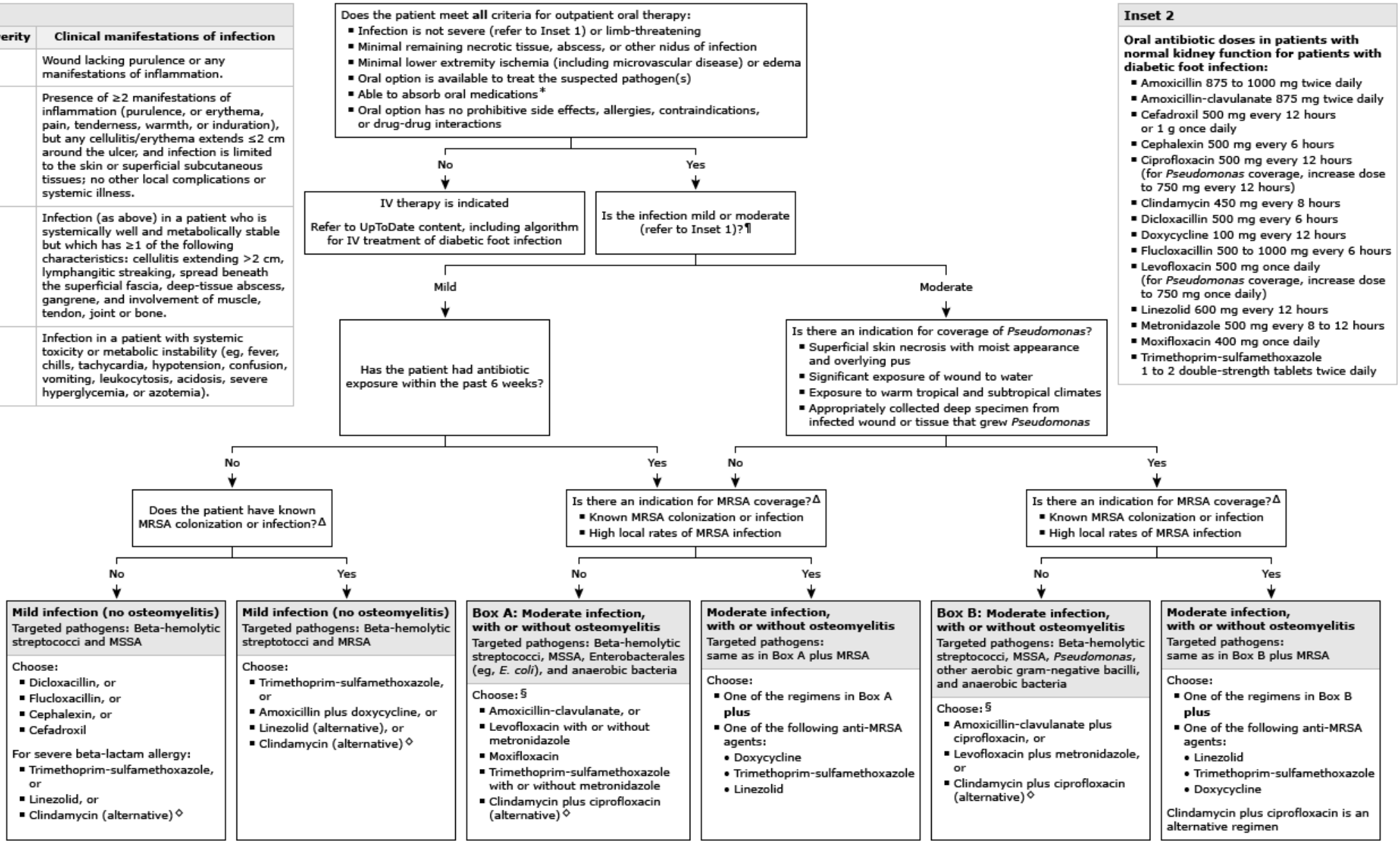
Empiric oral antibiotic selection for patients with diabetic foot infection, including osteomyelitis

Inset 1

Infection severity	Clinical manifestations of infection
Uninfected	Wound lacking purulence or any manifestations of inflammation.
Mild	Presence of ≥2 manifestations of inflammation (purulence, or erythema, pain, tenderness, warmth, or induration), but any cellulitis/erythema extends ≤2 cm around the ulcer, and infection is limited to the skin or superficial subcutaneous tissues; no other local complications or systemic illness.
Moderate	Infection (as above) in a patient who is systemically well and metabolically stable but which has ≥1 of the following characteristics: cellulitis extending >2 cm, lymphangitic streaking, spread beneath the superficial fascia, deep-tissue abscess, gangrene, and involvement of muscle, tendon, joint or bone.
Severe	Infection in a patient with systemic toxicity or metabolic instability (eg, fever, chills, tachycardia, hypotension, confusion, vomiting, leukocytosis, acidosis, severe hyperglycemia, or azotemia).



Inset 2

Oral antibiotic doses in patients with normal kidney function for patients with diabetic foot infection:

- Amoxicillin 875 to 1000 mg twice daily
- Amoxicillin-clavulanate 875 mg twice daily
- Cefadroxil 500 mg every 12 hours or 1 g once daily
- Cephalexin 500 mg every 6 hours
- Ciprofloxacin 500 mg every 12 hours (for *Pseudomonas* coverage, increase dose to 750 mg every 12 hours)
- Clindamycin 450 mg every 8 hours
- Dicloxacillin 500 mg every 6 hours
- Doxycycline 100 mg every 12 hours
- Flucloxacillin 500 to 1000 mg every 6 hours
- Levofloxacin 500 mg once daily (for *Pseudomonas* coverage, increase dose to 750 mg once daily)
- Linezolid 600 mg every 12 hours
- Metronidazole 500 mg every 8 to 12 hours
- Moxifloxacin 400 mg once daily
- Trimethoprim-sulfamethoxazole 1 to 2 double-strength tablets twice daily

This algorithm is intended for patients with mild to moderate diabetic foot infections; antibiotic selection for severe infections is outlined in a separate algorithm. Many patients with diabetic foot infection also require surgical intervention, as discussed in UpToDate content. Antibiotic regimens should be changed to target specific pathogens once culture and susceptibility results are available.

IV: intravenous; MRSA: methicillin-resistant *Staphylococcus aureus*; MSSA: methicillin-sensitive *Staphylococcus aureus*.

* For patients who are unable to absorb oral antibiotics, an IV regimen with a spectrum similar to the appropriate oral option should be chosen.

¶ By definition, patients with osteomyelitis have either moderate or severe infection (refer to inset 1).

Δ Other risk factors may not be as strongly associated with MRSA infection, so we individualize the decision to cover MRSA in such cases. A complete list of MRSA risk factors can be found in UpToDate content.

◊ We generally avoid clindamycin, if possible, due to risk of *Clostridioides difficile* infection and the possibility of streptococcal and staphylococcal resistance (refer to UpToDate content for details).

§ For patients with osteomyelitis who have received recent antibiotics and have no available deep culture results, some experts add double coverage for Enterobacterales (eg, *E. coli*, *Klebsiella*) with regimens such as amoxicillin-clavulanate plus either doxycycline or trimethoprim-sulfamethoxazole.

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