Official websites use .gov A .gov website belongs to an official government organization in the United States. Secure .gov websites use HTTPS A lock ( ) or https:// means you've safely connected to the .gov website. Share sensitive information only on official, secure websites. Persons who have pediculosis pubis (i.e., pubic lice) usually seek medical attention because of pruritus or because they notice lice or nits on their pubic hair. Pediculosis pubis is caused by the parasite Phthirus pubis and is usually transmitted by sexual contact (1393). The clinical diagnosis is based on typical symptoms of itching in the pubic region. Lice and nits can be observed on pubic hair. Permethrin 1% cream rinse applied to affected areas and washed off after 10 minutes OR Pyrethrin with piperonyl butoxide applied to the affected area and washed off after 10 minutes Malathion 0.5% lotion applied to affected areas and washed off after 8–12 hours OR Ivermectin 250 µg/kg body weight orally, repeated in 7–14 days Reported resistance to pediculicides (permethrin and pyrethrin) has been increasing and is widespread (1394,1395). Malathion can be used when treatment failure is believed to have occurred as a result of resistance. The odor and longer duration of application associated with malathion therapy make it a less attractive alternative compared with the recommended pediculicides. Ivermectin has limited ovicidal activity (1396). Ivermectin might not prevent recurrences from eggs at the time of treatment, and therefore treatment should be repeated in 7–14 days (1397,1398). Ivermectin should be taken with food because bioavailability is increased, thus increasing penetration of the drug into the epidermis. Adjustment of ivermectin dosage is not required for persons with renal impairment; however, the safety of multiple doses among persons with severe liver disease is unknown. Lindane is not recommended for treatment of pediculosis because of toxicity, contraindications for certain populations (pregnant and breastfeeding women, children aged <10 years, and those with extensive dermatitis), and complexity of administration. The recommended regimens should not be applied to the eyes. Pediculosis of the eyelashes should be treated by applying occlusive

ophthalmic ointment or petroleum jelly to the eyelid margins 2 times/day for 10 days. Bedding and clothing should be decontaminated (i.e., machine washed and dried by using the heat cycle or dry cleaned) or removed from body contact for at least 72 hours. Fumigation of living areas is unnecessary. Pubic hair removal has been associated with atypical patterns of pubic lice infestation and decreasing incidence of infection (537,1399). Persons with pediculosis pubis should be evaluated for HIV, syphilis, chlamydia, and gonorrhea. Evaluation should be performed after 1 week if symptoms persist. Retreatment might be necessary if lice are found or if eggs are observed at the hair-skin junction. If no clinical response is achieved to one of the recommended regimens, retreatment with an alternative regimen is recommended. Sex partners within the previous month should be treated. Sexual contact should be avoided until patients and partners have been treated, bedding and clothing decontaminated, and reevaluation performed to rule out persistent infection. Existing data from human participants demonstrate that pregnant and lactating women should be treated with either permethrin or pyrethrin with piperonyl butoxide. Because no teratogenicity or toxicity attributable to ivermectin has been observed during human pregnancy experience, ivermectin is classified as “human data suggest low risk” during pregnancy and probably compatible with breastfeeding (431). Persons who have pediculosis pubis and HIV infection should receive the same treatment regimen as those who do not have HIV. Scabies is a skin infestation caused by the mite Sarcoptes scabiei, which causes pruritus. Sensitization to S. scabiei occurs before pruritus begins. The first time a person is infested with S. scabiei, sensitization takes weeks to develop. However, pruritus might occur <24 hours after a subsequent reinfestation. Scabies among adults frequently is sexually acquired, although scabies among children usually is not (1400–1402). Scabies diagnosis is made by identifying burrows, mites, eggs, or the mites’ feces from affected areas. Skin scrapings can be examined under the microscope to identify organisms, although this method has low sensitivity and is time

consuming (1403). Alternatively, noninvasive examination of the affected skin by using videodermatoscopy, videomicroscopy, or dermoscopy can be used, each of which has high sensitivity and specificity, particularly when performed by experienced operators (1404). Low-technology strategies include the burrow ink test and the adhesive tape test. Permethrin 5% cream applied to all areas of the body from the neck down and washed off after 8–14 hours OR Ivermectin 200 ug/kg body weight orally, repeated in 14 days* * Oral ivermectin has limited ovicidal activity; a second dose is required for eradication. Lindane 1% 1 oz of lotion or 30 g of cream applied in a thin layer to all areas of the body from the neck down and thoroughly washed off after 8 hours* * Infants and children aged <10 years should not be treated with lindane. Topical permethrin and oral and topical ivermectin have similar efficacy for cure of scabies (1405–1410). Choice of treatment might be based on patient preference for topical versus oral therapy, drug interactions with ivermectin (e.g., azithromycin, trimethoprim/sulfamethoxazole [Bactrim], or cetirizine [Zytrec]), and cost. Permethrin is safe and effective with a single application (1411). Ivermectin has limited ovicidal activity and might not prevent recurrences of eggs at the time of treatment; therefore, a second dose of ivermectin should be administered 14 days after the first dose (1412). Ivermectin should be taken with food because bioavailability is increased, thereby increasing penetration of the drug into the epidermis. Adjustments to ivermectin dosing are not required for patients with renal impairment; however, the safety of multiple doses among patients with severe liver disease is unknown. Lindane is an alternative regimen because it can cause toxicity (1413); it should be used only if the patient cannot tolerate the recommended therapies or if these therapies have failed (1414–1416). Lindane is not recommended for pregnant and breastfeeding women, children aged <10 years, and persons with extensive dermatitis. Seizures have occurred when lindane was applied after a bath or used by patients who had extensive dermatitis. Aplastic anemia after lindane use also has been reported (1413). Lindane

resistance has been reported in some areas of the world, including parts of the United States (1413). Bedding and clothing should be decontaminated (i.e., either machine washed and dried by using the heat cycle or dry cleaned) or removed from body contact for >72 hours. Fumigation of living areas is unnecessary. Persons with scabies should be advised to keep fingernails closely trimmed to reduce injury from excessive scratching (1417). Crusted scabies is an aggressive infestation that usually occurs among immunodeficient, debilitated, or malnourished persons, including persons receiving systemic or potent topical glucocorticoids, organ transplant recipients, persons with HIV infection or human T-lymphotropic virus-1 infection, and persons with hematologic malignancies. Crusted scabies is transmitted more easily than scabies (1418). No controlled therapeutic studies for crusted scabies have been conducted, and a recommended treatment remains unclear. Substantial treatment failure might occur with a single-dose topical scabicide or with oral ivermectin treatment. Combination treatment is recommended with a topical scabicide, either 5% topical permethrin cream (full-body application to be repeated daily for 7 days then 2 times/week until cure) or 25% topical benzyl benzoate, and oral ivermectin 200 ug/kg body weight on days 1, 2, 8, 9, and 15. Additional ivermectin treatment on days 22 and 29 might be required for severe cases (1419). Lindane should be avoided because of the risks for neurotoxicity with heavy applications on denuded skin. The rash and pruritus of scabies might persist for <2 weeks after treatment. Symptoms or signs persisting for >2 weeks can be attributed to multiple factors. Treatment failure can occur as a result of resistance to medication or faulty application of topical scabicides. These medications do not easily penetrate into thick, scaly skin of persons with crusted scabies, perpetuating the harboring of mites in these difficult-to-penetrate layers. In the absence of recommended contact treatment and decontamination of bedding and clothing, persisting symptoms can be attributed to reinfection by family members or fomites. Finally, other household mites can cause symptoms to persist as a result of

cross-reactivity between antigens. Even when treatment is successful, reinfection is avoided, and cross-reactivity does not occur, symptoms can persist or worsen as a result of allergic dermatitis. Retreatment 2 weeks after the initial treatment regimen can be considered for those persons who are still symptomatic or when live mites are observed. Use of an alternative regimen is recommended for those persons who do not respond initially to the recommended treatment. Persons who have had sexual, close personal, or household contact with the patient within the month preceding scabies infestation should be examined. Those identified as being infested should be provided treatment. Scabies epidemics frequently occur in nursing homes, hospitals, residential facilities, and other communities (1420,1421). Control of an epidemic can only be achieved by treating the entire population at risk. Ivermectin can be considered in these settings, especially if treatment with topical scabicides fails. Mass treatment with oral ivermectin is highly effective in decreasing prevalence in settings where scabies is endemic (1422). Epidemics should be managed in consultation with a specialist. Infants and young children should be treated with permethrin; the safety of ivermectin for children weighing <15 kg has not been determined. Infants and children aged<10 years should not be treated with lindane. Ivermectin likely poses a low risk to pregnant women and is likely compatible with breastfeeding; however, because of limited data regarding ivermectin use for pregnant and lactating women, permethrin is the preferred treatment (431) (see Pediculosis Pubis). Persons with HIV infection who have uncomplicated scabies should receive the same treatment regimens as those who do not have HIV. Persons with HIV infection and others who are immunosuppressed are at increased risk for crusted scabies and should be managed in consultation with a specialist. Next

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