STANDARD TREATMENT WORKFLOW (STW)

Scabies

Binod K Khaitan¹, Deepika Pandhi², Ananta Khurana³, Dipankar De⁴, Rahul Mahajan⁵, Renu George⁶, Vishal Gupta⁷

¹All India Institute of Medical Sciences, New Delhi; ²University College of Medical Sciences, New Delhi; ³Dr. Ram Manohar Lohia Hospital, New Delhi; ⁴Postgraduate Institute of Medical Education and Research, Chandigarh; ⁵Postgraduate Institute of Medical Education and Research, Chandigarh; ⁶Christian Medical College, Vellore; ⁷All India Institute of Medical Sciences, New Delhi

CORRESPONDING AUTHOR
Dr Binod K Khaitan, Department of Dermatology, All India Institute of Medical Sciences, New Delhi
Email: binodkhaitan@hotmail.com

CITATION
DOI: https://doi.org/10.56450/JEFI.2024.v2i1Suppl.049
This work is licensed under a Creative Commons Attribution 4.0 International License.
©The Author(s). 2024 Open Access

DISCLAIMER
This article/STW, was originally published by Indian Council of Medical Research (ICMR) under Standard Treatment Workflow. The reprinting of this article in Journal of the Epidemiology Foundation of India (JEFI) is done with the permission of ICMR. The content of this article is presented as it was published, with no modifications or alterations. The views and opinions expressed in the article are those of the authors and do not necessarily reflect the official policy or position of JEFI or its editorial board. This initiative of JEFI to reprint STW is to disseminate these workflows among Health Care Professionals for wider adoption and guiding path for Patient Care.

SCABIES
ICD-10-886

SYMPTOMS AND SIGNS
• Intense itch that is worse at night
• Other members of the family are often also affected
• Red, itchy papules and excoriations are seen mainly over fingers (interdigital spaces), wrists, periumbilical area, breasts, buttocks, axillary folds, waist, genitalia, and extensor aspects of the limbs
• The face, palms and soles are usually spared in adults; but typically involved in young children
• Burrows is the most characteristic lesion of scabies, but is often not observed
• Burrows should be looked for in web spaces and wrists and appear as thin, brown-grey lines of 0.5-1 cm
• Sometimes, vesicles are also seen
• Lesions may be seen in those with

OTHER PRESENTATIONS
• Extremely itchy, persistent nodules may develop over male genitalia
• Secondary bacterial infection can occur in those with poor hygiene, especially in children
• CRUSTED SCABIES
• Severe form of scabies that develops in those with predisposing factors such as immunosuppression (due to disease or drugs – including topical steroids), neurological disorders, or physical incapacitation or mental retardation- associated inability to scratch
• Thick, yellow brown crusts form that are densely packed with mites
• The thick crusts may be localised to hands and feet

Standard Treatment Workflow (STW)
Khaitan BK, et al.: Scabies

**Standard Treatment Workflow (STW)**

**SCABIES**

**ICD-10-B86**

**SYMPTOMS AND SIGNS**

- Intense itch that is worse at night
- Other members of the family are often also affected
- Red, itchy papules and excoriations are seen mainly over fingers (interdigital spaces), wrists, periumbilical area, breasts, buttocks, axillary folds, waist, genitalia, and extensor aspects of the limbs
- The face, palms and soles are usually spared in adults; but typically involved in young children
- Burrows is the most characteristic lesion of scabies, but is often not observed
- Burrows should be looked for in web spaces and wrists and appear as thin, brown-grey lines of 0.5-1 cm
- Sometimes, vesicles are also seen
- Lesions may be sparse in those with a good hygiene

**OTHER PRESENTATIONS**

- Extremely itchy, persistent nodules may develop over male genitalia
- Secondary bacterial infection can occur in those with poor hygiene, especially in children
- **CRUSTED SCABIES**
  - Severe form of scabies that develops in those with predisposing factors such as immunosuppression (due to disease or drugs - including topical steroids), neurological disorders, or physical incapacitation or mental retardation - associated inability to scratch
  - Thick, yellow brown crusts form that are densely packed with mites
  - The thick crusts may be localised to hands and feet (including nails)

**DIAGNOSIS**

- Diagnosis is usually clinical
- Demonstration of mite, mite eggs, or mite faeces (scybala) may be attempted from burrows (if visible) or by dermoscopy (if available) and from the thick crusts in case of crusted scabies (where mite is easily demonstrable)

**GENERAL MEASURES**

- All family members and close contacts must be simultaneously treated to prevent re-infestation
- The clothes and other fabrics such as towels and bed linens used by the patient in preceding three days must be washed with hot water and dried in the sun
- The items may also be kept sealed in a plastic bag for at least 3 days (also useful for shoes and other non washable items)

**TREATMENT**

- Most patients are treated with topical alone
  - Permethrin 5% cream: Apply over the whole skin surface (neck downwards) on dry and clean skin; wash off after 8-12 hours (advice to apply late evening and keep overnight)
  - In infants, the face and scalp must also be treated
  - Special attention must be given to interdigital web spaces, axillae, area under the fingernails and toenails the external genitalia and the buttocks
  - To ensure 8 hours of contact time, Permethrin should be reapplied if hands are washed
  - About 30 grams of cream is used for one application in adults and children ≥ 5 years; 15 grams for children < 5 years
  - The application is to be repeated after 7-14 days
  - Alternatively, 1% Gamma Benzene Hexa-Chloride (CBHC/lindane) may be used for application as above for permethrin. Avoid use in infants
  - Oral treatment for patients with poor compliance or response to topical therapy
  - Oral Ivermectin: at a dose of 200 mg/kg (up to 12 mg); two doses 1 week apart; taken with food
  - Avoid Ivermectin in infants, children < 5 years old or <15 kg, and in pregnancy. Permethrin has been safely prescribed in these situations
  - Anthelminthics should be prescribed as per the patient’s requirement

**TREATMENT of secondary infection (Staphylococcal/ Streptococcal):** Refer to Bacterial skin infection STW

**TREATMENT of crusted scabies:** Ivermectin on days 1, 2, 8, 9 and 15 (additionally on days 22, 29 days in severe cases), with Permethrin 5% cream daily for 7 days, then twice weekly until cure. A keratolytic such as 3-6% Salicylic acid may be used over crusts

**Nodular lesions:** Potent topical steroid (Clobetasol propionate) or intralesional steroid (Triamcinolone acetonide 10 mg/mL) may be required for persistent nodules

**POST TREATMENT ADVISE**

- The patients must be explained that itching can continue for several weeks after successful treatment and repeated applications are not required; continue anthelminthics for symptomatic management
- However, if itching persists for more than 3-4 weeks or if new lesions are noted - a reinfestation is likely. This can occur if close contacts were not simultaneously treated

© 2024 JEFI