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APPENDIX E TAB D**MEDICAL TREATMENT PROTOCOL FOR SUBMARINE SKIN/SOFT TISSUE INFECTIONS (SSTI)**

Ref: (a) Naval Environmental Health Command, "Guidelines for the Management of Community-Acquired Methicillin-Resistant Staphylococcus aureus (CA-MRSA) Infections in the US Navy and Marine Corps," AUG 2006

1. Background: Skin and soft tissue infections are a frequent cause of MEDEVACs from Naval Submarines, with CA-MRSA infections being of particular concern. That said, CA-MRSA outbreaks have yet to be documented on submarines.

2. Action: All Submarine Force health care professionals should be familiar with reference (a). Additionally, the following, submarine-specific guidance is provided.

a. Given the significant role for supervisors in addressing skin/soft tissue infection, engage your ship's COB and EDMC on the hygiene and cleanliness factors impacting this issue.

b. Assess your command for infection control measures. Are all Sailors showering daily? Do their LPO's enforce this? Does the ship's hot racking policy seek minimize the potential spread of infection? Is the laundry capacity sufficient that all hands have clean, dry clothes to wear and clean shower towels? Are crew heads wiped down? Does all exercise equipment have antimicrobial spray/wipes and is it used? Do the showers have soap dispensers? Are they routinely filled? These questions should be revisited upon being presented with a new skin/soft tissue infection.

c. Infectious disease. All wounds or infections treated in port should have wound cultures collected and the causative organism identified. Cultures are best collected prior to starting antibiotic treatment; treatment should not be unnecessarily delayed to obtain the culture.

d. Rash/lesion identification. CA-MRSA infections are typified by abscess formation, often deep-seated, erythematous, warm and flocculent. Commonly, the lesions occur on hair-bearing surfaces or sites where the skin's integrity has been compromised. A prodrome of burning or pain, vesicles (frequently excoriated) or a well-circumscribed location consistent with a nerve distribution should raised suspicions of a viral vice bacterial infection.

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e. Index case. The History of Present Illness (HPI) should include close contacts and an assessment of the patient's personal hygiene. His living space should also be evaluated. Clothing and bedding should be laundered.

f. Treatment. Warm compresses at least QID. Limit movement of area. If a flocculent pocket exists, incise and drain. Monitor wound site for progression/resolution, check for constitutional symptoms and lymphadenopathy.

g. Antibiotics. Treatment of bacterial infections, whenever possible, should be guided by organism identification and sensitivities obtained by proper culture of wound material. A patient presenting with constitutional systems (fever, malaise) or the lack of access to lab facilities (at sea) may dictate empiric selection of antibiotics. Consistent with any existing drug allergies, initial treatment should be either TMP-SMZ "Septra" at 160mg/800mg (1 Double Tab) PO BID or Doxycycline at 100mg PO BID, for 10-14 days. If no response after 48 hours, add a second agent, either Rifampin at 300mg PO BID for five days or Clindamycin at 150mg PO QID to run concurrently with the first agent.

h. Notification. A skin/soft tissue infection requiring I&D inport should promptly be brought to the attention of the physician supervisor. Likewise for ANY skin/soft tissue infection occurring in the 60 day window preceding patrol or deployment. All efforts should be made to not have crew members with active MRSA infections/lesions to embark underway. Asymptomatic colonization alone should not prevent embarkation. At sea, if not already done, a MEDADVICE message should be sent if a second agent is started.

i. Physician supervisors are enjoined to ensure all skin/soft tissue infections are aggressively followed to resolution prior to patrol/deployment, and that appropriate preventive medicine measures are taken, to include, if clinically indicated, MRSA eradication.

