recommended to help identify whether *Staphylococcus aureus* and/or a β-hemolytic *Streptococcus* is the cause (strong, moderate), but treatment without these studies is reasonable in typical cases (strong, moderate).

2. Bullous and nonbullous impetigo can be treated with oral or topical antimicrobials, but oral therapy is recommended for patients with numerous lesions or in outbreaks affecting several people to help decrease transmission of infection. Treatment for ecthyma should be oral antimicrobial.

(a) Treatment of bullous and nonbullous impetigo should be with either mupirocin or retapamulin twice daily (bid) for 5 days (strong, high).

(b) Oral therapy for ecthyma or impetigo should be a 7-day regimen with an agent active against *S. aureus* unless cultures yield streptococci alone (when oral penicillin is the recommended agent) (strong, high). Because *S. aureus* isolates from impetigo and ecthyma are usually methicillin susceptible, dicloxacillin or cephalexin is recommended. When MRSA is suspected or confirmed, doxycycline, clindamycin, or sulfamethoxazole-trimethoprim (SMX-TMP) is recommended (strong, moderate).

(c) Systemic antimicrobials should be used for infections during outbreaks of poststreptococcal glomerulonephritis to help eliminate nephritogenic strains of *S. pyogenes* from the community (strong, moderate).