Medicine for Managers

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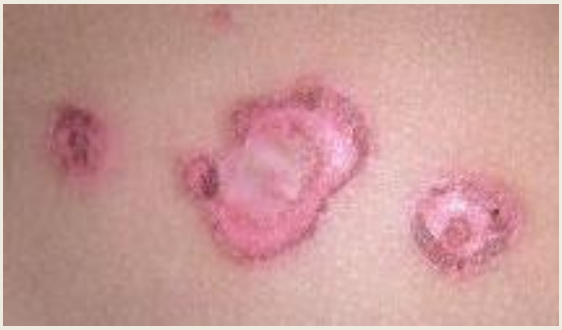
Impetigo

Impetigo is a highly contagious skin infection usually caused by a staphylococcus but less commonly by a streptococcus. It tends to spread rapidly amongst families of small children and in schools and other institutions. It is commonly mistaken for other skin disorders and other skin disorders are often mistaken for impetigo.

Impetigo may present as a blistering rash (bullous impetigo) or, more commonly, as small, flat inflamed areas which initially appear as a blister but quickly burst to form the raw red areas (non-bullous impetigo).



Impetigo can develop on healthy skin but it often develops in skin which is already damaged by, for example, eczema, insect bites, viral infections or trauma. Such infections are called secondary impetigo.

The sores develop a brownish crust (which may look like caramelised sugar) and, if left alone, they will heal and disappear without scarring over a period of a few weeks. The lesions are often itchy and scratching prolongs the infection and may result in damage which can scar. Furthermore scratching results in spread of the infection to other skin areas and can result in transmission to other people through direct contact or common usage of towels etc.

Only rarely does the infection cause any sort of constitutional disturbance, such as a temperature or feeling of ill-health. Impetigo is very much more common in children than in adults (possibly because of less well developed immune system in children) and spreads rapidly through schools and institutions. The infection does not cause symptoms for up to eight days after acquisition.

Of course, when the lesions appear on the face of a child as they commonly do, the appearance quickly drives the anxious mother to the GP.

Impetigo can be difficult to distinguish from other skin conditions such as cellulitis, which is an infection affecting deeper skin layers, herpes simplex virus, which produces cold sores, the scabies mite, which can cause intense itching, shingles, which produces localised crusted red

lesions in a local area, and thrush (candidiasis) which can cause redness in warm, damp, protected areas such as the skin of the groin, beneath the breasts and under the arms.

Impetigo can resolve spontaneously over a period of about three weeks. However, it is easy to treat and, depending on the severity, location and area affected, antibiotic may be supplied as a cream or as tablets.

For small areas topical fucidic acid *(Fucidin)* or mupirocin *(Bactroban)* may be applied for seven days. If more widespread, then oral flucloxacillin (provided the patient is not allergic to penicillin) is the treatment of choice. In allergic patients, clarithromycin would be a second choice.

Because it is so contagious, children with the infection should be kept away from other children until the risk of infection has resolved. This may be after a week if using topical antibiotic treatment or after three days if taking an antibiotic (even though the lesions may still be present – if the teacher will let the child return with an impetiginous appearance).

Most mothers can raise suspicions about impetigo in their children when they see it. As Geoffrey Hill said “In the schoolyard, in the cloakrooms, the children boasted their scars; wrists and knees garnished with impetigo”. We can expect it to continue!

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