PATIENT INFORMATION LEAFLET

IMPETIGO

WHAT IS THE AIM OF THIS LEAFLET?

This leaflet has been written to help you understand more about impetigo. It tells you what it is, what causes it, what can be done about it, and where you can find out more about it.

WHAT IS IMPETIGO?

Impetigo is a contagious bacterial infection (type of germ) of the surface of the skin. In the UK, it is the most common skin infection seen in young children. However, it may be seen in people of any age.

WHAT CAUSES IMPETIGO?

Bacteria that are known to cause impetigo are the *Staphylococcus* or *Streptococcus* bacteria. These germs pass from person to person by skin-to-skin contact. These germs can also be spread by everyday objects, such as bedding, clothing and towels.

Impetigo can spread rapidly through families and school classes. The bacteria that cause impetigo often appear in damaged skin as well as healthy skin. This can be from cuts or grazes, bites, cold sores, psoriasis or eczema. People with diabetes or low immunity (meaning weak immune systems) are more susceptible to getting impetigo.

Impetigo is more common in warm and humid weather.

IS IMPETIGO HEREDITARY?

No. Whilst you may catch impetigo from a close family member, it is not inherited.

WHAT DOES IMPETIGO FEEL AND LOOK LIKE?

Impetigo normally makes small patches of skin red, sore, and crusty or scabby. Sometimes it is itchy. It may cause tender swelling of the glands in your neck. It is unusual to have a fever or feel very unwell.

Impetigo can appear anywhere but is most common around the nose, mouth, and hands. Impetigo rash usually starts as a rash of small, fluid-filled blisters. These can burst, leaving red sores covered with yellow/golden/brownish crusts.The patches are often small (less than 1cm) but can slowly get bigger. Impetigo can spread easily, causing it to appear at new locations. Smaller 'satellite' patches may also appear.

Less commonly, impetigo may present with larger loose blisters which leave large red sores when they burst. This is known as bullous impetigo. This is more common in people who have another skin condition, like eczema or psoriasis. Rarely, impetigo may cause deep breaks in the skin, resulting in ulcers (areas where the full thickness of skin is lost). This is known as ecthyma.

As the patches clear up, the crusts fall off and the areas should heal without leaving scars. There may be temporary redness or altered skin pigment in the affected areas.

HOW WILL IMPETIGO BE DIAGNOSED?

The diagnosis is commonly based on the way the rash looks and the way you feel in yourself and can be made by school nurses and pharmacists for example. They may check to see if you have another skin condition, such as scabies or eczema. If you do have an underlying health condition or feel poorly, they may suggest you seek

advice from another healthcare professional such as your GP.

Treatment should be started immediately. If your rash is worsening or if you get recurrent episodes, a swab of the skin and from your nose may be sent.

CAN IMPETIGO BE CURED?

Yes. Impetigo usually clears within a few days of starting treatment. If you do not have any treatment, it normally settles on its own. If you have an underlying skin problem, this may be treated as well, to ensure the impetigo goes away.

HOW CAN IMPETIGO BE TREATED?

The first thing is to make sure the affected areas are regularly cleaned with water and anti-bacterial skin wash. It is also important to wash your hands regularly, especially after touching patches of impetigo.

Antiseptic creams such as hydrogen peroxide 1% cream can be applied 2-3 times per day for 5 days to the affected patches of skin if you are otherwise well. Different antiseptics are available for purchase in pharmacies.

If there are large areas of the skin affected, an antibiotic cream such as fusidic acid 2% or mupirocin 2% (3 times a day for 5 days) can be used instead. This can be increased to 7 days if needed. However, the bacteria can be resistant to certain antibiotics and so antiseptics are better if you can use those.

If you have widespread impetigo (multiple patches across the body) or feel unwell in yourself, a 5-day course of oral antibiotics such as flucloxacillin, clarithromycin or erythromycin may be recommended. This would be instead of any creams. Oral antibiotics are very rarely needed for impetigo.

If the treatment does not work or your impetigo recurs, it is important to see a healthcare professional for alternative treatment. In this case, a skin swab may be sent to look for the bacteria that is causing your impetigo and see what antibiotics it is sensitive too.

WHAT CAN BE DONE TO REDUCE THE SPREAD OF IMPETIGO?

There are lots of things you can do to help your impetigo heal quicker and stop other people from catching it.

- Avoid touching patches of impetigo and stop other people touching them too.
- Regularly wash your hands with soap and always wash them after accidentally touching an infected area. Ask other people to do the same.
- Wash your hands before and after putting the cream or ointment on the impetigo.
- Be careful with your creams. Use a clean spoon or cotton wool bud to remove cream then apply with clean hands. Then either wash your spoon or discard your cotton wool bud before taking any more cream out.
- Do not share towels, flannels or similar until the infection has cleared. Always use a clean cloth each time to dry the affected area.
- Towels, pillowcases, and sheets should be changed and washed on the hottest setting (at least 60 degrees). Clothing and bedding should be washed and changed daily during the first few days of treatment.
- Children with impetigo should be kept off school or nursery until affected areas have healed or 48 hours after starting antibiotic treatment.
- It is fine to continue with your normal bathing and skin care routine.

WHERE CAN I GET MORE INFORMATION ABOUT IMPETIGO?

Web links to other relevant sources:

patient.info/childrens-health/impetigo-leaflet

medlineplus.gov/impetigo.html

www.dermnetnz.org/topics/impetigo

Please note that the British Association of Dermatologists (BAD) provides web links to additional resources to help people access a range of information about their treatment or skin condition. The views expressed in these external resources may not be shared by the BAD or its members. The BAD has no control of and does not endorse the content of external links.

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

BRITISH ASSOCIATION OF DERMATOLOGISTS

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