Infection Severity	Preferred Empiric Regimens	Alternative Regimens	Comments
Mild ● Cellulitis less than 2 cm and without involvement of deeper tissues ● Non-limb threatening ● No signs of systemic toxicity	**Wound less than 4 weeks duration** ● cephalexin 500 mg PO four times daily* **Wound greater than 4 weeks duration** ● sulfamethoxazole/trimethoprim 800/160 mg PO twice daily* + metronidazole 500 mg PO three times a day ● clindamycin 450 mg po three times daily + ciprofloxacin 500 mg po twice daily	**Wound less than 4 weeks duration** ● clindamycin 450 mg PO three times daily (only if severe β-lactam allergy) **Wound greater than 4 weeks duration** ● amoxicillin/clavulanate 875/125mg PO twice daily*, OR ● doxycycline 100 mg PO twice daily + metronidazole 500 mg PO three times daily	● Outpatient management with oral antibiotics recommended. ● Tailor regimen based on C&S results & patient response. ● Consider risk for CA-MRSA
Moderate ● Cellulitis greater than 2 cm or involvement of deeper tissues ● Non-limb threatening ● No signs of systemic toxicity	**Wound less than 4 weeks duration** ● cefazolin 1 g IV q8h* , OR ● ceftriaxone 1 g IV once daily (to facilitate outpatient management when ambulatory administration of ceFAZolin not possible) **Wound greater than 4 weeks duration** ● cefazolin 1 g IV q8h* + metronidazole 500 mg PO three times daily, OR ● ceftriaxone 1 g IV once daily + metronidazole 500 mg PO three times daily (to facilitate outpatient management when ambulatory administration of cefazolin not possible)	**Wound less than 4 weeks duration** ● moxifloxacin 400 mg PO once daily* (only if severe β-lactam allergy) **Wound greater than 4 weeks duration** ● moxifloxacin 400 mg IV/PO once daily* ● piperacillin-tazobactam iv 4.5g q8h ● carbapenem iv, consult ID	● Initial management with inpatient or outpatient parenteral therapy with rapid step-down to oral therapy after 48 to 72 hours based on patient response recommended. ● Tailor regimen based on C&S results & patient response. ● Consider risk for CA-MRSA .
Severe ● Systemic signs of sepsis ● Limb or foot threatening ● Extensive soft tissue involvement ● Pulseless foot	● piperacillin-tazobactam 3.375 g IV q6h* or 4.5g iv q8h ● if high risk for CA-MRSA, add vancomycin 25 mg/kg loading dose, or Linezolid po 600 mg BID	● moxifloxacin 400 mg po once daily* ● ciprofloxacin 500 mg po twice daily + metronidazole iv or clindamycin iv ● ceftriaxone 2g iv q24h + metronidazole 500 mg iv q8h ● iv carbapenem, consult ID	● Inpatient management recommended. ● Urgent vascular assessment if pulseless foot. ● Tailor regimen based on C&S results & patient response.
**Adjust dose if eGFR ≤ 30 ml/min*			

If high risk for CA-MRSA: should include **sulfamethoxazole/trimethoprim** 800/160 mg PO twice daily (adjust dose if eGFR ≤30ml/min) or **doxycycline** 100 mg PO twice daily for mild infections; **vancomycin** weight-based dosing to a target trough of 15 – 20 mg/L for moderate-severe infections.

Clinical Pearls:

- Always consider **risk for CA-MRSA**..
- **<u>Bacteria change with duration of wound and severity of infection:</u>**
  - In **short duration** ulcers - targeting Staph and Strep initially;
  - with **longer duration** wounds - anaerobes may be an issue;
  - with **severe infection**s - need to think about gram negatives and MRSA
- **Debridement, good glycemic control and appropriate wound care** are essential for the management of diabetic foot infections.
- **Cultures**: prefer tissue specimens post-debridement and cleansing of wound.
- Surface or wound drainage swabs not recommended.
- Positive probe-to-bone test indicative of osteomyelitis.
- **Imaging:** recommend plain radiography, MRI if concerned about osteomyelitis (radionuclide imaging unnecessary).

Duration of Therapy:

- Soft tissue only – 2 weeks
- Bone involvement with complete surgical resection of all infected bone – 2 weeks
- Bone involvement with incomplete surgical debridement of infected bone – 6 weeks IV
- Bone involvement with no surgical debridement – 6 weeks IV, followed by 6 weeks PO

References:

1. Bowering K, Embil JM. Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada: Foot Care. Can J Diabetes 37(2013) S145-S149
2. Lipsky BA, Berendt AR, Cornia PB et al. 2012 Infectious Disease Society of America Clinical Practice Guidelines for the Diagnosis and Treatment of Diabetic Foot Infections. CID 2012:54(12):132-173
3. Lipsky BA, Armstrong DG, Citron DM et al. Ertapenem versus piperacillin/tazobactam for diabetic foot infections (SIDESTEP): prospective, randomized, controlled, double-blinded, multicentre trial. Lancet 2005; 366:1695 – 1703
4. Blond-Hill E, Fryters S. Bugs & Drugs An Antimicrobial/Infectious Diseases Reference. 2012. Alberta Health Services