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BCCDC Non-certified Practice Decision Support Tool Scabies

SCABIES

SCOPE

RNs may diagnose and recommend over-the-counter (OTC) treatment for classic scabies.

ETIOLOGY

A parasitic infestation of the skin caused by *Sarcoptes scabiei*, that can be classified as:

- classic scabies
- crusted (“Norwegian”) scabies - a more severe form of very infectious scabies that can occur spontaneously, but is more likely to occur in severely immunocompromised, elderly, or institutionalized individuals

EPIDEMIOLOGY

Risk Factors

- direct or prolonged skin-to-skin contact with an individual who has scabies
- transmission is unlikely with casual skin contact
- crowded conditions (e.g., residing in an institution)
- sharing of personal articles (e.g., clothing or bedding) with someone who has scabies

CLINICAL PRESENTATION

Classic scabies: severe itching, worse at night

- scabies-related to sexual contact typically presents on the:
 - abdomen
 - genitals
 - thighs
- other commonly affected areas:
 - hands (between fingers and around nailbeds)
 - axilla
 - elbows and wrists

- around the areola, usually when there is more breast/chest tissue

Crusted scabies: itching may be milder or absent; additional areas affected include the head, face, neck, palms and soles.

PHYSICAL ASSESSMENT

A head-to-toe assessment is recommended. Adult mites are 0.30 to 0.45 mm (eggs: 0.10 to 0.15 mm), making them difficult to visualize without a microscope.

Classic scabies

- wavy lesions approximately 2 to 10 mm long (“burrows”) that are grey, white, red, brown or skin coloured can be difficult to find
- can present as papules (pimple-like rash), hives, tiny bites, or eczema (scaly patches)
- can be erythematous and excoriated if there has been scratching
- prior use of topical steroids can result in atypical presentation, more similar to eczema
- less common: firm, erythematous and itchy nodules (bumps)

Crusted scabies

- thick, crusted lesions that can be scaly, erythematous and/or malodourous, and can house up to 2 million mites, compared to 10 to 15 mites typically seen in classic scabies

DIAGNOSTIC AND SCREENING TESTS

Diagnosis based on clinical presentation and physical assessment.

MANAGEMENT

Diagnosis and Clinical Evaluation

The following clients require treatment:

- clients diagnosed with scabies
- household, sexual and other close contacts, who may have had prolonged direct skin-to-skin contact with someone diagnosed with scabies within the prior month

Consultation and Referral

Consult with or refer to a physician (MD) or nurse practitioner (NP) all clients who:

- are pregnant or breast-/chest-feeding
- require an alternate treatment
- have no improvement, or new burrows or rash appearing 2 to 4 weeks following treatment
- have secondary infection potentially requiring antibiotics
- have extensive scabies or crusted scabies
- have nodules

- have extensive dermatitis, pruritus or pre-existing skin condition(s)

Treatment

Treatment	Notes
<p>First Choice</p> <p>permethrin 5% Cream (e.g., Kwellada-P Lotion or Nix 5%)</p>	<ul style="list-style-type: none"> • Refer to the product monograph. • Apply to clean, cool skin from the neck down. • Leave on for 8 to 14 hours. Then wash off, and wear clean clothing. • Re-apply to hands and nailbeds if soap is used to wash hands within 8 hours of application. • A single 30 g treatment is adequate for most adults. Physically larger individuals may require more, but treatment should not exceed 60 g in any single treatment. • Elderly people: although normally contraindicated, also apply product to the neck, face, side of the head and forehead, avoiding mucous membranes.
<p>Alternate Treatment</p>	<ul style="list-style-type: none"> • Consult with or refer to MD or NP if client is unable to take recommended treatments.

Monitoring and Follow-up

- **Repeat testing:** No
- **Test-of-cure (TOC):** No
- **Follow-up:** further treatment may be indicated if:
 - new burrows or rash occur 2 to 4 weeks after the first treatment
 - itching continues for more than 4 weeks after adequate treatment

Partner Counselling and Referral

- **Reportable:** No
 Partner notification is completed by client, providing assistance where needed. Reinforce the importance of partner follow-up, as re-infection can occur if all contacts are not assessed and treated where appropriate.
- **Trace back period:** 1 month
 All household, sexual and other close contacts who have had direct skin-to-skin contact.
- **Recommended partner follow-up:** assess and treat, regardless of whether symptoms are present or not

Potential Complications

- secondary bacterial infection from skin excoriation
- potential for sepsis in crusted scabies

Additional Client Education

Counsel client:

- that inadequate application of treatment can result in persistence of infection.
- that secondary skin infections can occur if lesions are scratched.
- to avoid re-infection:
 - no sexual contact until adequate treatment has been completed, and current sexual contacts have received adequate treatment.
 - for classic scabies, wash all clothes, bedding and fomites (e.g., pillows, toys) used within the prior 3 days in hot water (50⁰C) and dry in a hot dryer or dry-cleaned. Alternatively, place in plastic bags for at least 3 days.
 - vacuum mattresses and carpets.
- that pruritus may persist for several weeks after treatment.
- that itching can be controlled by antihistamines, local anesthetic creams and topical steroid creams which can be purchased OTC.
- [Standard Client Education for Sexually Transmitted Infections and Blood-Borne Infections \(STBBI\)](#)

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