



CLINICAL GUIDELINE

Diabetic Foot Infection Outpatient Management in Adults

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	1
Does this version include changes to clinical advice:	N/A
Date Approved:	25 th August 2020
Date of Next Review:	31 st August 2023
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Approval Group:	Antimicrobial Utilisation Committee

Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Outpatient Management of Diabetic Foot Infection

Good Practice Points

- Patients with severe infection (as per IDSA classification¹) should be considered for inpatient management
- PRIOR to commencing antibiotic therapy for osteomyelitis:
 - ensure wound swabs have been taken*
 - consider antibiotic oral bioavailability, bone penetration, current and prior microbiology, allergy/tolerability history, renal and hepatic function and drug-drug/drug-food interactions
- Discuss treatment with an infection specialist (Microbiology OR Infectious Diseases**) prior to initiating therapy for osteomyelitis if:
 - recommended empirical antibiotics are contra-indicated due to allergy, co-morbidities or drug interactions
 - recurrent osteomyelitis
 - current or previous positive microbiology
- All patients receiving treatment for osteomyelitis should be highlighted to the diabetes team to ensure ongoing review of culture/sensitivity results, tolerability of therapy and laboratory/ECG monitoring when required

*Wound swabs are not reliable for detecting the causative pathogen(s) in osteomyelitis and should not be used in isolation to guide therapy. Deep tissue/bone biopsy following local debridement is preferred to optimise appropriate therapy.

**Microbiology : North & Clyde 0141 201 8551 (18551), South 0141 354 9132 (89133), QEUF DFI MDT patients – contact Dr Beth White or Dr Neil Ritchie via email/switchboard, OPAT referrals via Trakcare or Tel. 83017 (0141 452 3017)

Use the following empirical guidance in the absence of positive microbiology

	Empirical Antibiotic Choice and Duration	Additional Comments
Localised non-severe Cellulitis	As per Scottish Diabetes Foot Action Group Guidance ¹ Oral Flucloxacillin 1g QDS <i>Or if true penicillin/β lactam allergy:</i> Oral Doxycycline 100mg BD Duration: 7 days	ALWAYS review patient's concomitant medication for drug interactions and counsel patient regarding potential side-effects. Use the British National formulary or Stockley's Drug Interaction Checker available via Staffnet or contact Pharmacy. Doxycycline absorption is reduced with multivalent cations e.g. Ca ²⁺ , Mg ²⁺ iron preparations and some nutritional supplements. This risks treatment failure. Withhold cation preparations or ensure doses separated to minimise effect-see BNF (oral iron MUST be withheld). Note associated risk of photosensitivity reactions and oesophageal ulceration – refer to BNF.
Non-acute Osteomyelitis	Doxycycline 100mg BD OR Clindamycin 450-600mg TDS Duration: 6 weeks (highlight to diabetes team for review)	Clindamycin is associated with increased risk of <i>C.difficile</i> infection, particularly in patients aged >65. Avoid if previous <i>C.diff</i> or discuss with ID/microbiology. Dosing: <70kg 450mg TDS and ≥70kg 600mg TDS. Patient should stop if diarrhoea occurs and discuss urgently with diabetic foot team. Oral flucloxacillin has no place in osteomyelitis treatment as suboptimal oral absorption (which is further reduced by administration with food)

References

1. [Scottish Diabetes Foot Action Group Guidance](#)