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Impetigo

Impetigo is a common superficial bacterial skin infection which is usually a mild infection[1].

Complications, while rare, include: acute glomerulonephritis, cellulitis, staphylococcal scalded skin syndrome, lymphangitis, osteomyelitis and septic arthritis and septicaemia, Scarlet fever, urticaria and erythema multiforme[1].

Impetigo can develop as a primary infection in otherwise healthy skin or as a secondary complication of pre-existing skin conditions such as eczema, scabies, or chickenpox.

It is common in children, with an annual incidence around 2.8% in children up to 4 years of age and 1.6% in children 5–15 years of age[1], and is the third most common skin disease seen in children after eczema and viral warts[2].

There are 2 main types of impetigo: non-bullous impetigo and bullous impetigo. The table below explains this further.

Clinical Forms of Impetigo[1]	
Non-bullous impetigo	**Bullous impetigo**
Non-bullous impetigo is caused by the bacteria Staphylococcus aureus, Streptococcus pyogenes or a combination of both, and accounts for the majority of cases (about 70%). • Non-bullous impetigo presents with thin-walled vesicles or pustules (seldom seen on clinical examination as they rupture quickly) which release exudate forming a golden/brown crust. • Non-bullous impetigo is usually asymptomatic but may be mildly itchy. • The area around the mouth and nose is most commonly affected, although other areas of the face and the extremities may also be involved.	**Bullous impetigo** is caused by the bacteria Staphylococcus aureus and commonly affects infants, although older children and adults can also be affected. • Bullous impetigo presents with flaccid fluid-filled blisters (bullae) (often with a diameter of 1-2cm), which can persist for 2-3 days. These blisters rupture leaving a thin flat yellow/brown crust. • Lesions most often occur on the flexures, face, trunk and limbs, and can be particularly widespread in infants. • Systemic features (such as fever and lymphadenopathy) may occur if large areas of skin are affected.

Transmission[1]

- Impetigo is usually transmitted by direct contact. Fomites, which are objects or materials likely to carry infection, such as clothes, towels, utensils, and furniture, can also spread impetigo.
- It is also more common in the summer months, and in areas with poor hygiene and in crowded living conditions.

Diagnosis[1]

- The diagnosis of impetigo is usually made based on clinical assessment.
- In cases where symptoms recur or are widespread despite treatment, a swab should be considered.

More information on page 2

For additional resources see www.ihv.org.uk

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Impetigo

Treatment[1]

- Localised non-bullous infections are treated with topical hydrogen peroxide for five days, or a topical antibiotic if hydrogen peroxide is not suitable.
- More extensive, severe or bullous infections may require oral antibiotics (flucloxacillin or clarithromycin if allergic to penicillin) for five days or possibly seven days if clinically indicated.
- Referral is rarely necessary unless there is diagnostic uncertainty - the impetigo is extensive with systemic symptoms, or unresponsive to optimal treatment, or if there is a recurrence of the impetigo. In such cases, it is recommended that a referral is made to a dermatologist or paediatrician and microbiology teams.

Management of impetigo[1]

Explain and provide parents with information below about how to manage impetigo. For further support, see the resources section.

The following advice includes measures to stop the infection spreading to other areas of the body and other people and also measures to promote healing.

- Wash affected areas with soap and water.
- Wash their own hands regularly, in particular after touching a patch of impetigo.
- Try to prevent their child scratching affected areas.
- Keep the sores or blisters clean and dry and cover them, if possible, with loose clothing or a gauze bandage.
- Avoids sharing towels, face cloths, sheets and other personal care products.
- Thoroughly clean with detergent and warm water any toys and play equipment a child with impetigo has used.
- **Advise** parents that children need to stay away from public spaces such as preschool until the lesions are dry and scabbed over or, if the lesions are still crusted or weeping, for 48 hours after antibiotic treatment has started.
- **Avoid** having close contact with anyone who has a weakened immune system until the impetigo is resolved.
- **Ensure** that parents are treating pre-existing skin conditions such as eczema, head lice, scabies or insect bites appropriately.
- **Reassure** parents that impetigo usually heals completely without scarring, and that serious complications are rare.
- **Advise** parents that if symptoms significantly worsen at any time, or have not improved after completing a course of treatment, to seek medical advice.

Good Practice Points

- Impetigo is common in young children and it is very infectious.
- Visit the resources section for help to identify what impetigo looks like to help you accurately spot it in practice.
- Signpost families to see their GP if a child presents with impetigo.
- Offer support to families on careful management of impetigo and avoiding its spread to others.
- Encourage parents to treat any other skin conditions their child may have in addition to impetigo such as eczema.

Resources

- NHS [Accessed 02/02/2023]
- Impetigo | NHS inform [Accessed 02/02/2023]

References

1. National Institute for Health and Care Excellence (NICE), Impetigo:NICE Clinical Knowledge Summaries (CKS). (2022). Available from: https://bit.ly/3YoGA9F [Accessed 06/02/2023].
2. Sladden MJ, and Johnston GA. Common skin infections in children. British Medical Journal. 2004; 329(7457): 95-99.

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