Introduction

This guidance has been developed by Shropshire Clinical Commissioning Group (CCG) infection prevention and control team to support General Practitioners (GPs) in the diagnosis, management and treatment of scabies in nursing and residential care homes.

The prevalence of scabies is currently rising in the UK and this is reflected locally with increasing numbers of outbreaks being reported to the CCG infection prevention and team in nursing and residential care homes. The diagnosis and management of scabies in care homes presents a number of challenges for GPs and care home staff. Scabies can look atypical in the elderly and be difficult to recognise particularly if scratching, inflammation or infection have obscured the presentation. Untreated scabies, delayed diagnosis contributes to prolonged outbreaks and is associated with secondary bacterial infection which may lead to cellulitis, folliculitis, boils, impetigo, or lymphangitis and may also exacerbate other pre-existing dermatoses such as eczema and psoriasis. The diagnosis of scabies is for the most part made by GP’s. GP’s are able to refer patients to dermatology but the waiting time for an appointment is not optimal when an outbreak is suspected.

A common difficulty appears to be in identifying an outbreak with some degree of certainty. In many cases this is due to multiple GP’s having responsibility for residents of one care home. The result of this can be inconsistency in opinion and diagnostic experience with no single GP having an accurate overview of case numbers and symptoms in the home. This is particularly important in an outbreak situation, when two or more residents or staff present with symptoms, as a co-ordinated approach to treatment is essential to ensure all cases and contacts are treated simultaneously on an agreed treatment date and cases receive a second application of a scabicidal lotion/cream 7 days later.

Treatment failures have been observed locally and occur as a result of failure to apply the scabicidal lotion/cream thoroughly and or if co-ordinated approach to treatment has not been followed.

The CCG infection prevention and control team are available to support and advise GPs and care homes when suspected and confirmed outbreaks of scabies occur.
Prevention and Control of Scabies in the Community
A Guide for General Practitioners

1. What is Scabies?

Scabies is an allergic response to an infestation of the skin by the mite Sarcoptes scabiei. The mites penetrate through the skin and excavate burrows at the epidermal/dermal junction. The female mite lays eggs which hatch after 3-4 days. Newly hatched larvae exit the burrows and appear on the surface of the skin before forming their own tunnels. The burden of mites can range from 10-20 to several thousand in people who are severely immune-compromised.

If Scabies is left untreated for a long period of time it can have an immunosuppressive effect and result in hyperkeratotic (Norwegian) scabies.

2. Mode of Transmission

Transmission occurs following transference of one or more mites, and is by direct and prolonged physical contact with an infected person of more than 10-15 minutes. Infected contacts can be asymptomatic for up to 8 weeks so empirical treatment of significant contacts is recommended especially in nursing or residential care homes. Transfer from underclothes or bed linen rarely occurs: mites can only survive away from their host for 24-36 hours at room temperature and average humidity. However with Hyperkeratotic Scabies transmission is possible via bedding, towels, clothes, and upholstery owing to the large numbers of mites on an infested individual. The mites can survive for up to 7 days as they are able to feed on skin in bed sheets, clothing, or chair covers. People who have been even minimally exposed (e.g. cleaning staff and laundry employees) should be considered to have been exposed to infested persons, and should also be treated.

3. Recognition of Symptoms

The most frequent symptom is itching which may affect all parts of the body and is particularly severe at night. There may be no sign of infection for 2-8 weeks after exposure.

Occasionally, small vesicles may be visible along the areas where the mites have burrowed. A papular rash may be visible in areas such as around the waist, inside the thighs, lower buttocks, lower legs, ankles and wrists. Firm nodules may develop on the front folds of the axillae and around the naval and in males around the groin. Pale burrows described as a greyish line resembling a “pencil mark” may be present in the skin between the fingers, but are less commonly seen than textbooks suggest.
(a) Nodular Scabies on trunk  
(b) Scabies on hand

Failure to find burrows does not exclude scabies as a diagnosis.

It should be emphasised that scabies may be difficult to recognise particularly if scratching, inflammation or infection have obscured the presentation. Also scabies can look atypical in anyone with immature or impaired immunity such as very young children and the very elderly. In immunosuppressed people, such as those with HIV infection or those on immunosuppressive therapy, hyperkeratotic (Norwegian Scabies) may develop.

4. Treatment in a Care Home Facility

4.1 Single Case

When there is a single suspected case of scabies occurring in a care home, confirmation from a clinician should be sought. Diagnosis of scabies is notoriously difficult and may require a specialist dermatology opinion. When confirmed a standard treatment of 2 applications of scabicidal cream such as Permethrin (Lyclear) or Malathion (Derbac M) 7 days apart.

People should be regarded as infectious until the first scabicidal treatment has been completed.

If Norwegian/hyperkeratotic scabies is highly suspected or confirmed it may be necessary to treat other residents and anyone with whom they have had direct contact e.g. staff (contact the CCG Infection Prevention and Control team to discuss).

4.2 Two or More Cases

For two or more confirmed cases of scabies the CCG infection prevention and control team should be contacted for advice. In order to get an accurate picture of numbers of residents symptomatic the care home manager may be asked to “body-map” all residents. This involves documenting any rash symptom on each resident using the template provided in the CCG Scabies Toolkit.
If an outbreak is declared it is important that all residents, staff and close contacts i.e. relatives/visitors who have had direct skin to skin contact, have treatment as they may be incubating the disease without showing any symptoms. The purchase of recommended treatment for staff use is the responsibility of the care home. Family members of symptomatic staff with rashes and relatives/visitors of symptomatic residents with rashes will also require treatment. Family members of staff, with no rash, and relatives/visitors of residents with no rash, will not require treatment.

The standard treatment for scabies is 2 applications of scabicide cream, such as Permethrin (Lyclear) or Malathion (Derbac M) 7 days apart. Ivermectin is sometimes advised by dermatologists for the treatment of severe or resistant cases.

As far as possible all those identified as requiring treatment should apply the treatment on the same day, otherwise they should be advised not to attend the home until completing a treatment. Staff in the affected area should be advised not to work in any other area in the home until a treatment has been completed.

Although transmission is via skin to skin contact it is good practice for the unit/home to be thoroughly cleaned and mattresses/furniture/carpets thoroughly vacuumed to ensure dust and skin scales are removed.

5. Further Advice and Support

The CCG Infection Prevention and Control Team - Telephone 01743 277523

Shropshire Clinical Commissioning Group Scabies Toolkit, available from Shropshire Partners in Care website: www.spic.co.uk

http://www.spic.co.uk/index.php?option=com_docman&task=cat_view&gid=81&Itemid=14

6. References


Clinical Knowledge Summaries (2011) NICE http://cks.nice.org.uk/scabies
