For more information or to provide feedback on this or any other decision support tool, email certifiedpractice@bccnp.ca

ADULT IMPETIGO

DEFINITION

A highly contagious, superficial bacterial infection of the skin, it primarily affects children during the summer. Beginning with vesicular lesions, it progresses to honey crusted lesions and is commonly seen on the face, arms, legs and buttocks.

POTENTIAL CAUSES

- *S. aureus* is the principal pathogen.
- *Group A Beta-hemolytic strep* presents alone or in conjunction with *S. aureus* in a minority of cases.

PREDISPOSING RISK FACTORS

- Local skin trauma such as insect bites, wounds
- Skin lesions from other disorders such as eczema, scabies, pediculosis
- Age – more common in pre-school and young children
- Crowded living conditions
- Poor hygiene
- Warm, moist climate

TYPICAL FINDINGS OF IMPETIGO

History

- More common on face, scalp and hands, but may occur anywhere
- Involved area is usually exposed
- Usually occurs during summer
- New lesions usually due to auto-inoculation
- Rash begins as tiny red lesions, which may be itchy
- Lesions rapidly become small vesicles, progressing to pustules, which rupture and drain to form yellow crusts
- Lesions painless

- Fever and systemic symptoms rare – mild fever may be present in more generalized infections
- Known methicillin-resistant staphylococcus aureus (MRSA) positive (client or household member)

Physical Assessment

- Thick, golden yellow, crusted lesion on a red base
- Numerous skin lesions at various stages present (vesicles, pustules, crusts, serous or pustular drainage, ulcers, healing lesions)
- Bullae may be present, but more common in children
- Lesions and surrounding skin may feel warm to touch
- Regional lymph nodes may be enlarged, tender

Diagnostic Tests

Identification of impetigo may be made upon consideration of clinical features and presentation.

- Culture and Sensitivity of exudate if widespread or treatment failure at 48 hours
- Determine blood glucose level if infection is recurrent or if symptoms suggestive of diabetes mellitus are present

MANAGEMENT AND INTERVENTIONS

Goals of Treatment

- Resolve infection
- Prevent auto-inoculation
- Prevent spread to other household members

Non-pharmacologic Interventions

- Apply warm saline compresses to soften and soak away crusts qid for 15 minutes and prn

Pharmacologic Interventions

- Apply topical antibiotic preparation after each soaking:
  - Mupirocin ointment to affected lesions tid for 5 days
- If non-responsive:
  - Fusidic acid ointment or cream tid or qid for 7 days
- Topical agents are sufficient when there are only a small number of non-bullous lesions.
- Oral antibiotics may be necessary if there are multiple lesions making topical treatment impractical, the client is febrile and has systemic symptoms including lymphadenopathy, or if bullous impetigo is present:
  - Cloxacillin 250-500 mg po qid for 7 days,

  OR

- Cephalexin 250-500 mg po qid for 7 days

- For clients with allergy to penicillin:
  - Erythromycin 250-500 mg/day divided qid po for 7 days

If known MRSA positive or MRSA positive swab result:

- Trimethoprim 160 mg /sulfamethoxazole 800mg (DS) 1 tab po bid for 10 days

OR

- Doxycycline 100 mg po bid for 5-10 days

Pregnant or Breastfeeding Women (dosing as above)

- Mupirocin, cloxacillin, cephalexin, and erythromycin may be used as listed above.
- Avoid fusidic acid ointment.
- DO NOT USE trimethoprim 160 mg/sulphamethoxazole 800 mg and/or doxycycline.

POTENTIAL COMPLICATIONS

- Localised or widespread cellulitis
- Post-streptococcal glomerulonephritis (uncommon in adults)
- Sepsis
- Acute rheumatic fever

CLIENT EDUCATION AND DISCHARGE INFORMATION

- Counsel client about appropriate use of medications (dose, frequency, compliance).
- Recommend proper hygiene (i.e., daily washing).
- Counsel client about prevention of future episodes.
- Suggest strategies to prevent spread to other household members (e.g., proper hand-washing by all household members, use of separate towels).
- Remain home from work / school for 24 hours after treatment started.

MONITORING AND FOLLOW-UP

- Follow-up in 2-3 days to assess response to treatment.
- Instruct client to return for reassessment if fever develops or infection spreads despite therapy.

CONSULTATION AND/OR REFERRAL

- Consult with a physician or nurse practitioner if no response to treatment.

DOCUMENTATION

- As per agency policy

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