

CELLULITIS - by John Falkner-Heylings BSc (Podiatric Medicine), DipPodM, FPSPract, Podiatrist

What is cellulitis?

Cellulitis is an infection of the tissues of the dermis and subcutaneous tissues. Erysipelas is the term used to describe a more superficial infection than cellulitis, but it is difficult to know how deep an infection is, and many workers use the terms interchangeably. Cellulitis is *'a common yet potentially serious condition'* (Halpern et al, 2008). Cellulitis affects one leg only – if both legs are affected, then it is not cellulitis, but peripheral vascular disease or some other 'red-leg syndrome'.

The lower leg is the most common site for the development of cellulitis. A small area may be affected, or an infection might affect an extensive area of skin. The reddened area of skin is seen to ascend, to advance from the foot upwards as bacterial toxins damage the proteins of the skin. Left untreated, the body's immune system would fight the infection, and the cellulitis should clear. But if the immune system cannot contain the infection it can spread rapidly and become a medical emergency as the infection invades deeper, spreads into the lymphatic system and may then be distributed throughout the body leading to complications. Untreated cellulitis can give rise to septicaemia or permanent damage to the lymphatic system and may produce a permanent oedema.



Cellulitis of left leg and foot

'Acute lower limb cellulitis may be defined as an acute spreading pyogenic inflammation of the dermis and subcutaneous tissues, characterised by a tender, warm, erythematous, swollen leg without sharp demarcation from uninvolved skin' (Swartz, 2004).

If the condition is mild it may be treated with antibiotics and will most often resolve. But if the condition does not quickly improve or becomes worse it may become necessary to admit to hospital for intravenous antibiotic therapy. In addition to flucloxacillin, intravenous benzylpenicillin may also need to be administered.

According to Halpern et al 2008, there were 49,500 cases that required admission for acute lower limb cellulitis in England in 2003-2004 with a mean length of stay of 10 days. This has considerable resource and cost implications.

Who is at risk of developing cellulitis?

Those at greatest risk of developing cellulitis may:

- suffer from chronic Tinea pedis (athletes foot) or onychomycosis
- have cracks or maceration between the toes, a portal of entry for staphylococcal or streptococcal bacteria that are responsible for causing the infection.
- have swollen legs, be overweight or obese
- have had previous episodes of cellulitis
- have a lowered immune system - may be on steroids, or chemotherapy
- have poorly controlled diabetes mellitus
- have suffered previous deep vein thrombosis (DVT)
- have experienced same-side orthopaedic surgery on the leg
- have a break in the skin, insect bite, excoriation or wound of the skin of the leg through which infection might enter.

The risk of developing cellulitis increases if:

- there has been a recent episode of skin trauma
- there is a history of diabetes mellitus
- current or recent smoker (within 1 year)

alcohol excess (over 21 units/week)

obesity (body mass index > 30kg/m²)

oedema/lymphoedema/venous incompetence/ulceration.

Halpern et al, in their 2008 paper: *Ethnicity and Other Risk Factors for Acute Lower Limb Cellulitis: a UK-based Prospective Case-Control Study* have established that ethnicity is a risk factor for cellulitis, reporting a population attributable risk of 44.1% for those of white ethnicity, -6.2% for Afro-Caribbeans, and -11% for those of Asian origin.

Recurrence of cellulitis

Approximately one-third of cellulitis cases recur. One of the predisposing factors for cellulitis is one or more previous episodes of cellulitis. And an episode of cellulitis may be followed by one or more recurrences in rapid succession. It is thought that if antibiotic therapy is ceased too early, some small foci of infection may remain to re-establish the condition. In some cases it is considered necessary to treat cellulitis prophylactically, with continuous antibiotics for an extended period until the risk of recurrence is thought to have receded. Mild cellulitis is often treated with flucloxacillin or erythromycin.

Differential diagnosis of cellulitis

Cellulitis is a unilateral condition. It has similar appearance to varicose eczema, both displaying an erythematous inflammation. A distinctive feature of varicose eczema is blistering, where the blisters exude fluid which dries and crusts. Any crusting present is therefore indicative of varicose eczema. Cellulitis does not crust and the skin remains smooth and shiny.

Cellulitis produces an erythema, and the leg may be swollen and tender. Deep vein thrombosis must be excluded, and since recent hospitalisation or surgery, miscarriage, hormonal contraception and long haul flights are all known to predispose to DVT, it is appropriate to screen for these histories. If palpation of the venous tract is painful then further hospital-based investigation is indicated.

Cellulitis, usually of streptococcal origin, that infects the subcutaneous tissues and fascia can on rare occasions lead to necrotising fasciitis. This is a serious medical emergency with one of the fastest rates of spread of infection known. The bacteria produce toxins that destroy skin and muscle tissue. The condition is accompanied by feeling ill, and becomes life threatening within a few hours, organs failing as the toxins have effect. The death rate from necrotising fasciitis is in excess of 30%. Symptoms not to be overlooked include:

pain 'out of proportion' to the appearance of the skin,

feeling unwell and becoming ill 'out of proportion to the appearance of the skin'

symptoms that worsen rapidly - either skin symptoms or feeling unwell

affected skin that goes dusky, purple or blisters.

Necrotising fasciitis is rare. It is included here for the purpose of completeness.

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CELLULITIS

Answers to these questions should be submitted on A4 paper and must be of sufficient length to demonstrate full understanding of the topic. Single word answers are not permissible. Try to answer in one or two short paragraphs, generally not more than 1/3rd page per answer.

- Q1. What is cellulitis?
- Q2. How does cellulitis arise?
- Q3. Cellulitis can lead to complications. What are they?
- Q4. What treatment intervention is necessary on diagnosis?
- Q5. List five factors that may predispose to development of cellulitis.
- Q6. List five factors that increase the risk.
- Q7. Why is cellulitis thought sometimes to recur?
- Q8. How would you recognise cellulitis?
- Q9. How are cellulitis and varicose eczema differentially diagnosed?
- Q10. Which is the pathogen that most often causes cellulitis?

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