

SCABIES GUIDANCE

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Date written:	1997
Date revised:	2003, 2005, August 2007, July 2009, July 2011
Approval route (names of committees):	Infection Control Committee
Level of Impact Assessment (Screening or Full – attach to policy)	Screening
Date of final approval:	11th August 2011
Date due for revision:	August 2013
Date policy becomes live:	November 2011
This document replaces:	Scabies Guidance 2009

This policy etc. covers: (Please tick ✓ relevant box below)

Healthcare Standards (CORE)	C4a	Monitor	
Healthcare Standards (DEVELOPMENTAL)		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Other (Please specify)	'Hygiene 'Code (Health Act 2006)		

Note: This policy has been assessed for any equality, diversity or human rights implications.

Controlled document

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1. General Information

The following information is based on and in line with the guidance produced by the Devon Health Protection Unit.

Sarcoptes scabiei is a parasitic mite which causes scabies infection in humans. The mite burrows under the surface of the skin, causing an allergic reaction which results in an itchy rash. It takes six to twelve weeks for this itchy rash to develop which is often worse after bathing or during the night. The burrows are close enough to the skin surface to be visible. The female mite lays her eggs in the burrows. The rash can appear anywhere on the body, though rarely above the jaw line. Those who have had previous infection may have symptoms within two days. Transmission, from person to person, is by close and prolonged physical contact. Shaking hands or other similar contact is unlikely to result in transmission as is contact with clothing or bedding. However with hyperkeratotic scabies (see below) fomites i.e. sheets, towels etc... might contribute to the spread. The mite does not survive for long outside the human body.

2. Classification of Scabies

There are two classes of scabies infestation, classic scabies and hyperkeratotic scabies

2.1 Classic Scabies

- This occurs in healthy people with normal immune status.
- Mites might be few in numbers.
- Symptoms might not appear for 2-4 weeks following initial infestation.

2.2 Hyperkeratotic Scabies (also known as Norwegian, atypical, crusted)

- Hyperinfestation which is highly contagious due to the high number of mites in the skin scales and the resultant exfoliation.
- Usually presents in patients who are immunocompromised, elderly, very young, people with Down's syndrome, malnourished and those on corticosteroids.

3. Diagnosis

Diagnosis is based on clinical presentation and a persistent, unexplained, irritating rash would be suggestive of infestation. If diagnosis is not clear, a dermatological opinion should be sought. Diagnosis can also be supported by obtaining skin scrapings to detect the mites, their eggs or faecal pellets, this can be undertaken by the infection control team.

4. Treatment

There are several topical insecticides available. Success depends upon the index case (the first person identified) and all members of the affected

household being treated at the same time, regardless of whether they have symptoms. On the basis of efficacy and tolerability data and if there are no contra-indications for its use, Permethrin 5% dermal cream is the treatment of choice. Malathion 0.5% liquid should be used as second-line treatment where possible. The appropriate preparation (dermal cream or lotion) must be used.

Successful eradication is dependant upon conscientious application of the treatment. The regime to follow:

- Do not take a bath immediately prior to treatment.
- Apply the lotion/cream to all parts of the body including non hair areas of the scalp, face/ears avoiding contact with eyes, nose/mouth. All areas must be covered, not just areas where the rash is visible.
- Attention is to be made to applying the treatment under the fingernails; a cotton bud can be used for this.
- The treatment is left on the skin for between 8 and 24 hours depending on the preparation used and then washed off thoroughly. **Guidance from the manufacturer must be followed.**
- If the cream/lotion is washed off from any area before the prescribed time, reapply and allow to dry.
- Bedclothes and nightwear should then be washed. For hyperkeratotic scabies a hot wash will be necessary and floors and chairs will need to be vacuumed well.
- The treatment regimen should be repeated one week later, **check manufacturer guidance.**
- Simultaneous treatment of other members of the household and close social contacts is required, with asymptomatic contacts requiring only one topical treatment.
- In severe hyperkeratotic scabies systemic treatment may be prescribed.

The rash and irritation may continue for up to six weeks following treatment. Topical emollients and weak or medium strength corticosteroids may be useful in controlling these symptoms. Further treatment with a parasiticide is not necessary at this stage.

5. Infection Control Measures

Plases refer to section 4, Table of Communicable Diseases & Appropriate Precautions, of the source isolation policy in the Infection Control Manual.

6. Outbreaks

1. Suspected outbreaks must be reported to the Infection Control Team to co-ordinate the treatment appropriately. Decisions to treat staff will be made in conjunction with occupational health.
2. In institutional outbreaks where there may be multiple cases of scabies, it may be necessary to treat all patients and staff who have had significant contact with the confirmed cases.
3. As scabies is highly infectious to close contacts, the family members of infected staff might require treatment.
4. The families of affected staff should normally undergo treatment under the supervision of their GP. Children under the age of 2 years must undergo treatment under the supervision of their GP.

Reference:

Health Protection Agency, Devon Health Protection Unit. 'Scabies in a community setting including isolated cases, households and Nursing residential settings' (2006) www.cdc.gov

Gould D (2010) 'Prevention, control and treatment of scabies' *Nursing Times* 25(9), 42-45