TARGET Skin Infections Clinical Scenarios Webinar – Panel Questions

The following document covers questions and answers given during the live webinar "Clinical decision making for skin infections: from Group A Strep to insect bites" in March 2026.

Find the live webinar recording here.

Answers have been provided by a group of clinical experts. They do not reflect the views of UK Health Security Agency (UKHSA) or the Royal College of General Practitioners (RCGP). *Please note the content of these webinars and this accompanying Q&A are accurate at the time of the event and are not reviewed for changes to guidance. Our clinical scenario slides are subject to evidence reviews and updated.*

1. How can you manage post-cellulitis skin changes?

    - Skin changes post cellulitis can take time resolve.
    - The British Association of Dermatologists have produced a leaflet for patients with cellulitis and erysipelas that includes taking care of skin after infection: Cellulitis and Erysipelas leaflet

2. How can we address primary care providers being asked to prescribe antibiotic for a skin infection that has been diagnosed by another healthcare professional?

    - Sharing as much clinical information about a case as possible (e.g. photographs, observations with detailed descriptions) can help an appropriate prescribing decision to be made
    - All clinical staff managing skin and infections should be encouraged to participate in training and education around cellulitis and antibiotic stewardship

3. Why should patients be referred to secondary care if they have a sting on their face?

    - Stings on the mouth, throat or tongue can cause swelling that leads to risk of airway obstruction.
    - Stings may also require further assessment.

4. How can you identify and treat lymphangitis, and when does a case need referral?

    - Acute lymphangitis may present as extending from the site of infection.

- Most patients can be managed with oral antibiotics but with appropriate safety netting if symptoms worsen.
- Determining the need for acute referral will be based on symptoms or if there is a concern for sepsis.

5. Can cellulitis present bilaterally? Is it appropriate to prescribe antibiotics for redness/skin discolouration in bilateral symptoms?

    - Cellulitis is rarely bilateral. Other causes of bilateral redness/skin discolouration, such as lipodermatosclerosis, are more likely.
    - In determining if antibiotics are necessary, you could consider duration of symptoms, pre-existing skin conditions (e.g. lymphoedema) and whether the patient has a fever.

6. What is the response to a case of invasive Group A Strep (iGAS) in a care home?

    - For a single case, the Health Protection Team will contact the home to identify close contacts or evidence of Group A Strep transmission.
    - If there is evidence of transmission, an Incident Management Team (IMT) will be held to complete a rapid risk assessment.
    - A decision will be made by the IMT on whether to offer antibiotic prophylaxis and/or screening for staff and other residents.
    - An Infection Prevention and Control review is likely to be considered depending on evidence of a wider outbreak.

7. Should the diameter of the area of cellulitis be considered when deciding whether to admit a patient?

    - There is arbitrary cut off for diameter of cellulitis but more extensive involvement may correlate with more severe infection.
    - Other features to consider include signs of systemic illness, evidence of infection spreading or poor response to treatment.
    - Advice on when to admit cellulitis patients is outlined in the NICE guidance.

8. What causes a Group A Strep infection (GAS) to develop into iGAS?

    - It is unclear what exactly causes susceptibility to iGAS infections. It is likely mediated by host factors. The role of pathogen factors is unclear.
    - The same strains that cause superficial GAS infections are also responsible for iGAS infection although strain type distribution differs slightly.
    - This is further exemplified by the observation that household contacts of patients with scarlet fever are at increased risk of iGAS infection.

9. How long will it take for post-cellulitis skin changes to improve?

- The area of warmth and redness should begin to improve after 2 – 3 days. Discolouration can take a couple of weeks to resolve.
- Swelling can lead to skin tears in some patients, which take additional time to heal.

10. How can I differentiate the 'bulls eye lesion' that is associated with Lyme disease, when other insect bites may mimic it?

- The Lyme-associated bulls-eyes rash will expand across the surface of the skin and then clears in the centre.
- It's crucial to recognise that it is not itchy – itchiness could indicate a reaction to an alternative type of insect bite.
- If the lesion is hot, that is more likely to indicate cellulitis.
- It is also recognising that a Lyme-associated lesion has an incubation period of at least 3 days so if this appears earlier after exposure to ticks it might not been Lyme disease.

11. Why are tetracycline and macrolide resistance rates in iGAS infections so high this year (2025-2026)?

- There is evidence of a proliferation of strains with high likelihood of resistance to second-line antibiotics.
- An increase in GAS infection outbreaks involving these resistant strains is being seen at the moment in people experiencing homelessness, injecting drug users and in prisoners.
- Repeat antibiotic exposure increases risk of resistance developing:
    - At the individual level, this means these antibiotics fail to effectively treat an infection
    - At the population level, the person will remain infectious for longer which increases risk of transmission

12. What determines the choice to treat cellulitis with 1g of flucloxacillin, instead of 500mg?

Infection severity, body mass index, renal function, antibiotic tolerance and acute presentation of the infection are examples of some of the factors to be considered when determining flucloxacillin dosage.

13. Are there specific criteria for prescribing antibiotics for sebaceous cysts?

- Some information regarding prescribing for boils and carbuncles can be find in NICE Guidelines.
- Infected sebaceous filaments may require discussion with acute general surgery teams for potential drainage.

14. What can be done to support those experiencing homelessness to complete antibiotic courses?

- There is no easy answer, we can aim to use antimicrobial agents that require a lower or shorter treatment regimes.
- It's important to consider seasonal resistance trends when deciding on treatment courses, for example, doxycycline is generally good for this population as they only have to take 1 tablet per day but this year has shown increased levels of doxycycline resistance in iGAS infections.