# Management of Diabetic Foot Infection based on Severity

| *Classification of Mild Infection* | *Classification of Moderate Infection* | *Classification of Severe Infection* |
|---|---|---|
| At least 2 of the following are present:<br>• Local swelling<br>• Erythema > 0.5 cm* (but < 2 cm*) around the wound/ulcer<br>• Local tenderness or pain (absence of pain does not exclude infection)<br>• Local warmth<br>• Purulent discharge<br>• Infection involving only the skin or subcutaneous tissue (without involvement of deeper tissues)<br>• No systemic signs or symptoms of infection (see severe)<br>**NOTE: In any direction from the rim of the wound. The presence of foot ischaemia makes both diagnosis and treatment of infection considerably more difficult.* | As in mild PLUS<br>• Infection involving structures deeper than skin and subcutaneous tissues (e.g., bone, joint, tendon, muscle) or erythema extending >2 cm* from the wound/ulcer margin.<br>• No systemic signs or symptoms of infection (see severe)<br>• Risk factors for poly-microbial infection; chronic ulcers, recent antibiotic use, and foot ischemia or dry gangrene<br>**NOTE: In any direction from the rim of the wound. The presence of foot ischaemia makes both diagnosis and treatment of infection considerably more difficult.* | Any foot infection with the systemic inflammatory response syndrome (SIRS), manifested by ≥2 of the following:<br>• Temperature >38˚ or <36˚ Celsius<br>• Heart rate >90 beats/minute<br>• Respiratory rate >20 breaths/minute or PaCO2 < 4.3 kPa (32 mmHg)<br>• White blood cell count >12,000 or <4,000/mm3, or >10% immature (band) forms<br>Community/Primary Care<br>• Systemic illness – fever, chills, shock, vomiting, confusion, metabolic instability<br>• Critical limb ischaemia<br>• Wet gangrene<br>• Gas in soft tissues (crepitus)<br>• Cellulitis >2cm around the ulcer associated with:<br>  ○ Lymphangitis<br>  ○ Foot failing to respond to oral antibiotics alone |
| ***Mild Infection*** | ***Moderate Infection*** | ***Severe Infection*** |
| **Flucloxacillin PO 500mg-1g QDS**<br><br>**Alternative (e.g. Penicillin allergy)**<br>Clarithromycin PO 500mg BD or<br>Doxycycline PO 100mg BD or<br>Clindamycin PO 300mg QDS (excluded for >65years old or previous or high risk of *C.difficile*)<br><br>***h/o MRSA positive seek Microbiology advice***<br><br>**Review at 1-2 weeks** | **Co-amoxiclav PO 625mg TDS or**<br>**Flucloxacillin PO 500mg-1g QDS plus**<br>**Metronidazole PO 400mg TDS**<br><br>**Alternative (e.g. Penicillin allergy)**<br>Clarithromycin PO 500mg BD plus Metronidazole PO 400mg TDS or Doxycycline PO 100mg BD plus Metronidazole PO 400mg TDS or Clindamycin PO 450mg QDS (excluded for >65years old or previous or high risk of *C.difficile*)<br><br>***h/o MRSA positive seek Microbiology advice***<br><br>**Duration: 2-4 weeks** | **Admit** |
| This guidance **excludes** the following conditions:<br>**Osteomyelitis**; principles are prolonged antibiotic treatment (minimum 6 weeks) according to local specialist guidance and microbiological sensitivities | | |



**Developped by Essex Partnership University NHS Foundation Trust, Southend University Hospital NHS Foundation Trust, NHS Castle Point and Rochford CCG and NHS Southend CCG. March 2019**