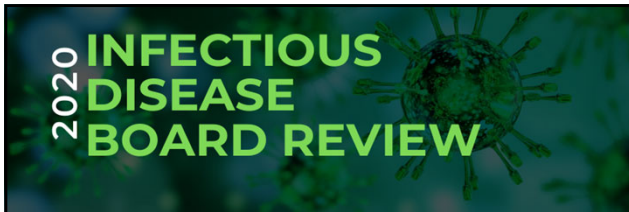


# 60 – Skin and Soft Tissue Infections

Speaker: Helen Boucher, MD



**2020 INFECTIOUS DISEASE BOARD REVIEW**

**Skin and Soft Tissue Infections**

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\*Special thanks to David Gilbert, MD, FIDSA

**Disclosures of Financial Relationships with Relevant Commercial Interests**

- Editor
  - ID Clinics of North America
  - Antimicrobial Agents and Chemotherapy
- 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)

**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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**Cat Bites**

- Most cat bites become infected with bacteria
- Wound types: puncture
- Microbiology: 63% polymicrobial
- Infection type:
  - nonpurulent wound with cellulitis, lymphangitis, or both (42%)
  - purulent wound without abscess (39%)
  - abscesses (19%)

Organism	Percentage
<b>Aerobic organisms</b>	
<i>Pasteurella</i>	75
<i>Streptococcus</i>	46
<i>Staphylococcus</i>	35
<i>Neisseria</i>	35
<i>Moraxella</i>	35
<i>Corynebacterium</i>	28
<i>Enterococcus</i>	12
<i>Bacillus</i>	11
<b>Anaerobic organisms</b>	
<i>Fusobacterium</i>	33
<i>Porphyromonas</i>	30
<i>Bacteroides</i>	23

Abrahamian FM1, Goldstein EJ. Microbiology of animal bite wound infections. Clin Microbiol Rev. 2011 Apr;24(2):231-46. doi: 10.1128/CMR.00041-10; NEJM 1999; 340: 25-32

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***Pasteurella multocida***

- In saliva of > 90% of cats and over 80% of wounds get infected
- Different species, *Pasteurella canis*, in saliva of 50% of dogs and only 2-10% get infected
- Small aerobic Gram-Negative bacillus
- Hard to remember antibiotic susceptibility profile, but amoxicillin sensitive; alternatives can be tricky

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Can you name 6 pathogens that can cause infection after cat bites?

1. *Pasteurella species*
2. Anaerobic bacteria: e.g., *Fusobacteria*
3. *Bartonella henselae* (Cat Scratch dis.)
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. It was cleansed, tetanus toxoid given, and the dog placed under observation.

The 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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## Dog Bites and Splenectomy

- Only 2-10 % get infected
- Potential pathogens from
  - Dog's mouth:
    - *Pasteurella canis*, *Capnocytophaga canimorsus*
  - Human skin: *S. aureus*, *S. pyogenes*
- *Capnocytophaga* is an important cause of overwhelming sepsis in splenectomized patients
- *Capnocytophaga*
  - Susceptible to: AM/CL, PIP/Tazo, Penicillin G, and clindamycin
  - Resistant to: TMP/SMX and maybe vancomycin

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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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## Rat bite fever

- USA: *Streptobacillus moniliformis*
- Asia: *Spirillum minus*
- Bites or contaminated food/water
- *S. moniliformis*:
  - Fever, extremity rash
    - Macular/papular, pustular, petechial, purpuric
  - Symmetrical polyarthralgia
- Treatment: Penicillin or doxycycline

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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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## *Eikenella corrodens*

- Anaerobic small gram-negative bacillus
- Susceptible to: penicillins, FQs, TMP/SMX, Doxy, and ESCs.
- Resistant to: Cephalexin, clinda, erythro, and metronidazole

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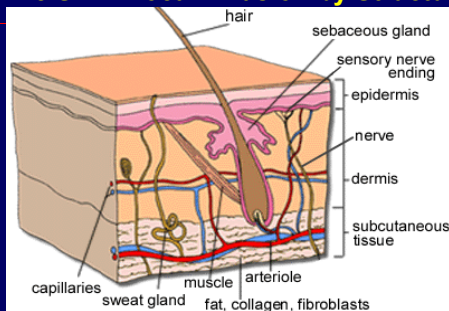
## Question #5 (Extra Credit)

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



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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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## Purulence (sometimes mixed with blood) where hair follicles exit skin

- Diagnosis: Superficial Folliculitis
- 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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## Microbial etiology ?

Infection of outer layers of epidermis with production of "honey-crust" scales  
Prevalent in warm, humid environments – esp. in children  
Microbial etiology?

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## Streptococcal

Infection of outer layers of epidermis with production of "honey-crust" scales  
Prevalent in warm, humid environments – esp. in children  
Microbial etiology?

- Streptococci: Groups A, B, C, G

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## Name of 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?

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## Streptococcal Infection of the Epidermis

Infection of outer layers of epidermis with production of “honey-crust” scales.

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

Microbial etiology?

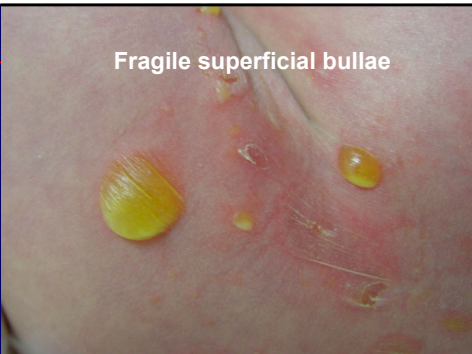
- Streptococci: Grps A, B, C, G

Name?

- Streptococcal impetigo

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Fragile superficial bullae



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## Fragile Bullae in Epidermis

Diagnosis?

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## Fragile Bullae in Epidermis

Diagnosis?

- Bullous impetigo

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## Fragile Bullae in Epidermis

Diagnosis?

- Bullous impetigo

Etiology?

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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

- 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

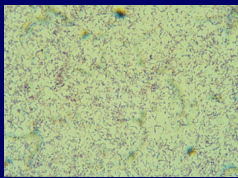
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## Erysipelothrix (Gram + rod)

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

(Continued)

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## 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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## Toxic Shock Syn. (TSS): Staph vs Strep

Feature	Staphylococcal	Streptococcal
Predisposition	Tampon, surgery; colonization	Cuts, Burns, Varicella, erysipelas
Focal Pain	No	Yes
Tissue necrosis/inflammation	Rare	Common
N/V, renal failure/DIC	Yes	Yes
Erythroderma	Very common	Less Common
Bacteremia	Very rare	60%
Mortality	<3%	30-70%

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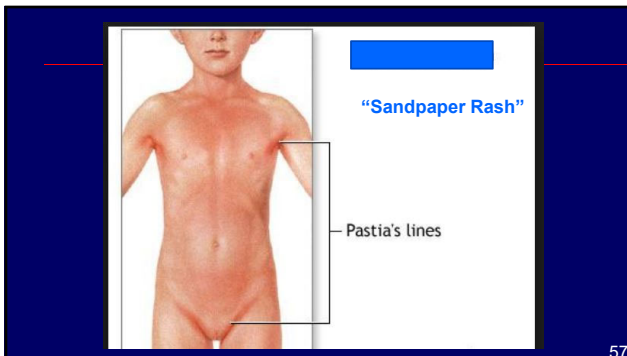
### Sore throat and skin rash

- 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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### 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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# 60 – Skin and Soft Tissue Infections

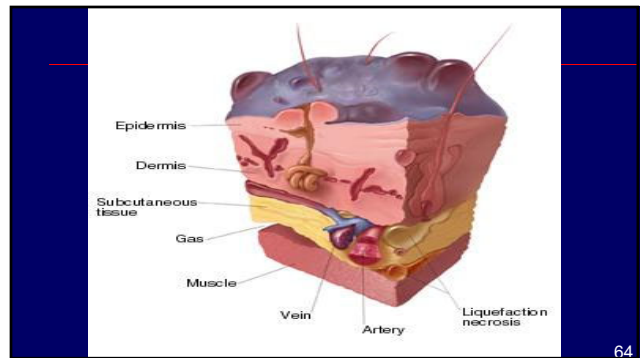
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**The Skin and Toxins of *S. aureus* and *S. pyogenes***

Organism	Toxin	Clinical Diagnosis
<i>S. aureus</i> colonization	TSST	TSS & Erythroderma
<i>S. aureus</i> colonization	Exfoliative toxin	Impetigo; scalded skin syndrome
<i>Strept. pyogenes</i> invasion	TSST	TSS; Erythroderma (not always)
<i>Strept. pyogenes</i>	Pyrogenic exotoxin	Pharyngitis; Scarlet Fever (sandpaper rash)

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

**Necrotizing fasciitis due to which one ?**

- Streptococcal fasciitis
- Staphylococcal fasciitis
- Clostridial infection
- 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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## 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
	Carbunculosi
<b>All of this is</b>	
	<b>Cellulitis</b>
Superficial fascia	Necrotizing fasciitis
Subcutaneous tissue	
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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## Vibrio vulnificus

- Leading cause of shellfish(e.g., oysters)- associated deaths in USA
- Portal of entry: skin abasions or GI
- Liver disease, **hemochromatosis**, and exposure to estuaries are major risk factors
- **Infected wounds manifest as bullae in 75%; primary bacteremia also occurs.**
- Treatment (look up): doxy plus ceftriaxone (alternative is an FQ)

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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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Back up slides

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## Common Masqueraders of Cellulitis

- Vascular Disorders
  - Superficial thrombophlebitis
  - Deep venous thrombophlebitis
- Primary Dermatologic Disorders
  - Contact dermatitis
  - Insect stings or bites and other envenomations
  - Drug reactions
  - Eosinophilic cellulitis (Wells syndrome)
  - Sweet syndrome
- Rheumatic disorders
  - Gouty arthritis
- Immunologic-idiopathic disorders
  - Erythromelalgia
  - Relapsing polychondritis
- Malignant disorders
  - Carcinoma erysipelatoides
- Familial syndromes
  - Familial Mediterranean fever
  - Familial Hibernian fever
- Foreign-body reaction
  - Reaction to metallic implant
  - Mesh intolerance
  - Foreign-body granulomatous reactions

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## Skin Abscesses

- Predisposing factors
  - *S. aureus* colonization
  - IV/SQ drug injection
  - Underlying diseases
    - DM, immunodeficiencies, etc
- Microbiology
  - *S. aureus*: the vast majority
  - Treatment: Drainage, antibiotics
  - Always cover *S. aureus*. Broad spectrum in special cases (septic IVDU)



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## CA-MRSA & CA-MRSA-Like Skin Lesions



Cutaneous Anthrax



Ecthyma gangrenosum



Bite of *Loxosceles reclusa*

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