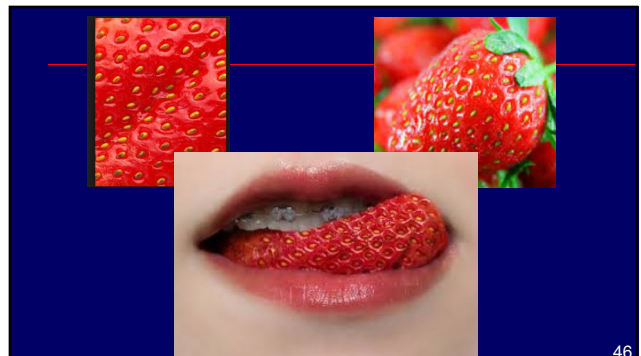
- A. Bacteremic shock due to *S. pyogenes*?
- B. Toxic shock due to *S. pyogenes*?
- C. Bacteremic shock due to *S. aureus*?
- D. Toxic shock due to *S. aureus*?

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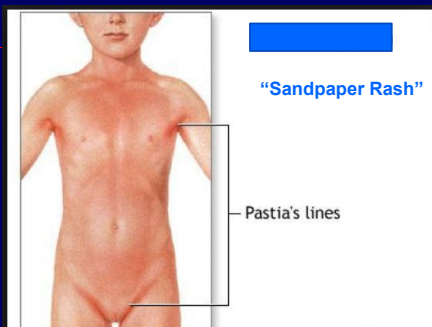
Sore throat and skin rash

- 20 year old man with 3 days of sore throat, fever, chills, and skin rash
- Rash is nonpruritic and involves abdomen, chest, back, arms, and legs
- Exam: Exudative tonsillitis, strawberry tongue, rash, and tender cervical lymph nodes

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The most likely diagnosis ?

- Infectious mononucleosis
- Coxsackie hand, foot and mouth disease
- Scarlet fever
- *Arcanobacterium hemolyticum*

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The most likely diagnosis ?

- Infectious mononucleosis
- Coxsackie hand, foot and mouth disease
- **Scarlet fever**
- *Arcanobacterium hemolyticum*

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Question 7:

- 18 year old male on anti- seizure meds for idiopathic epilepsy develops fluctuant tender furuncle on right arm
- He develops fever and generalized erythroderma; wherever he is touched, a bullous lesion develops
- **Skin biopsy shows intra-epidermal split in the skin**

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Question #7

Which one of the following is the likely etiology of the skin bullae?

- A. *S. aureus* scalded skin syndrome?
- B. Bullous pemphigus?
- C. Drug-induced Toxic epidermal necrolysis (TEN)?
- D. *S. pyogenes* necrotizing fasciitis?

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Erysipelas with loss of pain, hemorrhagic bullae, rapid progression..

Necrotizing fasciitis is due to which one ?

- a. Streptococcal fasciitis
- b. Staphylococcal fasciitis
- c. Clostridial infection
- d. Synergy between aerobe (*S.aureus*, *E.coli*) plus anaerobe (anaerobic strep, *Bacteroides sp*) equals Meleney's, Fournier's

Lancet ID 2015;15:109

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Necrotizing Fasciitis: at the bedside



Sudden onset excruciating pain & systemic toxicity
Note swelling of leg & 2 small purple bullae on anterior shin
Pressures in the anterior/lateral compartments (blood at needle entry) elevated; surgical exploration performed

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Treatment of necrotizing fasciitis

- Think of it
- Surgical debridement: sometimes several times so as to achieve source control
- Appropriate antimicrobial therapy

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| Anatomy | Syndrome |
|---|---|
| Epidermis | Erysipelas |
| Skin | Impetigo |
| | Folliculitis |
| Dermis | Ecthyma |
| | Furunculosis |
| | Carbunculos |
| | All of this is Cellulitis |
| Superficial fascia | |
| Subcutaneous tissue | Necrotizing fasciitis |
| Subcutaneous fat, Nerves, arteries, veins | |
| Deep fascia | |
| Muscle | Myonecrosis (clostridial and non-clostridial) |

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Question #8

A 50-year-old male african american fisherman with known alcoholic cirrhosis suffers an abrasion of his leg while harvesting oysters. Within hours, the skin is red, painful, and hemorrhagic bullae appear.

Which one of the following conditions predisposes to this infection?

- G6PD Deficiency
- Hemochromatosis
- Sickle cell disease
- Achlorhydria

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Organisms Whose Growth is Stimulated by Excess Iron

- *Vibrio vulnificus* V
- *Escherichia coli* E
- *Listeria monocytogenes* L
- *Aeromonas hydrophilia* A
- *Rhizopus species (Mucor)* R
- *Yersinia enterocolitica* Y

Definition:
"The sails
of a ship"

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Thank You!

- David Gilbert

- Our patients and their families

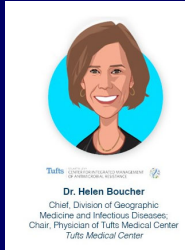
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Questions, Comments?

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