

Intramuscular Ceftriaxone with Oral Antibiotic Therapy in the Treatment of Outpatient Cellulitis

1*

2

3

1,4

1

1

FÖ^]æ/c { ^}c{~!Oæ { i|^~^A T^æä&^}æÉ Tæ^ [iÖ|}æ&^iÜ[&@^•c^É T|i} } ^•[caÉiWÜCE
GÖçä•i{ }~!O|•^æ•^•^•^æÉ Tæ^ [iÖ|}æ&^iÜ[&@^•c^É T|i} } ^•[caÉiWÜCE
HÖ^]æ/c { ^}c{~!U@æ/ { æ&~!U^/çä&^•^æÉ Tæ^ [iÖ|}æ&^iÜ[&@^•c^É T|i} } ^•[caÉiWÜCE
IÖ^]æ/c { ^}c{~!Oæ { i|^~^A T^æä&^}æÉ Tæ^ [iÖ|}æ&^iP^æ|@iÜ^•c^ { É|CE^•cä}æÉ T|i} } ^•[caÉiWÜCE

*

coverage in cases where cellulitis is associated with abscess formation. Since most cases of cellulitis are caused by beta-hemolytic *streptococci* and *staphylococci* [4], it is arguable that IM β -lactam antibiotics in the setting of outpatient cellulitis would qualify as an avoidable antimicrobial exposure.

Antimicrobial choice is of particular concern to primary care providers, as the association between antibiotic prescribing practices and antimicrobial resistance is well-documented [7-10]. In a recent study conducted within the Denver Health system, it was found that half of all uncomplicated skin infections involved avoidable antibiotic exposure [11]. Given the need for antimicrobial stewardship, cost, resistance and adverse effects, it is still relevant to consider the potential etiology of the cellulitis and our choice of antibiotics in the outpatient setting.

The objectives of this study were to compare rates of outpatient treatment failure in cellulitic skin infections among those who received IM β -lactam antibiotics in addition to oral antibiotics versus oral antibiotics alone. Because β -lactam antibiotics

and *g*: tissue infections: 2014 update by the Infectious Diseases Society of America Clin Infect Dis 59: e10-52

- 6 Marshall WF, Blair JE (1999) *Y* cephalosporins. Mayo Clin Proc 74: 187-195.
7. Owens RC Jr; Donskey CJ, Gaynes RP, Loo VG, Muto CA (2008) Antimicrobial-associated risk factors for *Clostridium difficile* infection. Clin Infect Dis 46 1: S19-31.
- 8 Pallin