

## Management of infection in the diabetic foot

Grade of Infection (PEDIS <sup>1</sup> )	Signs/symptoms	First antibiotic Choice	Alternative	Notes	Duration	Investigations	Referral route
<b>Mild</b>	Two or more signs of inflammation, e.g. pus, pain, warmth, induration. Infection limited to skin or subcutaneous tissue and spreads no more than 2cm from any ulcer margin. No systemic signs of infection, e.g. abscess or suspected osteomyelitis.	Oral flucloxacillin 1g QDS	Oral clarithromycin 500mg BD	If known to be an MRSA carrier, consider empirical MRSA treatment with a suitable oral antibiotic such as such as doxycycline	1–2 weeks	Tissue sample by curettage or scraping with a scalpel blade after debridement of the wound and washing with water is preferable to superficial swab. If there is pus, needle aspiration yields the most suitable specimen.	Outpatient referral To MDT foot team
<b>Moderate</b>	Systemically well patient who has any of: <ul style="list-style-type: none"> <li>Cellulitis extending &gt;2cm from the ulcer margin</li> <li>Lymphangitic streaking</li> <li>Spread beneath the deep fascia including local abscess</li> <li>Suspected osteomyelitis</li> </ul>	Oral co-amoxiclav 625mg TDS	Oral levofloxacin 500mg OD or BD and clindamycin 300-450 mg QDS	If the patient is a known MRSA carrier, empirical IV teicoplanin or PO doxycycline AND PO rifampicin. When MRSA is excluded, the anti-MRSA treatment can be stopped. Suspect osteomyelitis in any ulcer with visible bone or bone that can be easily probed and if an ulcer fails to heal after 6 weeks of appropriate wound care and offloading.	Typically 2–4 weeks for non bone infections  Treat osteomyelitis for at least six weeks	As above Suspected osteomyelitis: Xray and repeat 2–4 weeks. If osteomyelitis still suspected MRI. If bone biopsy is required, this should be an operative or radiological procedure under local anaesthesia. Microbiological and histological examination can be carried out. White cell counts and CRP lack specificity. Lytic bone on X-ray is likely to represent osteomyelitis especially if there are progressive changes over time with no other reason for lytic osteoarthropathy	Outpatient referral To MDT foot team  Inpatient assessment and initiation of treatment

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<b>Severe</b>	Clinical infection with systemic toxicity or metabolic instability <b>REFER TO DERRIFORD VIA SAU</b>	Tazobactam plus teicoplanin plus PO/IV Rifampicin	Teicoplanin, PO/IV Rifampicin, PO/IV Levofloxacin and Metronidazole	If MRSA is excluded as a causative organism, the anti-MRSA treatment can be stopped	2–4 weeks		Inpatient assessment and initiation of treatment
<b>Management of residual infection after minor or major amputation</b>							
<b>What is left after amputation debridement</b>		<b>First antibiotic Choice</b>		<b>Alternative</b>		<b>Duration</b>	
All infected tissue removed		Stop surgical prophylaxis <72 hours		Stop surgical prophylaxis <72 hours		<72 hours	
Residual infected <b>soft</b> tissue ONLY		Co-amoxiclav 625mg TDS		Oral levofloxacin 500mg OD or BD and clindamycin 300-450 mg QDS		2–4 weeks	
Residual infected <b>VIABLE</b> bone		As above		As above		6 weeks	
Residual dead <b>NONVIABLE</b> bone (Why has dead bone been retained, can this not be removed?)		As above		As above		Review at a minimum of 12 weeks	