# Scabies

## *Executive summary*

## Introduction

## Scabies is a cutaneous infestation caused by the mite *Sarcoptei scabei* and usually affecting the extremities. It is transmitted by close cutaneous contact, sexually, and by contact with infested fomites (e.g. towels, clothing).

### Target User

* Doctors
* Nurses

### Target area of use

OPD

### Key areas of focus / New additions / Changes

This guideline focuses on the common types of scabies and their management and recommends use of topical treatment. It also advises on the elimination of the causative mites.

Management of scabies is dependent on the type of scabies the patient presents with and there may be need to add oral medication to the treatment.

It is important that close human contacts and fomites are treated as well as the presenting patient.

### Limitations

## None.

## Presenting symptoms and signs

Presentation is dependent on the immune status of the patient.

### Classical scabies

Occurs in immunocompetent patients.

Symptoms include:

* Erythematous papules located in the interdigital spaces of fingers, periumbilical region, axillary folds, breasts, genitalia, extensor surfaces of limbs. The face, soles and palms are usually spared.
* Pruritus which is worse at night
* There may be signs of secondary bacterial infection

### Crusted scabies

Occurs in patients who are severely immune-compromised e.g. in HIV, malignancy.

* Pruritus is often absent or mild
* Lesions are generalized, consisting of poorly defined fissured plaques covered by crusts and scales
* Secondary bacterial infection may result in malodorous lesions

## Examination findings

Examination of affected areas may reveal

* Scratch marks
* Papular lesions, which are erythematous, located in areas of predilection
* Fissured plaques covered by crusts and scales
* The burrow (a pathognomonic sign) appearing as a thin, brown-grey elevations in the superficial epidermis usually of 0.5–1 cm in size.

## Differential diagnoses

* Drug reactions
* Viral exanthem
* Bullous pemphigoid
* Necrotizing vasculitis
* B-cell lymphoma with monoclonal infiltrate
* Dermatologic manifestations of renal disease
* Erythroderma (generalized exfoliative dermatitis)
* Folliculitis
* Insect bites
* Lice
* Lichen planus
* Neurotic excoriations
* Papular urticaria
* Psoriasis
* Sea bather’s eruption
* Syphilis

## Investigations

* Microscopy of skin scrapings to identify mites, eggs or faecal matter.
* STI screen should be done in all sexually active patients

## Management

All patients diagnosed with scabies should be advised to machine wash all clothing, towels and beddings at 50 degrees Celsius or higher OR to seal all clothing, towels and beddings in a plastic bag for at least 1 week. In our context, leaving all items outside in the hot sun for a full day is also effective.

### Classical scabies

Benzyl benzoate lotion 10–25% applied once daily at night on 2 consecutive days with re-application at 7 days

Topical treatment should be applied to all skin regions including scalp, groin, navel, external genitalia, finger and toe web spaces and the skin beneath the ends of the nails at night, and left for 8–12 h. The skin should be cool and dry. Re-application is recommended after 7–14 days. After applying treatment, patients should change into clean clothing. All the patient’s close personal contacts should be treated simultaneously to avoid re-infestation.

### Crusted scabies

Benzyl benzoate lotion 10-25% applied once daily on 7 consecutive days, then twice weekly until cured AND oral Ivermectin 200 µg/kg OD on days 1, 2, 8, 9, and 15. Ivermectin should not be used in children < 15 kg and pregnant women.

Follow up visit for microscopy examination should be made 2 weeks after completion of therapy .

**References**

UpToDate: Management of scabies https://www.uptodate.com/contents/scabies-management?csi=aafa7509-fad8-4d21-89d6-c7bf3b5272d4&source=contentShare

European guideline for the management of scabies C.M. Salavastru et al https://iusti.org/regions/Europe/pdf/2017/Scabies.pdf

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