Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: Management of Scabies Policy

Version: 5

Reference Number: CL80

Supersedes

Supersedes: V4

Description of Amendment(s):

- **Amended section 5: included 'recognition' of scabies**
- **Reduced roles and responsibilities**
- **Updated medication**
- **Amended section 12**
- **Updated References**

Originator

Originated By: Infection Prevention & Control Team

Designation: Infection Prevention & Control Nurse

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Laura Birch

ERA undertaken on: 2/4/14

ERA approved by EIA Work group on: N/a

Where policy deemed relevant to equality- N/a

ERA undertaken by: Laura Birch

EIA undertaken on: 2/4/14

EIA approved by EIA work group on: 2/4/14

Approval and Ratification

Referred for approval by: Infection Prevention and Control Team

Date of Referral: 1st April 2016

Approved by: Infection Prevention and Control Committee

Approval Date: 1st April 2016

Date Ratified by Executive Directors: 18th April 2016

Executive Director Lead: Director of Nursing

Circulation

Issue Date: 19th April 2016

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 1st April 2018

Responsibility of: Infection Prevention & Control Team

Designation: Infection Prevention & Control Team

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 19th April 2016

1. INTRODUCTION

The parasite Sarcoptes scabei is a skin mite that is about 0.35 mm long. The female mite tunnels into the epidermis, and deposits eggs along the burrow. The larvae hatch in a few days and create new burrows (moulting pockets) where they remain until maturity. Development from egg to adult takes about 10-15 days, and mites die after 4-6 weeks. Scabies has a cyclical rise in incidence roughly every 20 years in the UK.

Reported cases have begun to rise in the UK since 1991, often presenting as outbreaks in schools, residential and nursing homes as well as hospitals. Scabies is more prevalent in urban than rural areas, and there is a higher prevalence during winter than summer. Scabies is not life-threatening or serious however the itching does cause discomfort. The itching is usually intense and is generally worse at night.

The symptoms and their severity are strongly influenced by the immune status of the individual. Scabies may, therefore be variable in presentation and may mimic other skin conditions.

2. AIM OF THE POLICY

The aim of this policy is to provide practical guidance in the treatment and control of Scabies, and to prevent or reduce any impact an outbreak of Scabies may have on the patients, public and staff.

3. ROLES AND RESPONSIBILITIES

Refer to Infection Prevention and Control Policy CL4 for individual responsibilities.

4. TYPES OF SCABIES

Classical Presentation of Scabies

The main symptoms of Scabies are caused by an immune response to the mites and their saliva or faeces.

Itching, particularly at night, is the most common presenting symptom. Itching is most intense when the person is in bed. It usually develops 2-6 weeks after initial infestation, and coincides with the appearance of a rash. However, symptoms reappear within a few hours if the person is re-infested (owing to prior sensitisation to the mite and its saliva and faeces).

The accompanying **rash** is symmetrical. The rash is usually made up of small, red papules, but vesicles or a nodular reaction may also be seen. The rash is usually most obvious on the inside of the thighs, the axillae, the periumbilical region, the buttocks, and the genitals.

Burrows can be difficult to identify, as they are easily distorted or destroyed by scratching. They are most commonly found on the finger webs, wrists, and elbows, and appear as fine, wavy, greyish, dark or silvery lines 2-15 mm long

with a minute speck (the mite) at the closed end. They may also be found on the ankles, feet, genitals (in males), and nipples.

In infants, young children, the elderly, and the immunocompromised, mites can also infect the face, neck, scalp and ears. Those who have experienced treatment failure may also have mites in these areas. Immobile patients often have lesions on the soles of their feet.

Scabies is usually diagnosed from the history and clinical findings. If household or sexual contacts are affected by a similar rash, this increases the likelihood of Scabies.

Classical Scabies is transmitted mainly via direct skin contact. Transmission may be from close family contact (e.g. prolonged hand-holding).

Atypical Scabies

Scabies is atypical in any person whose immune system is immature or impaired e.g. the very young or the elderly. Itching may be minimal or absent and if scaling and crusting are absent then it may be some time before Scabies is diagnosed.

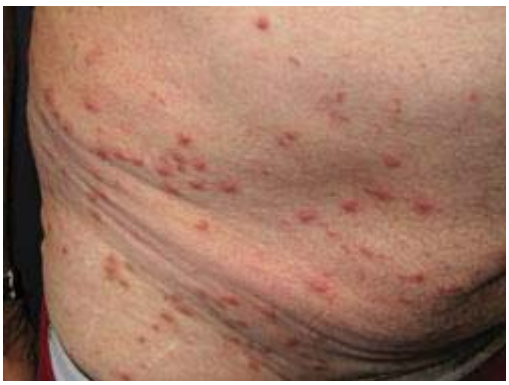
Crusted (Norwegian) Scabies

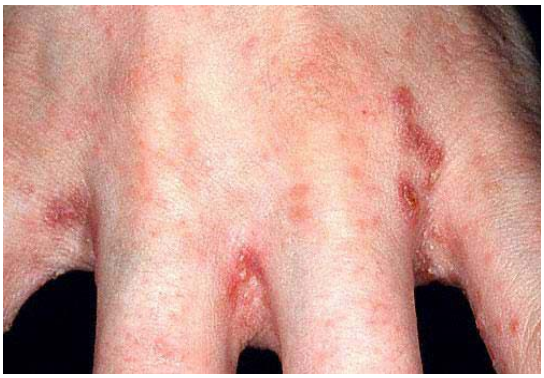
Crusted (hyperkeratotic or Norwegian) Scabies is a different clinical manifestation of Scabies that occurs in people with an impaired immune response. Thick, crusted lesions are usually seen on the hands, feet, nails, scalp, and ears. Crusted Scabies may not cause itching, or may occasionally mimic eczema or psoriasis. An immunocompromised person with crusted Scabies can have thousands to millions of mites. Outbreaks of Scabies in institutions can often be traced to one index case of crusted Scabies. Crusted (Norwegian) Scabies can also be transmitted via bedding, towels, clothes, and upholstery, owing to the large numbers of mites on an infested individual. **Crusted Scabies is highly infectious.**

5. TRANSMISSION & RECOGNITION OF SCABIES

The transmission of Scabies occurs where there is **continuous** skin to skin contact lasting for as little as 2-3 minutes. This happens most frequently within household family settings, between partners and from holding hands. During this time the mite burrows into the outer layers of the skin where it lays eggs which will hatch after 3-4 days.

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.





1) Nodular scabies on trunk **2) Scabies on hands**

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.

It should be emphasised that scabies may be difficult to recognise particularly if scratching, inflammation or infection have obscured the presentation.

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

6. TREATMENT FOR SCABIES

Treatment Classical Scabies

Once diagnosed, the patient and all close contacts must be treated simultaneously to prevent re-infestation.

Include close contacts who are asymptomatic (a close contact is someone who has had a period of continuous skin contact with a case of Scabies for at least 2-3 minutes). It is important that all contacts apply treatment on the same day to minimise the chances of re-infestation from an untreated contact.

Crusted (Norwegian Scabies)

Patients with crusted (Norwegian Scabies) may need several courses of treatment e.g. weekly for approximately 4 weeks then every 2 weeks for approximately 3 months.

Crusted Scabies also requires descaling and debulking of the thickened skin. This may be done with gentle scrubbing with a nail brush or pumice stone while the patient is bathing or showering. The brush or pumice stone should be discarded afterwards. Moisturising ointment or cream should be applied to skin after the patient has finished bathing.

Medication

There are several agents that can be used for the treatment of scabies. The first line choice is permethrin (Lyclear dermal cream) and malathion (Derbac-M liquid) can be used if permethrin is inappropriate. All medication must be prescribed by a doctor or non-medical prescriber.

Instructions for using Permethrin (Lyclear dermal cream)

Adults and adolescents over 12 years of age:
Apply up to 30 g of cream (corresponding to one tube of 30 g).

It is advisable for someone else to apply the treatment to ensure that all parts of the body are covered.

Always wear gloves when applying a cream to someone else to prevent unnecessary contact with the scabicide.

The cream should be applied to dry, cool, clean skin and left on for 12 hours (usually overnight). The patient must NOT be given a hot bath prior to application as this increases systemic absorption (toxicity) and may result in treatment failure.

Treatment should be applied to the whole body including the scalp, neck, face and ears. Particular attention should be paid to the webs of the fingers and toes and lotion brushed under the ends of the nails.

Ideally the skin should not be washed during the 12 hour treatment period. If any skin surfaces are washed e.g. hand-washing the cream should be reapplied to that area. After the treatment period, bathe or shower as normal.

The treatment should be repeated after 7 days, for those affected with Scabies, it is not necessary to repeat for asymptomatic contacts.

The patient should be warned that although the medication will kill the mite immediately, the itching may persist for several weeks. An anti-pruritic emollient with / without oral antihistamines may be necessary to relieve the itch. Cool cotton clothing may also help as itching may be worse when the body is warm or in contact with man-made fibres e.g. nylon.

The recommended number of applications should NOT be exceeded. If itching persists for more than 4 weeks after the treatment, consult the doctor.

Reassurance

Reassure the patient that Scabies is a common community disease so that they do not feel stigmatised by the diagnosis.

Pregnancy and Breastfeeding

Both permethrin and malathion can be used during pregnancy and breastfeeding. If breastfeeding the cream or lotion should be removed from the nipples before feeding and reapplied after feeding has finished.

7. TREATMENT FOR STAFF

Staff SHOULD NOT instigate treatment for Scabies themselves. They should consult the Occupational Health Department and ALL treatment should be co-ordinated via the Occupational Health Department.

Management of asymptomatic close contacts of a case is straightforward but the management of asymptomatic staff contacts is more controversial. For single cases it is reasonable to merely observe for symptoms and treat if they occur. Alternatively some asymptomatic close staff contacts wish to receive prophylactic treatment.

Treated staff who have had symptoms can return to work after one overnight application.

8. ADDITIONAL TREATMENTS

An important part of treating scabies is treating the associated eczema and itching. The associated eczema and itching often lasts for 6-8 weeks, even when the initial infestation with scabies has been treated successfully. It is NOT a sign of treatment failure.

Antihistamines are of little help in treating itching. However, it may be useful to give a sedative oral antihistamine at night for temporary help with sleeping, to break the itch-scratch cycle.

Anti-eczema lotions and creams may be applied on days when specific scabies treatment is not applied. If anti-Scabies treatment is applied on day 1 and day 7 anti-eczema treatment may be applied on days 2-6 and day 8 onwards for as long as necessary, which may be up to 8 weeks.
Crotamiton cream or lotion has soothing qualities and may help to relieve itch, although no controlled studies have been published that assess its efficacy. It should be applied 2–3 times a day (once a day only for children under 3 years).

Treatment failure is likely if:

- The itch still persists at the same or increasing intensity at least 6-8 weeks after compliant treatment.
- Treatment was uncoordinated or not applied correctly.
- New burrows appear at any stage after treatment.

In these cases the advice of a Dermatologist should be sought.

9. MANAGEMENT OF SCABIES

For all cases of Scabies the Infection Prevention & Control (IP&C) Team should be notified as soon as possible.

In the Community
The patient and all the close contacts e.g. family/household and sexual contacts must be treated whether they have symptoms or not. In addition, there may be a need to advise other potential close contacts to seek advice from their GP if their degree of contact may have placed them at risk, e.g. best friend of a young child.

In a School or Nursery
If a parent reports a case of Scabies to a school or nursery, the child will need to stay off school until treatment has been completed. If the case of Scabies appears to be an isolated incident no further action is required, but the school should remind the parents to advise parents of particular friends of their child about the potential risk so that they are made aware and can look out for symptoms and/or seek advice from their own GPs. The school should inform their school nurse so that she/he can be alerted to further potential problems.

In an inpatient facility

- Patients with a classical presentation of Scabies do not need isolation in a single room. Contact precautions should be employed. Patient information leaflet on *The Management of Scabies* is available via the IP&C website via the intranet.

- Those patients with Norwegian/Crusted Scabies should be nursed in a single room until adequately treated. Additional precautions in addition to standard contact precautions involve wearing gowns with long sleeves to carry out any procedures requiring direct patient contact.

- If the case was detected on or within a short time of arrival, ask staff to look out for any itchy rashes on themselves or other patients. Staff should **always** report any suspicious rashes to the person in charge.

- Deceased patients with Norwegian (Crusted) Scabies should be placed in a body bag. Deceased patients with classical Scabies need no special precautions.

10. OUTBREAKS

An outbreak of Scabies should be considered when there is more than one case of Scabies in a ward/clinical area within a specific time.

A co-ordinated response to enable simultaneous and appropriate treatment of all patients, appropriate staff and close contacts of symptomatic patients and staff can then be drafted.

Outbreaks of Scabies should be referred to the IP&C Team

During outbreaks additional environmental cleaning may need to be instituted as instructed by the relevant IP&C Team.

For any further advice/information please contact the PCFT IP&C Team. Outbreak Policy CL75)

11. TRAINING

Staff requirements for training are identified in the training needs analysis in the Education, Training and Development Policy CO5.
This will be monitored by auditing the staff who have attended training.

12. AUDIT & MONITORING

In the event of a scabies outbreak a report will be fed back to staff and their managers and will go to the IP&C Committee and governance groups.

13. EQUALITY & DIVERSITY

The Trust strives to ensure equality of opportunity for all both as a major employer and as a provider of health care. This Policy Document has therefore been equality impact assessed by the Infection Prevention and Control Committee to ensure fairness and consistency for all those covered by it regardless of their individual

14. REFERENCES

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