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The Latest in Cellulite Treatment and Management

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INTRODUCTION

Cellulitis is a bacterial infection that usually affects the inner layers of the skin. Signs and symptoms include reddened areas that get bigger over a few days. The borders of red areas are generally not sharp and the skin may be swollen. Redness often fades to white under pressure, but this is not always the case. The infected area is usually painful. Lymphatic vessels may invade, causing fever and malaise. Cellulitis can appear on any part of the body, but the legs and face are the most commonly affected areas. The legs are usually affected after a skin tear. Other risk factors include obesity, swollen legs, and old age. For facial infections, previous skin damage is usually not the case. The bacteria most commonly involved are Streptococcus and Staphylococcus aureus.

DESCRIPTION

Unlike cellulitis, erysipelas is a bacterial infection that affects the more superficial layers of the skin, has reddened areas with clear borders, and is more commonly associated with fever based on the signs and symptoms present, which rarely allows for cell culture. Underlying bone infections and more serious infections such as necrotizing fasciitis must be ruled out before making a diagnosis. Treatment is usually oral antibiotics such as cephalexin, amoxicillin or cloxacillin.

People allergic to penicillin may be prescribed erythromycin or clindamycin instead. Maybe there are concerns about the presence of pus and previous MRSA infection in him. Lifting the infected area can help, as can pain relievers. Diagnosis of cellulitis is generally based on the morphologic features of the lesion and the clinical presentation. Gram stain and culture can confirm the diagnosis if there is drainage, an open wound or an obvious entry point.

In the absence of culture findings, it is difficult to determine the bacterial etiology of cellulitis. Insome cases, staphylococci and streptococcal cellulitis have similar characteristics and are indistinguishable from each other. Needle aspirate culture is not indicated for routine care because results rarely change treatment regimens. There is only a 20% chance of positive cultures from needle aspirations and core biopsies, even when taken from the leading edge of inflammation. This suggests that a small number of bacteria may cause this condition and that the expansion of symptomatic areas within the skin may be the effect of extracellular toxins or host-induced inflammatory mediators. Despite the low aspiration rate in individual patients, the study produced important insights for overall treatment strategies. Data from a number of studies examining both needle aspiration and core biopsies suggest that antimicrobial therapy for cellulitis should focus on immunocompetent hosts, particularly the Gram-positive cocci of Staphylococcus aureus and Streptococcus pyogenes.

CONCLUSION

Surgical drainage is usually required if an abscess is also present, and antibiotics are often prescribed if cellulitis is present, especially if it is widespread. Pain relievers are often prescribed, but excessive pain is a symptom of necrotizing fasciitis and should always be evaluated. Supportive care includes elevating and resting the affected limb to reduce swelling and applying sterile saline dressings to remove pus from open lesions. dermatophyte infections should be treated with topical antifungals until they disappear. Prompt use of antifungal drugs prophylactically or at the earliest sign of relapse can reduce the risk of spread.

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