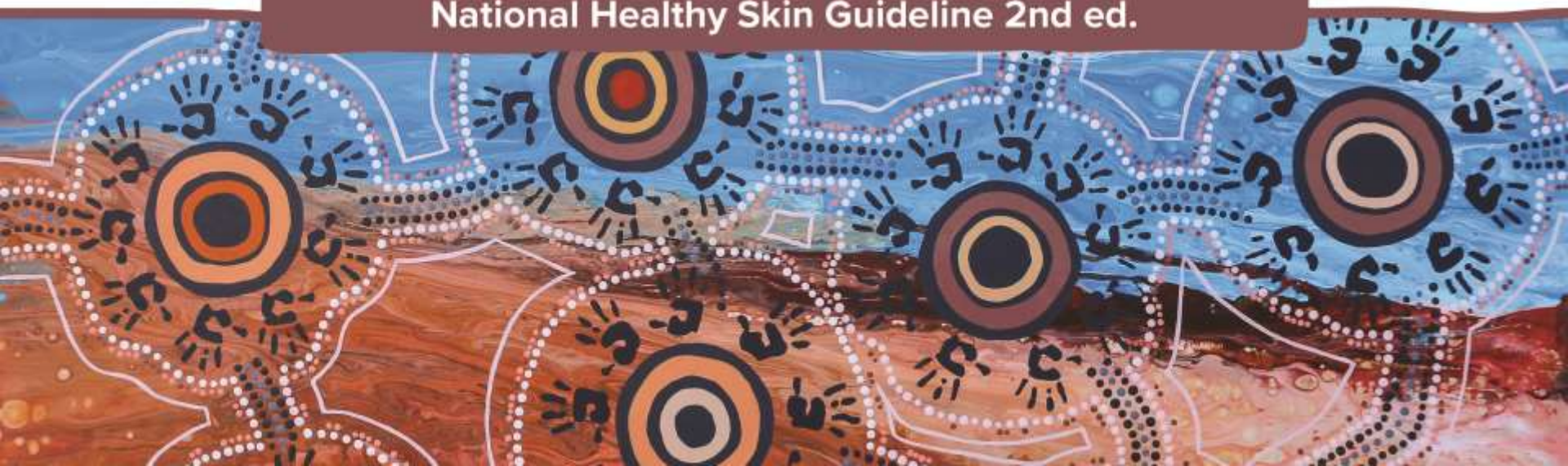


Recognising & Treating Skin Infections

A VISUAL CLINICAL HANDBOOK

Supporting clinical resource of National Healthy Skin Guidelines 2nd ed. (2023)

National Healthy Skin Guideline 2nd ed.



History



This is the fourth edition of the Recognising and Treating Skin Infections resource.

The first edition, entitled *Recognising and Treating Skin Conditions*, was produced in 2004 by the Cooperative Research Centre for Aboriginal and Tropical Health (now the Lowitja Institute) and the Menzies School of Health Research, to train healthcare professionals as part of the East Arnhem Regional Healthy Skin Project. This was updated to the second edition by Lowitja and Menzies in 2009 and has been widely used throughout Australia both in hardcopy and online formats.

In 2018, Telethon Kids Institute obtained permission to adapt *Recognising and Treating Skin Conditions* into a third edition, for use by healthcare workers in conjunction with the first edition of the *National Healthy Skin Guidelines*. This edition was been widely downloaded across Australia.

In 2023, Telethon Kids Institute produced the second edition of the *National Healthy Skin Guidelines*. Accordingly, the third edition of the resource was updated to the current recommendations.

We acknowledge the generosity of the Menzies School of Health Research and the Lowitja Institute in allowing us to use and adapt their resources for ongoing use by clinicians across Australia.

Citation: The Healthy Skin & ARF Prevention Team, Bowen AC, *Recognising & Treating Skin Infections: A visual clinical handbook*, 4th edition, 2023, Telethon Kids Institute



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1. Impetigo (Skin Sores)

- Bacterial skin infection, very common in children
- Skin sores & scabies often occur at the same time
- Must treat as can lead to serious health problems

Look for:

- Yellow-brown crusted sores
- Sores with pus in them
- Check & treat for scabies at the same time



Identify Impetigo



Due to the **serious consequences** if left untreated, skin sores (impetigo) should be recognised and always treated as **a high priority**

Skin Sore Stages



Pus



Crust



Healing flat, dry

If impetigo is present, check for scabies and treat.

Purulent Impetigo



Crusted Impetigo



Healing Impetigo

Flat, dry sores

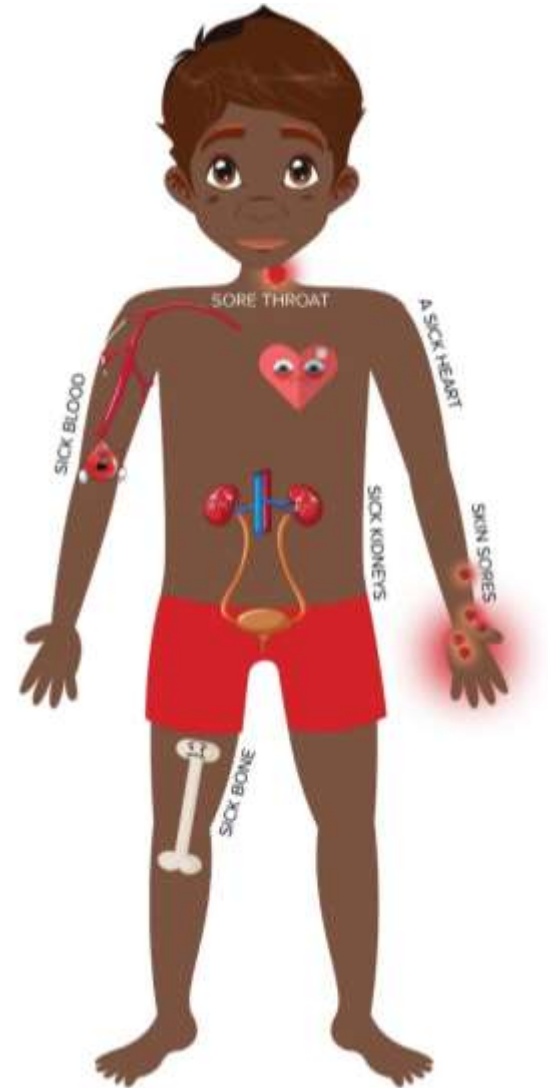


Impetigo: Why do we treat?

Skin sores are caused by Strep A and *S. aureus*

These bacteria can cause:

- Boils
- Bone and Joint infections
- Sepsis
- Kidney Disease (APSGN)
- Rheumatic Heart



Treat Impetigo

Always ask the carer or patient which option is best for them

A

Oral co-trimoxazole

Trimethoprim +
sulfmethoxazole 160 +
800mg orally

Twice daily for 3 days

OR

B

IM benzathine penicillin G (BPG)

Single weight
band dose

**Topical 2% mupirocin ointment can be applied directly to
the sores for two or less sores, twice a day for 5 days**

Treat Impetigo

A Give oral **co-trimoxazole** 4mg / kg / dose of trimethoprim component Twice daily for 3 days

Table 4.

Weight Band	Syrup Dose (Give morning and night) Trimethoprim-sulfamethoxazole is 40mg trimethoprim/5ml	Tablet Dose (Give morning and night) Tablets are 180/800 of trimethoprim/ sulfamethoxazole components
3 - < 6kg	1.5 mL (12mg BD)	N/A
6 - < 8 kg	3 mL (24 mg BD)	N/A
8 - < 10 kg	4 mL (32 mg BD)	N/A
10 - < 12 kg	5 mL (40 mg BD)	N/A
12- < 16 kg	6 mL (48 mg BD)	N/A
16- < 20 kg	8 mL (64 mg BD)	N/A
20- < 25 kg	10 mL (80 mg BD)	½ tablet (80mg BD)
25- < 32 kg	12.5 mL (100 mg BD)	¾ tablet (120mg BD)
32- < 40 kg	16 mL (128 mg BD)	¾ tablet (120mg BD)
≥40kg	20 mL (160 mg BD)	1 tablet (160mg BD)

Treat Impetigo

B Give **IM benzathine penicillin G (BPG)** as a **single** weight band dose

Table 5.

Weight Band	Injection Dose 1 syringe contains 900mg BPG in 2.3ml
Child	
<10kg	450,000 units (0.9mL)
10 - < 20kg	600,000 units (1.2mL)
≥ 20kg	1,200,000 units (2.3mL)

Prevent Impetigo

1) Clean

- Bathe/wash children **every day**
- Clean hands with **soap & water**
- **Wash towels, clothes & bedding** regularly and dry in the sun

2) Check

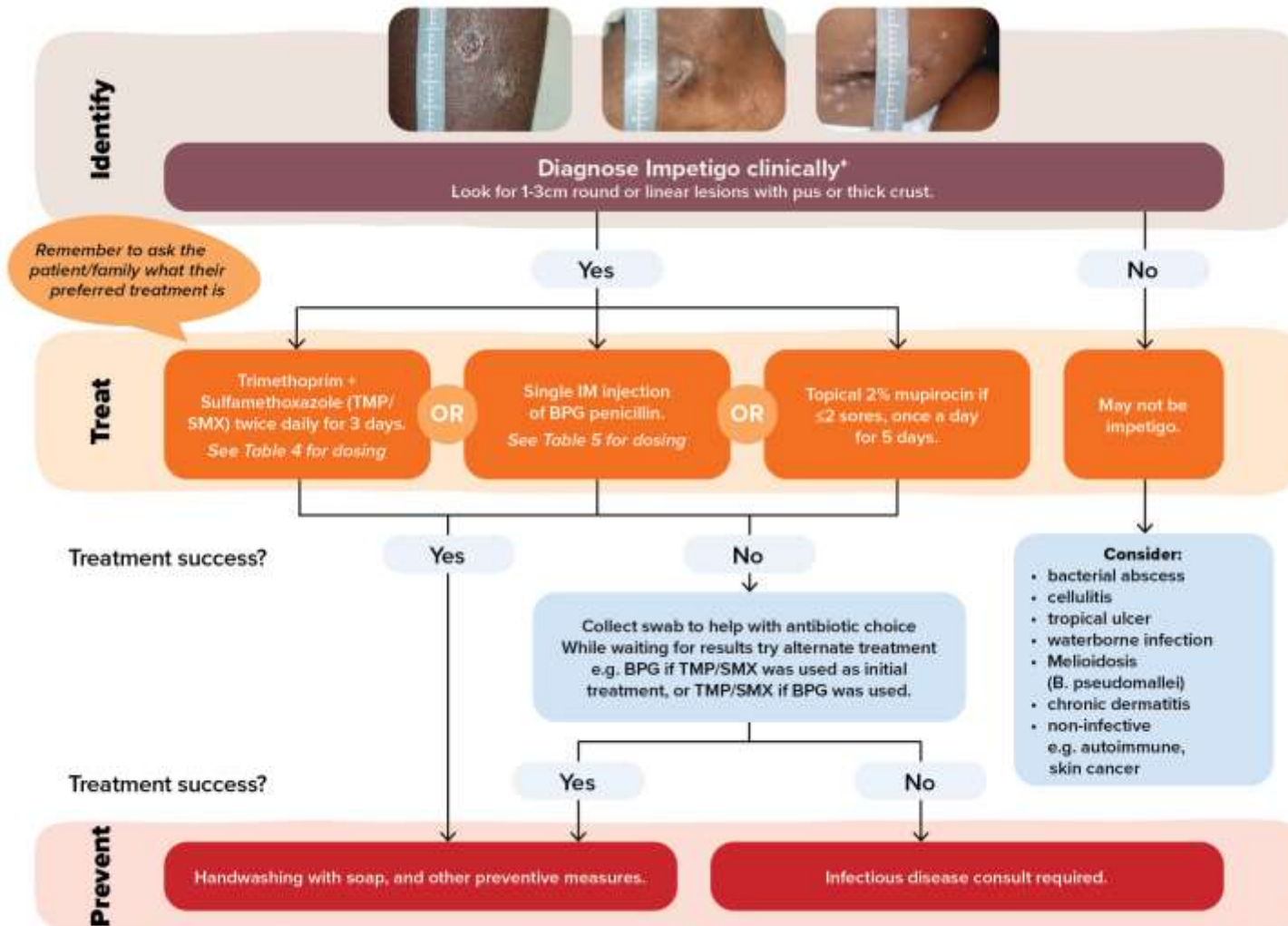
- If skin is not improving after a week, **speak to your health clinic**

3) Prevent transmission

- **Prompt treatment** of skin sores prevents further transmission



Impetigo Algorithm



*If impetigo infection is present, consider and examine for evidence of scabies infestation. Follow instructions in Chapter 7.

2. Scabies

- Tiny mites burrow under the skin to lay their eggs
- Very itchy skin, especially at night
- Spreads easily between people who are in close contact

Look for:

- Scratches & sores between fingers & toes; on wrists, elbows, knees, ankles & bottom
- Babies often have “pimple-like” pustules on the hands & feet



Identify Scabies

- ✔ Scabies should be **recognised** and **treated** as a **high priority**
- ✔ Treatment of scabies **reduces itch** leading to better sleep and daytime concentration
- ✔ Treatment of scabies **reduces the clinical need for treatment of skin** and soft tissue infections



If scabies is present, check for impetigo and treat.

Scabies vs Infected Scabies

- **Infected scabies** occurs when **papules** caused by the burrowing scabies mite become **secondarily infected with bacteria** (commonly Strep A and *S. aureus*).
- If **scabies is infected**, please follow **both** the scabies and impetigo algorithms.



Scabies



Infected scabies

Signs that scabies could be infected:

- Crust
- Pus

Infected Scabies



Treat Scabies

Always ask the carer or patient which option is best for them

A

Topical permethrin 5%

Complete on
Day 1 and Day 8

OR

B

Oral ivermectin

**For children over 5 years
of age (or over 15kg) and
for non-pregnant /
non-breastfeeding adults**

200 µg / kg dose on
Day 1 and Day 8

Household contacts require treatment with single dose of ivermectin or single application of topical permethrin.








Treat Scabies



Give **Topical permethrin**
Complete on Day 1 and Day 8

Box 1.

Application of Creams & Lotions for Scabies

-  Rub cream on **after shower**
-  Leave cream on **overnight**
-  **Start with head**
(including the scalp & face)
-  Avoid the eyes, lips and mouth
-  **Work carefully down** the entire body
-  Put on hands again after washing
-  Put on child's hands again before bed

Make sure no skin is missed especially the back, buttocks and difficult to reach spots!

REMEMBER

Body creases

Behind ears,
under jaw,
neck, armpits,
groin, bottom,
under breasts

Between fingers & toes

Soles of feet
Under nails

Joint & joint creases

Elbows, knees
and heels

Recommendation

Application of topical treatments should cover the **entire body from head to toe.**

Treat Scabies

B Give **Oral Ivermectin**
200 µg / kg dose on
Day 1 and Day 8

Table 6.

Weight Band	Dose
15 – 24 kg	3 mg (1 tablet)
25 – 35 kg	6 mg (2 tablet)
36 – 55 kg	9 mg (3 tablet)
56 – 65 kg	12 mg (4 tablet)
66 – 79 kg	15 mg (5 tablet)
>80 kg	18 mg (6 tablet) or 200 µg/kg (rounded up to the nearest 3 mg)

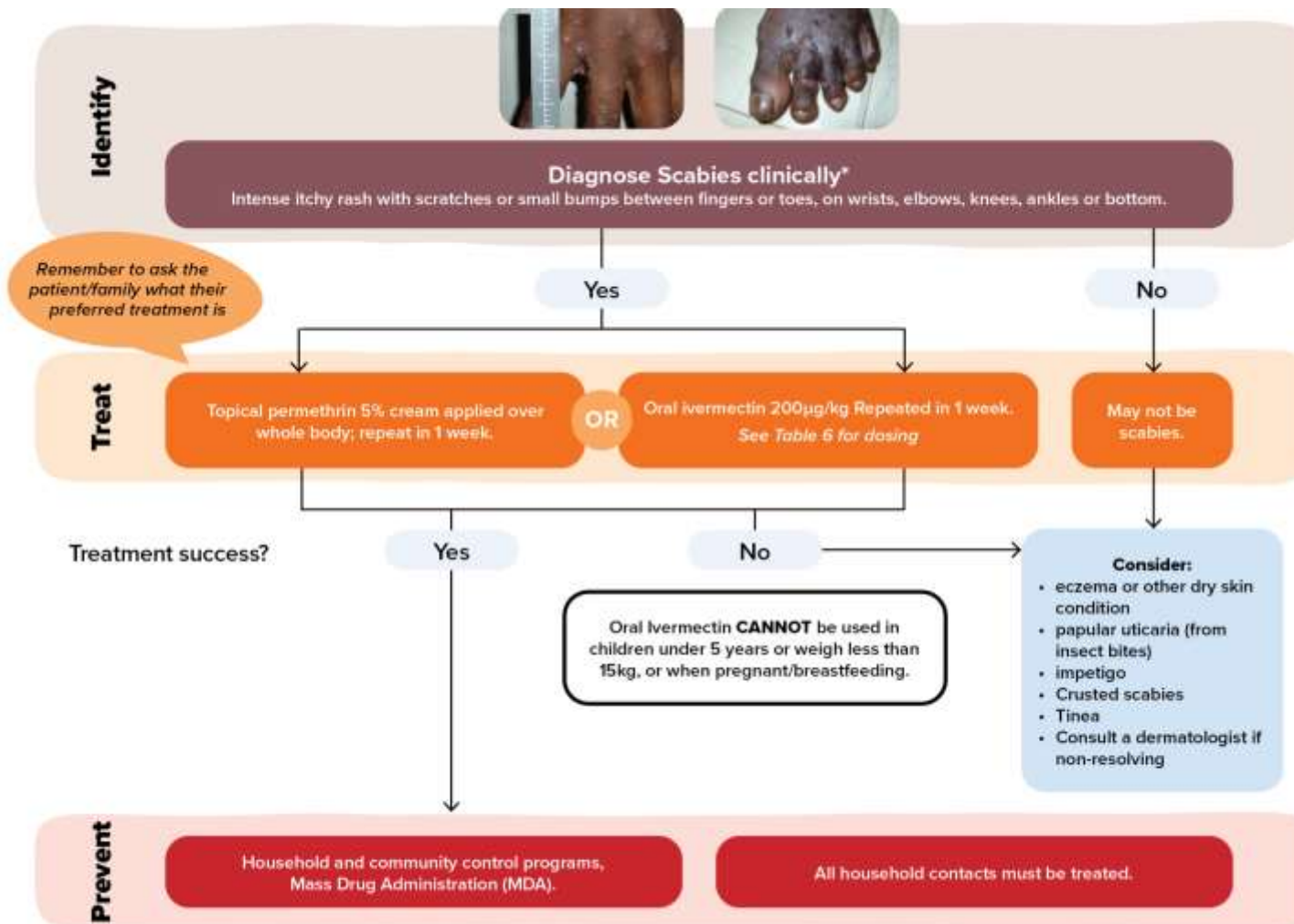
*Oral ivermectin cannot be used in children less than 5 years of age or under 15kg, and in pregnant or breastfeeding individuals.

Prevent Scabies

- ◉ **Prompt treatment** of scabies prevents further transmission.
- ◉ **Treatment of household contacts is recommended** for the community control of scabies.
- ◉ **Treatment of cases and contacts** is recommended in scabies outbreaks.



Scabies Algorithm



*If scabies infestation is present, consider and examine for evidence of impetigo. Follow instructions in Chapter 6.

3. Crusted Scabies

- Severe form of scabies
- Skin forms scales & crusts
- Requires more extensive treatment
- Often not itchy



Look for:

- Patches of skin with a thick & flaky crust
- Area of depigmented or lighter skin
- Usually on hands, elbows, armpits, under breasts, buttocks & feet
- Different from scabies with sores (pus & crusts)



**Collect scrapings
of the skin to look
for scabies mites**

Identify Crusted Scabies

- ✔ Crusted scabies is **highly infectious** and causes further **scabies outbreaks** in affected communities. Prompt treatment and control efforts are essential.
- ✔ To keep crusted scabies patients in a scabies-free environment, regular skin checks of children and family members and early treatment of scabies when it occurs are required.



If crusted scabies is present, check for impetigo and treat.

Crusted Scabies Grading Scale

Table 7.

Category	Description	Score		
A. Distribution & extent of crusting	Wrists, web spaces, feet only OR <10% total body surface area (TBSA)	1		
	As above + forearms, lower legs, buttocks, trunk OR 10–30% TBSA	2		
	As above + scalp OR >30% TBSA	3		
B. Crusting/shedding	Mild crusting (<5mm deep); minimal skin shedding	1		
	Moderate crusting (5-10mm deep); moderate skin shedding	2		
	Severe crusting (>10mm deep); profuse skin shedding	3		
C. Past episodes of crusted scabies	Never had it before	1		
	1–3 prior hospitalisations OR depigmentation of elbows and/or knees	2		
	≥4 prior hospitalisations OR depigmentation as above and/or legs/back OR residual skin thickening or scaly skin	3		
D. Skin condition	No cracking or pus	1		
	Any of: multiple pustules, weeping sores, superficial skin cracking	2		
	Deep skin cracking with bleeding, widespread pus	3		
Scoring	Grade 1 = 4-6	Grade 2 = 7-9	Grade 3 = 10-12	Total

Grading scale can be helpful in discussing and referring patients to a specialist.

Treat Crusted Scabies



Call a doctor to discuss crusted scabies

Treatment guidelines for Grade 1

For Grades 2-3 referral to specialist and treatment as per Therapeutic Guidelines is required.

1

Oral ivermectin
with **topical keratolytics** and
topical Scabies
treatment

2

Intensive
supportive
treatment is
required for
patients

3

Coordinated
case
management
may be of
benefit

Treat Crusted Scabies



Call a doctor to discuss crusted scabies

Grade 1

Give tablet **ivermectin** 200µg/kg once daily at **days 0, 1 & 7** with food/milk (see page 20 for dosing)

PLUS

- Apply **Topical benzyl benzoate 25% lotion** diluted with water (for children) or tea tree oil (for adults) OR **5% Permethrin cream** to the entire body after bathing every second day, then twice a week until cured.
- On alternate days, apply **Calmurid** (10% urea, 5% lactic acid in moisturizing cream) to the affected areas only.

Practice points:

- Crusted scabies may need hospital admission: contact paediatrician or doctor for advice
- Ivermectin **CANNOT** be used in **pregnant or breastfeeding individuals** or **in children under 5 years of age or who weigh <15kg**

Crusted Scabies Follow-Up

Refer to a doctor as soon as possible

Treat **person with crusted scabies** with **oral ivermectin** on **days 0, 1 & 7** (plus topical scabicide and keratolytics on alternate days)

Treat **all others in the household** for scabies with **topical Permethrin 5%**
Repeat in 1 week

Review regularly until crusts resolve and skin is in good condition

Prevent Crusted Scabies

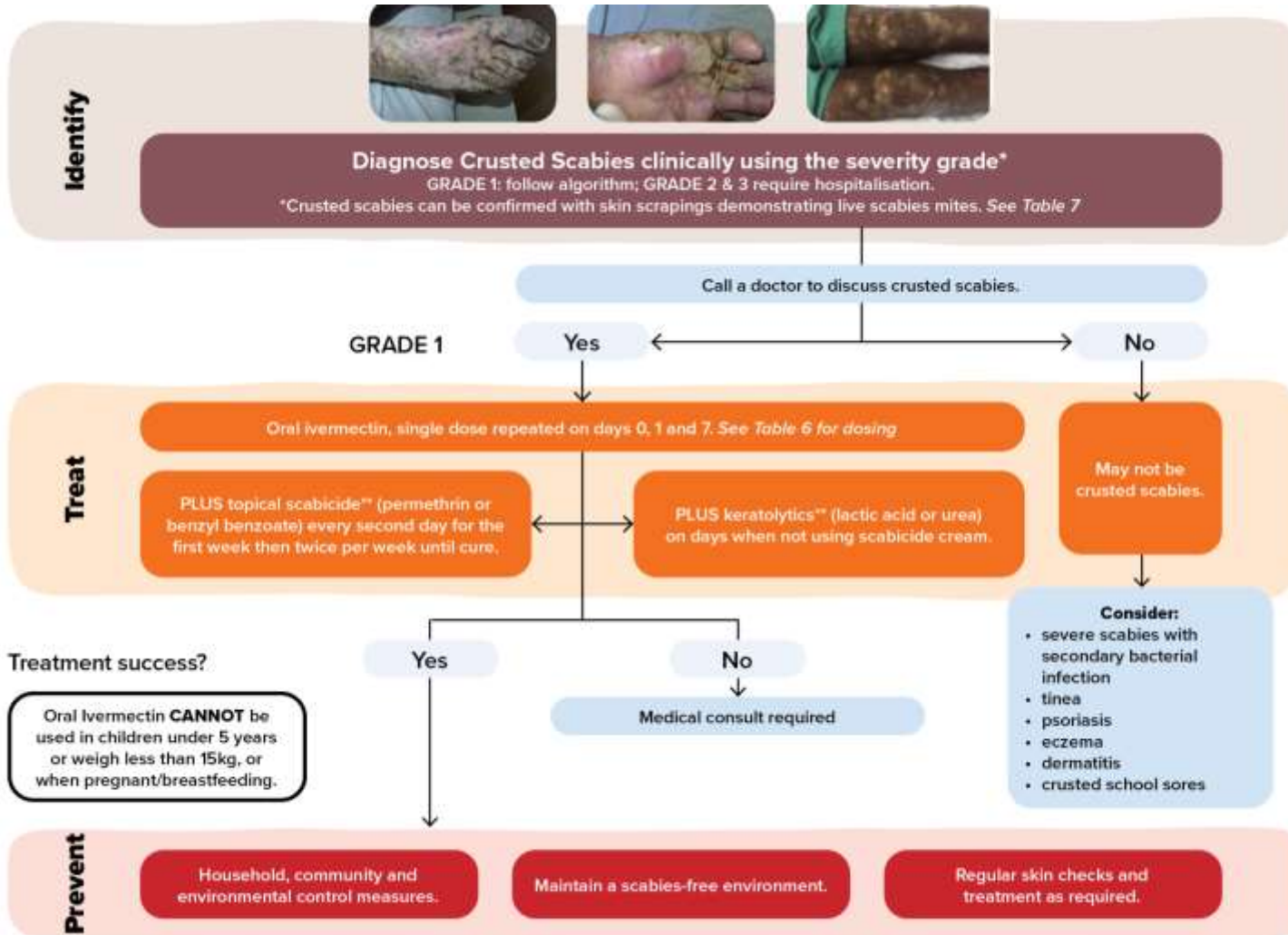
- **Break the cycle of transmission:** Keep individuals scabies free & in a scabies free environment by regularly assessing skin for signs of scabies infection and keeping skin moisturised and in good condition.
- **Prompt treatment** of scabies in individuals and their contacts prevents further transmission.



Maintain scabies free households



Crusted Scabies Algorithm



*If crusted scabies is present, consider and examine for evidence of impetigo.

4. Fungal Infections – Tinea “Ringworm”

- Common fungal infection of the skin, scalp & nails
- Mainly spread between people
- Lasts a long time without treatment

Look for:

- Scaly, well-defined patches on skin
- Often the skin is darker & tougher
- Any area of the body can be affected
- Thickened, broken white or yellow nails



Identify Tinea



Due to the **serious consequences** if left untreated, **fungal infections** should be recognised and treated as a **high priority**.



Scalp Tinea



Nail tinea



Skin tinea



Treat Tinea – Skin (tinea corporis)

For small patches

- **Terbinafine 1% cream – twice a day for 2 weeks** or until resolved completely.

OR

- **Miconazole 2% cream – apply twice a day for 4 to 6 weeks** and for **2 weeks after rash is cleared.**

For refractory tinea following skin scrapings:

Use itraconazole and seek expert advice re dosing from infectious diseases specialist or dermatologist.

For widespread rash

- **Oral terbinafine*** once a day for 2 – 4 weeks
- **Oral fluconazole** 150mg once a week for 6 weeks (for adults)
- **Oral griseofulvin*** once a day for 2-4 weeks, and continue for 1-2 weeks after resolution



Take skin scraping to confirm the diagnosis

Discuss treatment with oral terbinafine with a doctor

*See page 36 for weight-band dosing.

Treat Tinea – scalp & nails

Tinea of the scalp (tinea capitis)

- **Oral terbinafine***, once a day for 4 - 6 weeks, or until resolved
- **Oral griseofulvin*** once a day for 4 - 8 weeks or until resolved
- If terbinafine isn't tolerated, **oral itraconazole** or **oral fluconazole** may also be effective
- **Antifungal shampoo e.g. ketoconazole** in conjunction with oral treatment may limit the spread scalp ringworm

✓ Take hair pluck to confirm the diagnosis, and after treatment if uncertainty persists regarding clinical resolution

Tinea of the nails (onychomycosis)

- **Oral terbinafine*** once a day for 6 weeks (fingernails) or 12 weeks (toenails)
- **Oral griseofulvin*** once a day for at least 4 months (fingernails) or 6 months (toenails)

✓ Take nail cutting to confirm the diagnosis
Combinations of topical therapy and oral therapy are **NOT** recommended

*See page 36 for weight-band dosing.

Treat Tinea

Table 8. Oral terbinafine dosing

Weight Band	Dose — 1 tablet contains 250mg of terbinafine
10 - < 20kg	$\frac{1}{4}$ tablet (62.5 mg) once daily
20 - < 40 kg	$\frac{1}{2}$ tablet (125 mg) once daily
≥ 40 kg	1 tablet (250mg) once daily

*If possible, wait until after pregnancy and breastfeeding before treating.
Note: splitting tablets worsens the bitter taste of terbinafine for children. This may be masked with chocolate flavourings e.g. Nutella or chocolate syrup.

Table 9. Oral griseofulvin dosing

Age Group	Dose
Children 1 month > 12 years	10-20mg/kg (to a maximum of 500mg) once daily. If using the higher dose, reduce dose when clinical improvement occurs.
>12 years to 18 years	500 mg daily. Up to 1 gram daily can be used for severe infections; reduce dose once response occurs.
Adults	500 mg daily. Up to 1 gram daily can be used for severe infections; reduce dose once response occurs.

*Griseofulvin should be administered with a high fat meal or milk to increase absorption and reduce stomach upset. **Oral Griseofulvin can be compounded as a liquid (250mg/mL) for patients who do not tolerate tablet formulation.

Treat Tinea

Precautions for oral terbinafine

Serious side effects can develop after 4 weeks of treatment:
Treatment lasting > 2 weeks needs medical supervision and blood testing

Individual Factors

Action

- > 40 years-old
- Acute or chronic liver disease
- Kidney disease
- High alcohol consumption

- Check FBE, U&E and LFT before treatment
- If LFTs abnormal – retest after 2 weeks of treatment
- If LFTs worsen – consider giving half usual dose
- Retest LFTs, FBE and E&U again after another 2 weeks

Adult with no risk factors

Check FBE, U&E and LFT after 2 weeks and then after every 4 weeks of treatment

Child on treatment >4 weeks

Check FBE, U&E and LFTs at 4 weeks

Child with medical co-morbidities

Check FBE, U&E and LFTs at 2 weeks

If symptoms of **low white cell count** or **liver toxicity**
 (i.e. fever, nausea, jaundice, abdominal pain, sore throat)

Cease medication and check LFTs, U&E and FBE

Treat Tinea

Precautions with all oral anti-fungal agents

ALL oral anti-fungal agents have potential drug interactions and a thorough drug interaction screen should be performed prior to their prescription.

Many oral anti-fungal agents should be avoided during pregnancy and breastfeeding – check product information

Blood tests should be completed at onset and every 4 weeks of treatment

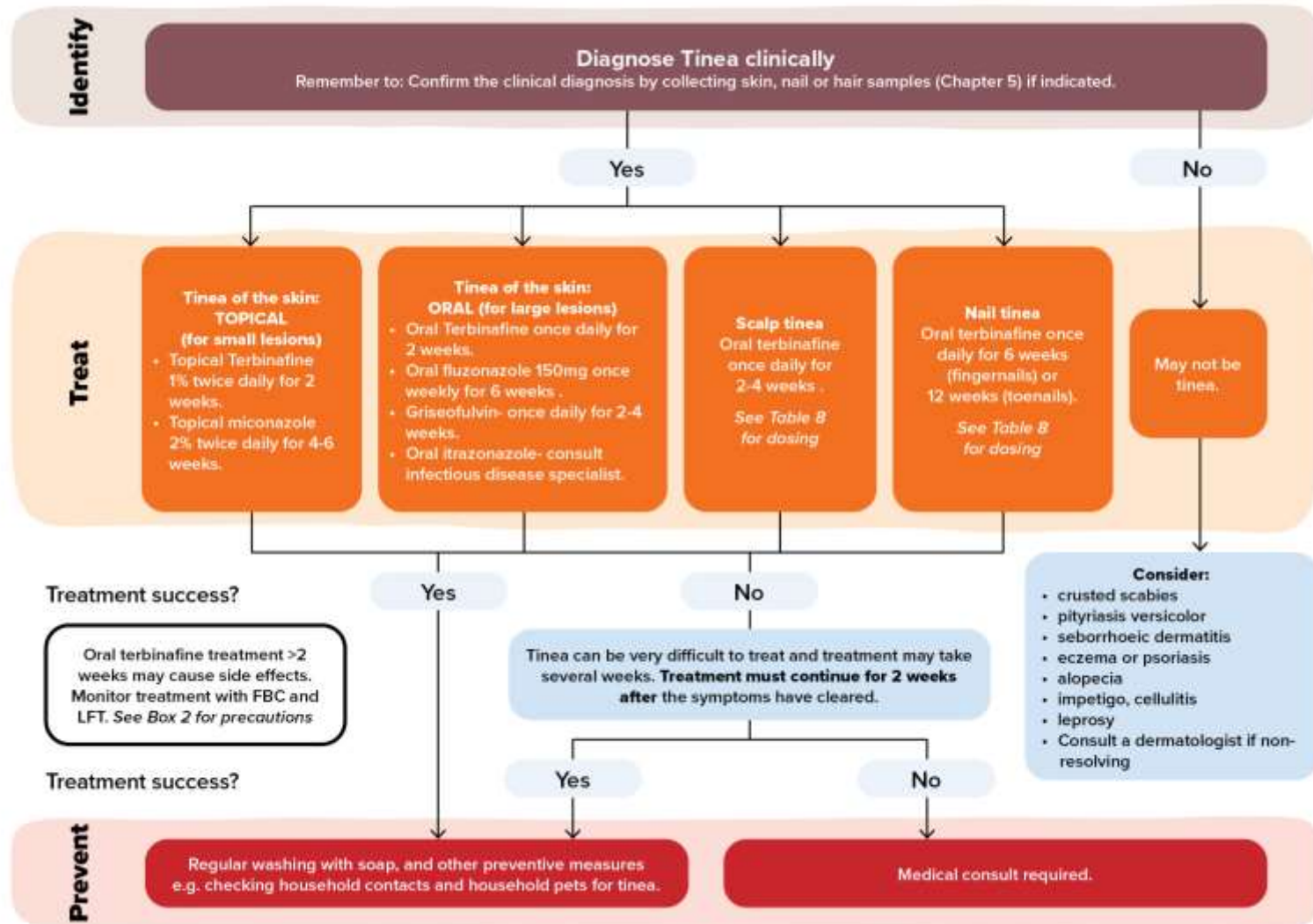
Individual Factors	Action
Severe liver disease	Terbinafine, griseofulvin and fluconazole are contra-indicated Itraconazole is the preferred oral agent; ● Seek specialist advice
Renal insufficiency	Terbinafine dosing needs adjusting down ● Seek specialist advice

Prevent Tinea

- **Anti-fungal soap is recommended** as an adjunct to treatment as a preventative measure against tinea
- **Check household or community pets** for tinea
- **Avoid sharing clothes, bedding, hair combs and hats** with people with tinea of the skin or scalp



Tinea Algorithm



5. Fungal Infections

– Pityriasis Versicolor “white spot”

- Common skin fungal infection
- Usually not itchy but appearance may be distressing
- NOT contagious!



Look for:

- Multiple pale oval to round patches, often quite spread out
- Finer scale than tinea
- Not raised & often not itchy



Treat Pityriasis Versicolor

- ◉ **Ketoconazole 2% shampoo** – rub on affected skin and leave for 3 to 5 minutes than wash off. Do once a day for 5 days.
- ◉ AND shampoo hair every day for 1 week

OR

- ◉ **Selenium sulfide 2.5% shampoo** – rub on affected skin, leave on for 10 minutes then wash off. Do once a day for 7 -10 days or until resolved.
- ◉ AND shampoo hair every second day for 2 weeks

OR

- ◉ **Econazole 1% foaming solution** – apply to wet skin at night, leave on overnight and wash the next morning. Repeat for 3 nights.



Take skin scraping to confirm the diagnosis

If infection doesn't respond to treatment, use fluconazole 400 mg orally, as a single dose

NOTE: No scale means treatment has worked. It may take several months for colour to return to skin even after successful treatment. Repeat treatment if necessary as it can often come back even after successful treatment.

Prevent Pityriasis Versicolor

- Avoid sharing towels and bedlinen
- To prevent reoccurrence, continue with a maintenance regimen of Econazole 1% foaming solution performed 1 night per month, or Selenium sulfide 2.5% / Ketoconazole 2% shampoo used fortnightly.



6. Atopic Dermatitis “Eczema”

- Very itchy inflammatory skin condition
- May be accompanied by other atopic conditions e.g., asthma, allergic rhinitis



Look for:

- Dry skin, scratch marks & redness on:
 - *Facial, neck, & extensors in infants & children.*
 - *Flexural lesions in any age group.*
- Lesions often spare the groin & axilla.

Treat Atopic Dermatitis

Mild to moderate

- Apply moisturiser daily in a thick layer
- Use soap-free cleansers
- If not responding, apply topical corticosteroids twice daily until skin is smooth and itch-free
- Where topical corticosteroids have failed, in patients more than 3 months old **Pimecrolimus 1% cream** is recommended for maintenance treatment on face or eyelids
- Antihistamines are **not recommended**

Moderate to severe/refractory

- Refer to specialist dermatology service
- Wet-wrap therapy with topical corticosteroids is recommended
- Dilute bleach baths may be used to prevent recurrent skin infections
- Check serum Vitamin D levels to ensure they're within the recommended range



Treat associated bacterial infections
Do not use topical antibiotics

Treat Atopic Dermatitis

Moisturising recommendations for AD

Regularly applying moisturizer will improve the skin barrier

- Apply immediately after washing to damp skin, then pat dry
- Apply to whole body, including the face, once to twice daily
- The drier the skin, the thicker the moisturiser should be
- Avoid products containing food-derived proteins and fragrance

Ointments

- Thicker
- Don't contain preservatives, so are less likely to sting

Creams & Lotions

- More watery and thin
- Often contain alcohol as preservative, which can sting
- May be more comfortable in hot and humid seasons and on hairy skin

Treat Atopic Dermatitis

Topical corticosteroid potency

Potency	Suitability	Application	Corticosteroid options
Low (mild corticosteroids)	flaring AD over the eyelids	1-2 times daily until the skin is smooth and itch-free, followed by a slow taper to the minimal effective dose.	Hydrocortisone acetate 1% ointment or cream (30g or 50g tube)
Medium (moderate corticosteroids)	flaring AD over the face, neck and skin folds	1-2 times daily until the skin is smooth and itch-free, followed by a slow taper to the minimal effective dose.	Methylprednisolone aceponate 0.1% fatty ointment, ointment or cream (15 g tube) * Methylprednisolone aceponate 0.1% lotion (20mL bottle) **
High (potent corticosteroids)	flaring AD over the torso and limbs	1-2 times daily until the skin is smooth and itch-free, followed by a slow taper to the minimal effective dose (not for use on the face or skin folds).	Betamethasone dipropionate 0.05% ointment or cream (15g tube) * Mometasone furoate 0.1% ointment or cream (15g tube) * Mometasone furoate 0.1% ointment or cream (50g tube) Mometasone furoate 0.1% lotion (30mL bottle) **

* PBS streamlined authority numbers exist for prescription of increased quantities of these topical corticosteroids for corticosteroid-responsive dermatoses, such as atopic dermatitis (AD). See page 71 of the National Healthy Skin Guidelines, 2nd ed.

Topical corticosteroid lotions are generally only prescribed for atopic dermatitis affecting the scalp.

Treat Atopic Dermatitis

Wet dressings

- ✓ Wet dressings are best applied at night before bed and usually help with better sleep.
- ✓ Apply every night until the eczema clears, and then every second night for one week after.

How to apply wet dressings:

- 

1 After bathing, pat dry the skin.
- 

2 Apply cortisone ointment to all eczema areas on the face and body.
- 

3 Put cotton clothes in a bowl of lukewarm water then wring them out.
- 

4 Put the wet layer of clothing on your child.
- 

5 Put a dry layer on top.
- 

6 Leave the wet wraps in place for 20 mins.
- 

7 Remove wet wraps.
- 

8 Apply moisturiser to the whole body and face after the wet wraps are removed.

Treat Atopic Dermatitis

Bleach baths reduce the amount of bacteria on the skin. They may be recommended to treat children with infected eczema and children who have repeated skin infections. Bleach baths are often used in combination with other eczema treatments.

What you will need

- ✓ Unscented bleach (containing 4.2% sodium hypochlorite) e.g. White King bleach
- ✓ 10L bucket
- ✓ 12mL measure (20mL syringe or measuring cup) **OR** ¼ measuring cup depending on which of the recipes you choose to use
- ✓ Bath oil (1 capful of bath oil can be added if the skin feels very dry)
- ✓ Fresh clean towels

The image contains a 3x3 grid of nine numbered steps, each with an illustration and a text box:

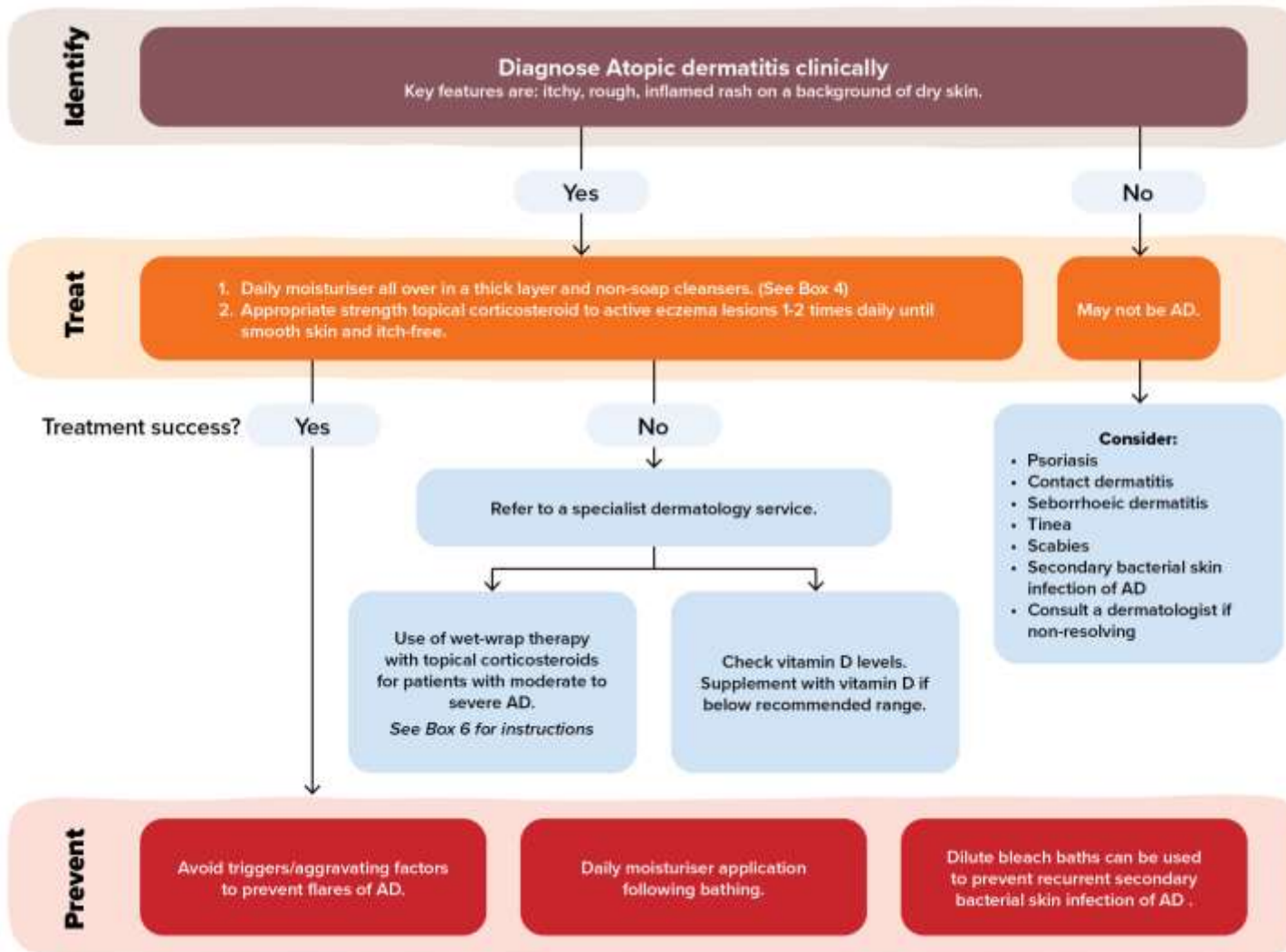
- 1** **oil**: Illustration of a yellow cap being poured into a green bath tub. Text: "Fill a standard sized bath tub to half full of lukewarm water. 1 capful of bath oil can be added if the skin feels very dry."
- 2** **bleach**: Illustration of a white cap being poured into a green bath tub. Text: "Add 1/4 cup of White King bleach **OR** Add 12mL of White King bleach to every 10L of water."
- 3**: Illustration of a child in a green bath tub washing their face. Text: "Wash the face and scalp while in the bath avoiding the eyes."
- 4**: Illustration of a child in a green bath tub wiping their skin with a yellow cloth. Text: "Gently wipe any crusts off the skin while in the bath."
- 5**: Illustration of a child standing and looking at their skin. Text: "Your child can soak in the bath for up to 10 mins, no longer."
- 6**: Illustration of a child in a green bath tub. Text: "You do not have to rinse after bathing."
- 7**: Illustration of a child standing with a towel. Text: "Use a fresh towel to pat the skin dry."
- 8**: Illustration of a child applying cream to their skin. Text: "Apply moisturiser to the whole body and face as soon as your child gets out of the bath and is dry."
- 9**: Illustration of two children, one applying cream to the other's skin. Text: "If a cortisone ointment has been prescribed, apply it to all eczema areas as directed before the moisturiser."

Prevent Atopic Dermatitis

- Have a short bath or shower once a day using warm (not hot) water (5-10 minutes).
- Avoid using soap. Use bath oil and a soap-free wash.
- Beware that using bath oil, can make the bath very slippery.
- After bathing/showering, pat dry the skin and apply moisturiser all over.
- Avoid scratching the skin and keep fingernails short.
- Avoid triggers to prevent flares of atopic dermatitis, including:
 - Soaps, shampoos, shower gels and bubble baths,
 - Prickly or rough clothing (including wool),
 - Overheating, overdressing, sweat, friction,
 - Direct contact with grass and sand,
 - Prolonged exposure to chlorine and salt water or
 - Emotional stress.



Atopic Dermatitis Algorithm



7. Headlice

- Bloodsucking insects living on the scalp
- Spread between people as well as objects like combs
- Asymptomatic or itchy scalp

Look for:

- Moving adult lice in good light
- Brown or white eggs stuck on hair near the scalp
- Sores on scalp



Treat Headlice

- A combination of **topical treatment** and **thorough combing of the hair** is needed:
- Topical treatments:
 1. **Topical permethrin shampoo**. Repeat treatment after 1 week
 2. OR **Dimethicone 4%** – if using the lotion, leave on for 8 hours, rinse with warm water. If using the fast-acting gel, leave on for 15 mins, rinse with warm water. Repeat treatment after 1 week
 3. OR **Malathion 0.5% shampoo** – leave on for 12 hours, rinse with warm water. Repeat treatment after 1 week
 4. OR **Malathion 1% foam**, leave on for 30 mins, rinse with warm water. Repeat treatment after 1 week
- In between topical treatments, rub a thick layer of conditioner through dry hair, comb hair with headlice comb to remove live lice and eggs.

**For refractory headlice or when topical treatment is unavailable:
oral ivermectin may be used for children over the age of 5
(or over 15kg) and for non-pregnant, non-breastfeeding adults**

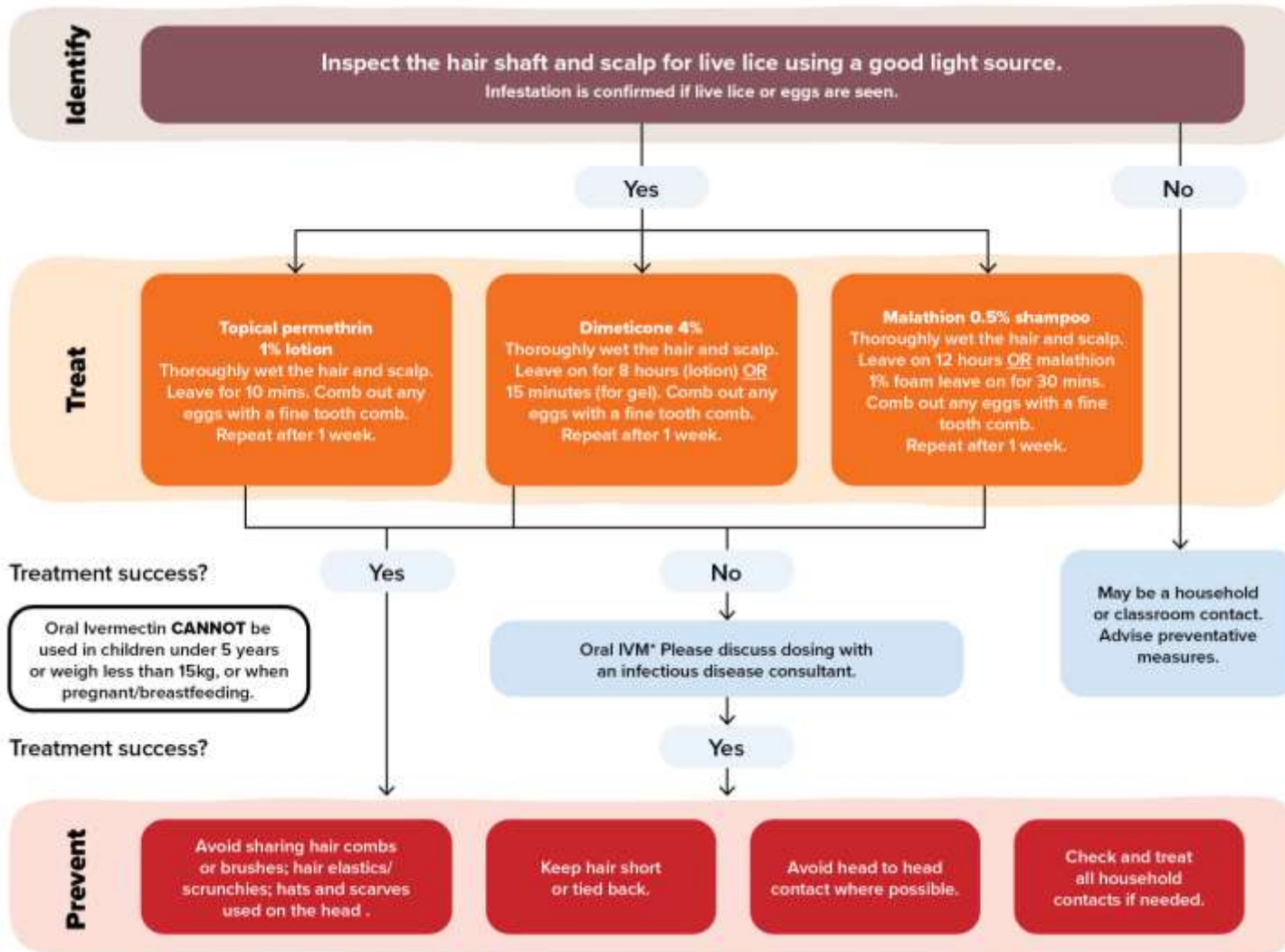
Please seek advice on dosing from an infectious diseases specialist

Prevent Headlice

- Avoid sharing hair combs or brushes, hair elastics, hats and scarves used on the head
- Keep hair short or tied back
- Avoid head-to-head contact where possible
- When head lice are found in one household member, check other household members



Headlice Algorithm



8. Molluscum contagiosum (MC)

MC is highly infectious so accurate diagnosis and advice on prevention is also a priority.

- Common viral infection caused by the Molluscum contagiosum virus
- Contagious, spreads via skin-to-skin contact and especially wet surfaces (bath, swimming pool, damp towels)
- Usually asymptomatic, but can be itchy and induce eczema or bacterial infections



Look for:

- Small skin-coloured, umbilicated (central dimple) papules
- Usually 1 -3 mm in diameter, but can grow to 10cm
- Usually found where there is skin-to-skin contact
- Average number is 30, but it can be in the hundreds

Treat Molluscum Contagiosum

MC will usually self-resolve within 3 months and 3 years.

General recommendations:

- Keep nails short and hands clean
- Shower, rather than bath
- Avoid sharing towels/clothing/linen
- Avoid swimming in heated pools
- Keep lesions covered with clothing or bandages
- Moisturise the skin daily
- Lesions often become inflamed but antibiotic treatment is usually not required

Prevent Molluscum Contagiosum

- Molluscum contagiosum can spread to other parts of the body or to siblings through **shared bathwater and towels**.
- **Counsel family about household activities** to prevent transmission.
- The **lesions will self-resolve in time** but may be troubling or become secondarily infected.



9. Health Promotion Resources

Alongside accurate and timely diagnosis and treatment of skin infections, health promotion activities to improve health literacy and to enhance recognition of skin conditions will help prevent further infections.

When developing healthy skin resources, adopting a co-design approach with genuine community involvement is highly recommended.

To access community-driven healthy skin promotion resources, please see the Telethon Kids Institute website



SCAN HERE



9. Health Promotion Resources



8:48 - Merredin 'Gotta Keep It Strong'

Merredin "Gotta Keep It Strong"



SCAN HERE



8:48 - Merredin 'Gotta Keep It Strong'



3:08 - Hip Hop 2 STOp

Hip Hop 2 STOp



SCAN HERE



3:08 - Hip Hop 2 STOp



1:00 - Moorditj Skin Means Moorditj Health

Moorditj Skin Means Moorditj Health



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