



MRSA infection in the community

Information for healthcare providers

Community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) are strains of MRSA that are known to cause infections in people living in the community. Those infected are often otherwise healthy, with no traditional risk factors for MRSA acquisition, such as chronic disease or prior medical interventions.

CA-MRSA primarily cause community-onset skin and soft-tissue infections (SSTIs), which are often recurrent and can spread easily to others, who are in close contact with a person who has CA-MRSA, especially those who share the same household. Less commonly, CA-MRSA can lead to more severe disease, such as bacteraemia, musculoskeletal infections and pneumonia. CA-MRSA strains are also the cause of the majority of healthcare associated MRSA infections acquired in Western Australian hospitals.

Key points

Antibiotic therapy

- CA-MRSA strains, like all MRSA, are resistant to most beta-lactam antibiotics.

Management of skin and soft tissue infections

- Patients may present with cellulitis, abscess, or both.
- Incision and drainage (I&D) is recommended as a priority, when applicable.
- I&D alone may be sufficient for small abscesses and boils and when the patient is otherwise well and has no systemic symptoms or co-morbidities.
- Prescribe antibiotics if I&D is not possible, when there is cellulitis; they are febrile or systemically unwell (table 1).
- Management in a hospital is likely to be required for patients with large or deep abscesses, extensive cellulitis, or who are unwell with systemic symptoms.

Decolonisation treatment

- Colonisation with *S. aureus* increases risk for staphylococcal infection following invasive medical or surgical procedures. Decolonisation is the process of eradicating or reducing asymptomatic carriage of MRSA.
- Decolonisation should only commence once the infection has cleared.
- The decision to recommend decolonisation should follow an assessment of the individual that includes their willingness and capability to comply with the regimen.

- Decolonisation may be offered on a case-by-case basis when individuals or their household contacts:
 - have recurrent CA-MRSA or staphylococcal-like infections
 - are at increased risk for acquiring staphylococcal infection, such as those with chronic skin disorders, diabetes, peripheral vascular disease or immunosuppression
 - are healthcare workers or carers
 - prior to some surgeries (e.g. joint replacement)
 - or when there are ongoing MRSA infections occurring in a well-defined, closely-associated cohort or group, for example a dormitory, day care centre or sports club.
- If there are ongoing infections in a household despite treatment, decolonisation of all household members should be considered, even if some members do not have an active infection. All household members should commence decolonisation on the same day.
- For specific information refer to:
 - [Decolonisation treatment for MRSA](#)
 - Visit [Healthy WA](#) for further information on MRSA, including information for consumers.

Table 1: Antibiotic Therapy

Note that all MRSA are resistant to all oral beta-lactam antibiotics (e.g. flucloxacillin, amoxicillin/ clavulanate and cephalexin).

Antibiotic recommendations in this table relate specifically to skin and soft tissue infections, and not to other infection types. Refer to the Therapeutic Guidelines Antibiotic Version 16 (or the latest published version available on the [website](#)) for further information.

The decision to prescribe antibiotics requires clinical judgment and an assessment of the severity of the infection. The choice of antibiotics is dependent on the age, allergy history and co-morbidities of the patient.

It is advised that you discuss with an infectious diseases physician or clinical microbiologist if:

- the patients symptoms are worsening despite therapy
- the patient has multiple drug allergies
- the isolate is resistant to the antibiotic agents suggested below
- the patient is less than 2 months of age (see Note 3 below).

Adults			
In order of preference	Antibiotic	Dose	Pregnancy category #
First line	Trimethoprim with sulfamethoxazole	160+800mg BD, orally for 5 days (see Note 1 below)	C
Second line	Clindamycin ^Δ	450mg TDS, orally for 5 days (see Note 1 below)	A
Third line	Doxycycline	100mg BD, orally for 5 days (see Note 1 below)	D

Children			
In order of preference	Antibiotic	Dose	
First line	Trimethoprim with sulfamethoxazole	4+20mg/kg (up to max 160+800mg) per dose orally, 12 hourly for 5* days Tablets/oral suspension available on PBS (See Note 2 below)	
Second line	Clindamycin ^Δ	10mg/kg (up to max 450mg) per dose orally, 8 hourly for 5* days (suitable for older children if able to swallow 150mg capsule) Oral suspension not on PBS list nor readily available off PBS	
Third line	Doxycycline	ONLY suitable for children >8 years: 2.5mg/kg (up to max 100mg) orally, 12 hourly for 5* days Tablets and capsules available on PBS	

Therapeutic Guidelines Antibiotic Version 16 (or the latest published version available on the [website](#)).

Δ Clindamycin should NOT be used for MRSA isolates RESISTANT to erythromycin and related macrolide class antibiotics (azithromycin, clarithromycin, roxithromycin). PBS restricted benefit listing for clindamycin courses of ≤24 150mg capsules. PBS authority prescription required for courses >25 150mg capsules (Indication: Gram-positive coccal infections where these cannot be safely and effectively treated with penicillin).

* See Note 1.

Note 1: Longer therapy may be required for carbuncles and those with associated cellulitis. Therapeutic Guidelines – Dermatology Version 3 (available online).

Note 2: Where trimethoprim with sulfamethoxazole is not appropriate (MRSA is resistant or patient allergy) and second line agent clindamycin capsules cannot be swallowed or taken, consider use of PBS listed erythromycin ethyl succinate oral suspensions, provided MRSA sensitivity to erythromycin has been demonstrated.

Note 3: Neonates (<2 months) requiring antibiotic therapy should be discussed with relevant specialist colleagues with paediatric expertise. Erythromycin is specifically contraindicated in this age group because of an increased risk of pyloric stenosis.

Note 4: Group A streptococci (GAS) are another common cause of skin and soft tissue infection, particularly cellulitis and impetigo. If GAS infection is suspected, therapy should include an agent active against this organism (beta-lactam or clindamycin) for serious infections. Trimethoprim-sulfamethoxazole may not be included in the antibiotic testing panel but is effective against GAS infection. Doxycycline is not a recommended treatment for suspected GAS.

This document can be made available in alternative formats on request for a person with disability.

© Department of Health 2025

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the Copyright Act 1968, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.

health.wa.gov.au