What diagnostic strategies can help differentiate cellulitis from other causes of red legs in primary care

Article  (Published Version)


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What diagnostic strategies can help differentiate cellulitis from other causes of red legs in primary care?

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What you need to know

- Red legs owing to non-infectious causes are often misdiagnosed as cellulitis, resulting in unnecessary antibiotics and hospitalisation
- Novel approaches such as thermal imaging, clinical prediction models, point-of-care tests, and a visually based computerised diagnostic decision support system could potentially aid the diagnosis of cellulitis, but there is very limited and weak evidence to support their use in primary care
- Clinically, a unilateral presentation increases the odds of cellulitis, and lack of elevated temperature compared with the unaffected limb can help rule out cellulitis

Cellulitis is the most common bacterial infection causing red legs. It is treated with antibiotics, and patients with severe disease may need to be hospitalised. In 2017-18, 317 522 patients were given a diagnosis of cellulitis in UK hospitals. The true incidence, including patients managed through primary care, is likely to be higher.

Redness is often accompanied by other classic signs of inflammation: tenderness, warmth, and swelling. Other causes of red legs can present with some, or all, of these common symptoms (table 1). These conditions may be misdiagnosed as cellulitis. Studies in US emergency departments have reported that between 28% and 30.7% of cellulitis diagnoses are incorrect. Misdiagnosis can result in unnecessary antibiotic treatment and hospitalisation. Conversely, untreated cellulitis can have complications such as extensive tissue damage and necrosis, disseminated infection, septic shock, and potentially death. Figures 1 and 2 show alternative diagnoses for red legs.

Differentiating red legs with bacterial causes from those with non-infectious causes presents a diagnostic dilemma in primary care. A systematic review published in 2019 highlighted the lack of validated diagnostic aids for lower limb cellulitis. In this review we also included studies of patients with cellulitis of any site on the body, and additionally searched conference abstracts. We excluded any technology or test that was unsuitable for use in primary care.

What is the evidence of uncertainty?

We searched Medline, Embase, and Web of Science from inception to July 2019 using terms for skin or soft tissue infection including: cellulitis (MeSH term) OR bacterial skin disease OR soft tissue infections OR wound infections OR skin diseases OR bacterial OR erysipelas AND diagnosis of skin infections including: diagnose* OR detect* OR screen* OR test*. Devices to aid differentiation of infectious from non-infection cases including: point of care testing, skin AND thermometers OR thermography, skin temperature, teletethermogra*, bio* OR chem* OR electrochem* sensor OR sensors OR probe. We included studies of patients with skin or soft tissue infections, including cellulitis, erysipelas, and necrotising fasciitis. We included studies if they reported on the detection of skin infections, or investigated the differential of infectious and non-infectious skin. Studies of other infections, management strategies, prognosis, or severity were excluded, as were studies of technologies that were unsuitable for primary care.

We found eight small observational studies investigating different diagnostic strategies for cellulitis that are non-invasive and potentially viable in primary care (box 1). Table 2 describes the findings of these studies. There is insufficient evidence to recommend implementation of any of these strategies in primary care. Seven of eight studies recruited patients from emergency departments, who may have had more severe symptoms than those presenting to primary care. All studies used highly selective populations, including only patients who were suspected to have cellulitis by an emergency department clinician or dermatologist and excluding patients with other...
relevant diagnoses such as soft tissue abscess, osteomyelitis, and diabetic ulcers. In an undifferentiated primary care population test performance may be poorer.

Box 1: Possible diagnostic aids to detect cellulitis in primary care

Thermal imaging

Thermal imaging compares the temperature of an area of suspected cellulitis with a contralateral site on the body. Thermal cameras are available as smartphone attachments

Clinical prediction models

ALT 70

Using final discharge diagnosis of cellulitis as a reference standard, four features were found to be predictive of "true" cellulitis: Asymmetry (3 points), Leucocytosis (1 point), Tachycardia (1 point), and age ≥70 (2 points).

Unilateral leg involvement was associated with an adjusted odds ratio of 8.65 for cellulitis, the highest of the four variables in the score.

NEWHaUN score system

New onset, Erythema, Warmth/lever, History of trauma, Ache, Unilaterality and Number of white cells

Visually based computerised diagnostic decision support system (VCDDSS)

The VCDDSS suggests alternative diagnoses in the form of peer reviewed photographs or diagrams of medical conditions from the most to the least likely, based on symptoms input by the clinician

Procalcitonin

Procalcitonin is an inflammatory response protein which can be measured at the point of care. Procalcitonin levels greater than 0.25 mcg/L are associated with some bacterial infections.

The quality of all studies, assessed using the QUADAS-2 framework (recommended tool to evaluate the risk of bias and applicability of primary diagnostic accuracy studies) was poor. In five studies it was unclear whether the researchers using the novel tests were blind to the confirmed diagnosis. Prolonged time intervals between the test of interest and confirmation of disease in most studies and the use of different methods to confirm diagnosis (in two studies) may have biased the results.

Cellulitis is largely a clinical diagnosis and the lack of a diagnostic reference standard poses a key challenge to assessing the performance of diagnostic tests. Most studies rely on diagnosis of cellulitis by a dermatologist as a proxy diagnostic reference standard with little description of how the dermatologists reached their diagnosis. No in vitro diagnostics can give a definitive diagnosis, at least in part because of the lack of obvious substrate for testing. Superficial swab and blood cultures are typically negative even in true diagnostic can give a definitive diagnosis, at least in part dermatologists reached their diagnosis.

What should we do in the light of the uncertainty?

Given the current limitations in the evidence for the use of novel diagnostic approaches in primary care, clinical assessment is the mainstay of diagnosis. Box 2 lists criteria on history that increase the likelihood of cellulitis. On examination, recent overviews describe classic signs of cellulitis as acute unilateral erythema, pain, heat, swelling, and tenderness. There may be ascending lymphangitis and tender groin lymphadenopathy. The affected area may be well demarcated or diffuse.

Box 2: Clinical features that increase the likelihood of cellulitis

History

- Previous cellulitis
- Lymphoedema/chronic leg oedema
- Excoriating skin diseases
- Tinea pedis or obvious site for infection to have penetrated through
- BMI >30

The observational studies we identified suggest that, in differentiating cellulitis from other causes of red leg, a unilateral presentation greatly increases the odds of cellulitis. Bilateral cellulitis is uncommon but may complicate chronic dependent oedema or lymphoedema.

In unilaterally affected limbs, a lack of elevated temperature compared with an unaffected limb can help to rule out cellulitis. Consider alternative diagnoses (table 1), the approach supported by VCDSS, in particular, for patients with bilateral red legs and red legs that are not warmer than other body parts. However, given the ongoing uncertainty and risk of complications, antibiotic prescription is reasonable if in doubt. Consider referring patients with signs of systemic toxicity or uncontrolled comorbidities for hospitalisation. Identifying necrotising fasciitis requires a high index of suspicion as characteristic features may be absent initially (table 1) and emergency referral to hospital for investigation is indicated.

Education into practice

- What alternative diagnoses would you consider when a patient presents with a red leg?
- What factors would you consider when making a decision to start antibiotics in a patient presenting with red legs? How could you share the decision making around antibiotic prescribing with a patient where you are not confident in the diagnosis of cellulitis or stasis dermatitis?

What patients need to know

- Several conditions can cause red legs. One of these is a bacterial infection called cellulitis. Cellulitis should be treated with antibiotics to avoid potentially serious complications
- Emergency department studies have found that up to a third of patients seen with red legs are given antibiotics for cellulitis when they actually have another condition for which these are not the best treatment
- Four different kinds of tests have been evaluated to see if they can help doctors tell whether red legs are caused by cellulitis
- These new tests have been evaluated in only small studies, and no studies were conducted in primary care settings
- Before GPs could start using a new test, research would be needed to show that it was able to identify cellulitis accurately in patients seen in general practice, and to show that by using it patient outcomes were improved
Recommnendations for further research

Studies of diagnostic accuracy and randomised controlled trials in primary care settings to address the following clinical questions: What is the test accuracy of procalcitonin/VCDSS/cclinical prediction models/skin surface temperature in the diagnosis of cellulitis in patients with “red legs” compared with current clinical practice using dermatology assessment to confirm diagnosis? What are optimal thresholds for these strategies for the diagnosis of cellulitis? What is the impact of novel diagnostic strategies on rate of misdiagnosis, antibiotic prescription, rate of hospitalisation, and patient outcomes including symptom resolution and quality of life? How could these diagnostic technologies be used to monitor antibiotic response and guide duration of treatment?

How patients were involved in the creation of this article

We shared the research question and our findings with the NIHR Community Healthcare MedTech and IVD Cooperative’s “Appropriate antibiotic prescribing” patient and public involvement group. The group suggested that the focus should be on management outside hospital settings, and we incorporated this into our exclusion criteria. Group members advised that recommendations should take into account the likely discomfort or invasive nature of potential tests and their applicability to home monitoring of antibiotic response. We have included these elements in our discussion. We thank these patients for their input.

Competing interests The BMJ has judged that there are no disqualifying financial ties to commercial companies. The authors declare the following other interests: none.

Characteristics of The BMJ policy on financial interests are here: https://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests

Contributorship GE, KF, ML, and GH all contributed to the planning, conduct, and report of the work described in this article. GH is responsible for overall content as guarantor. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

Acknowledgments The authors would like to thank Nia Roberts for performing literature searches. This work is supported by the National Institute for Health and Care Excellence (NHS), the NIHR or the Department of Health and Social Care. Literature searches. This work is supported by the National Institute for Health and Care Excellence (NHS), the NIHR or the Department of Health and Social Care.


23 Chis A, Miller LG. Staphylococcus aureus is the most common identified cause of cellulitis: a systematic review. Epidemiol Infect 2010;138:131-7. 10.1017/S095026880900483X 19465308


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Table 1 | Distinguishing cellulitis from other causes of red legs. Major alternatives to consider and diagnostic considerations, adapted from clinical guidelines

<table>
<thead>
<tr>
<th>Unilateral causes of red leg</th>
<th>Bilateral causes of red leg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infective</strong></td>
<td><strong>Bilateral true cellulitis</strong></td>
</tr>
<tr>
<td><strong>Cellulitis</strong></td>
<td>Historically considered to be rare but is increasingly common, complicating chronic dependent oedema or lymphoedema</td>
</tr>
<tr>
<td>Acute necrotising soft tissue infection</td>
<td>History of chronic swelling or presence of oedema</td>
</tr>
<tr>
<td>Pain out of proportion to appearance, anaesthesia over affected skin, toxaemia, “woody” hard oedema, blisters, bullae</td>
<td>May have different microbiological causes from true cellulitis including potentially antibiotic resistant organisms</td>
</tr>
<tr>
<td>Deep sub-acute/chronic infection, eg, Osteomyelitis</td>
<td></td>
</tr>
<tr>
<td>Flare of longstanding or recurrent symptoms/ diabetic patient, overlying sinus</td>
<td></td>
</tr>
<tr>
<td>Septic arthritis/bursitis</td>
<td></td>
</tr>
<tr>
<td>Localised around a joint.</td>
<td></td>
</tr>
<tr>
<td>Joint movement severely limited</td>
<td></td>
</tr>
<tr>
<td><strong>Unusual pathogens</strong></td>
<td></td>
</tr>
<tr>
<td>Exposure to animals, bites, water</td>
<td></td>
</tr>
<tr>
<td><strong>Non-infective</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Vascular disease</strong></td>
<td><strong>Vascular disease</strong></td>
</tr>
<tr>
<td>Deep venous thrombosis</td>
<td>Varicose/ostasis eczema</td>
</tr>
<tr>
<td>Typically features of local and systemic inflammation are less marked than in true cellulitis</td>
<td>The commonest misdiagnosis for cellulitis; may be mostly unilateral, itchy, brown chronic skin changes</td>
</tr>
<tr>
<td>Venous obstruction</td>
<td>Systemic inflammatory diseases</td>
</tr>
<tr>
<td>Swelling higher in the leg. Lack of features of local and systemic inflammation</td>
<td>Vasculitis, erythema multiforme, pyoderma gangrenosum</td>
</tr>
<tr>
<td>Compartment syndrome</td>
<td>Multifocal or ulcerating lesions a characteristic distribution or appearance; features of systemic illness</td>
</tr>
<tr>
<td>History of trauma, severe pain</td>
<td></td>
</tr>
<tr>
<td>Arterial compromise</td>
<td></td>
</tr>
<tr>
<td>Reactive hyperaemia may be confused with cellulitis, tissue necrosis can cause overlying inflammation; signs of poor tissue perfusion</td>
<td></td>
</tr>
<tr>
<td><strong>Crystal arthropathies</strong></td>
<td></td>
</tr>
<tr>
<td>Inflammation localised around one or more joint; joint movement severely limited; distribution or history suggestive of gout/pseudogout</td>
<td></td>
</tr>
</tbody>
</table>
Table 2 Summary of eight* studies evaluating diagnostic strategies for the differential diagnosis of cellulitis versus non-infectious skin conditions

<table>
<thead>
<tr>
<th>Diagnostic approach</th>
<th>Study reference</th>
<th>Study population</th>
<th>Site of cellulitis</th>
<th>Design; setting</th>
<th>Reference standard</th>
<th>Clinical question</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin surface temperature</td>
<td>Ko 2018</td>
<td>32 adults with presumed cellulitis (validation cohort)</td>
<td>Not specified</td>
<td>Prospective cohort; ED</td>
<td>General hospital physician</td>
<td>Cellulitis v pseudocellulitis</td>
<td>96.6</td>
<td>50</td>
<td>85.7</td>
<td>100</td>
<td>A temperature difference of 0.47°C between the affected and non-affected limb</td>
</tr>
<tr>
<td></td>
<td>Li 2018</td>
<td>67 adult patients with presumed lower limb cellulitis</td>
<td>Lower extremity</td>
<td>Prospective cohort; ED</td>
<td>Examination by a dermatologist based on clinical impression</td>
<td>Cellulitis v pseudocellulitis</td>
<td>87.5</td>
<td>38.1</td>
<td>75.5</td>
<td>57.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Raff 2018</td>
<td>30 patients with presumed cellulitis</td>
<td>Not specified</td>
<td>Prospective cohort; ED</td>
<td>Diagnosis by a dermatologist (no further details)</td>
<td>Cellulitis v pseudocellulitis</td>
<td>No threshold specified</td>
<td>95.2</td>
<td>77.8</td>
<td>90.9</td>
<td>90.0</td>
</tr>
</tbody>
</table>

| Clinical prediction models | Raff 2017     | 259 adults with presumed lower limb cellulitis | Lower extremity cellulitis | Retrospective cohort; ED | Final discharge diagnosis | Cellulitis v pseudocellulitis | 61.3 | 70.9 | 82.2 | 45.5 | ALT-70 score of ≥3 |
| Li 2018                | 67 adult patients with presumed lower limb cellulitis | Lower extremity | Prospective cohort; ED | Examination by a dermatologist based on clinical impression | Cellulitis v pseudocellulitis | 96.5 | 29.1 | 74.9 | 79.3 | ALT-70 score of ≥3 |
| Ezaldein 2018          | 20 adult patients with dermatologist confirmed cellulitis and 37 with dermatitis | Not specified | Retrospective cohort; Not specified | Diagnosis by a dermatologist (no further details) | Cellulitis v stasis dermatitis | 97.8 | 47.6 | 80.4 | 90.9 | NEW HAvUN criteria 4/7 |
| VCDDSS                | David 2011    | 145 adult patients hospitalised with presumed cellulitis (inpatient) | Not specified | Prospective cohort; An inpatient population | NA | Cellulitis v cellulitis misdiagnoses | 100 | 95.0 | NR | NR | |
| Procalcitonin         | Raff 2015     | 48 adult ED patients (31 with erysipelas, 17 with deep vein thrombosis) | Lower limb | Case-control; ED | Clinical diagnosis by the treating physician team | Erysipelas/cellulitis versus deep vein thrombosis | 58.1 | 82.4 | 85.7 | NR | Patients with erysipelas had significantly higher PCT concentrations than those with DVT |
| Pallin 2016           | 21 ED patients with a diagnosis of cellulitis or dermatitis | Skin lesion in a location other than above the clavicle, or on the hand, foot, or genitals. | Case-control; ED | Confirmed microbiological testing | Cellulitis versus pseudocellulitis | <0.5 ng/mL (0.5 µg/L) | 0 | NR | NR | NR | In contrast to the study above, none of three histopathologically confirmed cases of bacterial cellulitis had detectable PCT levels |

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*The table includes studies published from 2011 to 2018.

**This study is only cohort.
Table 2 (continued)

<table>
<thead>
<tr>
<th>Diagnostic approach</th>
<th>Study reference</th>
<th>Study population</th>
<th>Site of cellulitis</th>
<th>Design; setting</th>
<th>Reference standard</th>
<th>Clinical question</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
<th>Summary</th>
</tr>
</thead>
</table>

* Li et al 2018 reported outcomes for a prediction model and skin surface temperature using thermal imaging
** Thermal imaging together with diffuse reflectance spectroscopy

ED=emergency department; PPV=positive predictive value; NPV=negative predictive value; VCDDSS=visually based computerised diagnostic decision support system; NA=not applicable; NR=not reported
Figures

**Fig 1** Alternative diagnoses of red legs: (a) cellulitis, (b) varicose eczema, (c) deep vein thrombosis, (d) gout

**Fig 2** Concurrent cellulitis and deep vein thrombosis. The manifestation of skin diseases can vary between ethnic groups and skin colours
**Erythema of the leg**

Differentiating cellulitis from other causes of red legs in primary care

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Diagnostic aid</th>
<th>Threshold</th>
<th>Sensitivity %</th>
<th>Specificity %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ezekiel 2018</td>
<td>57</td>
<td>Clinical Prediction Model - New HAuLN</td>
<td>≥3</td>
<td>97.8</td>
<td>47.6</td>
</tr>
<tr>
<td>Raff 2017</td>
<td>259</td>
<td>Clinical prediction model - ALT-70</td>
<td>≥3</td>
<td>96.5</td>
<td>29.1</td>
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<td>30</td>
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<td>Skin surface temperature</td>
<td>Differential of 0.47°C</td>
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<td>50.0</td>
</tr>
<tr>
<td>Li 2018</td>
<td>67</td>
<td>Skin surface temperature</td>
<td>Differential of 0.47°C</td>
<td>87.5</td>
<td>36.1</td>
</tr>
<tr>
<td>Rest 2015</td>
<td>48</td>
<td>Procalcitonin</td>
<td>0.1 µg/L</td>
<td>58.1</td>
<td>82.4</td>
</tr>
<tr>
<td>Pallin 2016</td>
<td>21</td>
<td>Procalcitonin</td>
<td>0.5 µg/L</td>
<td>Not reported</td>
<td></td>
</tr>
</tbody>
</table>

**What to do when uncertain**

1. **Refer to patient history**
   - Previous cellulitis
   - BMI ≥30
   - Lymphoedema/chronic leg oedema
   - Excoriating skin diseases
   - Times pinprick obvious site for infection to have penetrated through

2. **Examine patient for**
   - Acute unilateral erythema, pain, heat, swelling, and tenderness
   - Can be associated with ascending lymphangitis and tender groin lymphadenopathy
   - Affected area may be well demarcated or diffuse

**What else could it be?**

- **Unilateral redness**
  - **Infective**
    - Acute necrotising soft tissue infection
    - Deep subacute/chronic infection
    - Septic arthritis/bursitis
    - Unusual pathogens
  - **Non-infective**
    - Vascular disease
    - Crystal arthropathies

- **Bilateral redness**
  - **Infective**
    - Bilateral true cellulitis
    - Infected ulcers
  - **Non-infective**
    - Vascular disease
    - Systemic inflammatory diseases

---

1. New onset, Erythema, warmth, tenderness, History of trauma, Acne, Unilateral and Number of white cells
2. Asymmetry (3 points), Leucocytosis (1 point), Tachycardia (1 point), and age >70 (2 points)
3. Skin temperature differential between the affected and non-affected limb

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