

key points

SELECTED BY

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Impetigo is a common contagious bacterial infection of the skin. The causative organisms are either *Staphylococcus aureus* or, less commonly, *Streptococcus pyogenes*.

The infection can occur at any age, but it is particularly common in children, especially the pre-school and early school age years, and tends to be more frequent during the summer months. It may arise on previously normal skin or complicate a pre-existing dermatosis, in particular eczema, herpes simplex infection, insect bites and scabies. Impetigo is usually transmitted by interpersonal contact or via fomites, but an individual may harbour the bacteria on the skin, particularly in the anterior nares or on the perineum.

The more common non-bullous form is the result of either staphylococcal or streptococcal infection, or both.

The bullous form is caused by exfoliative (epidermolytic) toxin-producing strains of *Staphylococcus aureus*.

The non-bullous form typically presents as a moist or exudative area of skin, progressing to the formation of a golden or honey-coloured crust. The crust eventually dries up and separates initially leaving erythema which gradually fades but scarring tends not to occur. Bullous impetigo presents as one or more flaccid blisters containing a turbid liquid. The blisters usually rupture quickly to leave an erosion with a rim of scale. Healing follows the same course as in non-bullous impetigo.

The diagnosis of impetigo is essentially a clinical one,

but if in doubt a swab should be taken for bacteriological culture. In patients with recurrent impetigo, carriage of potentially pathogenic bacteria should be excluded, and consideration given to excluding carriage in family members or close contacts. Good hygiene measures help to prevent the spread of impetigo to other areas of the body and other people. Affected children should be kept away from school and childcare facilities until the impetigo has healed or until 48 hours after initiation of antibiotics.

The first line of treatment for localised non-bullous impetigo

in an otherwise well patient is a topical antiseptic; hydrogen peroxide 1% cream is recommended. If this is unsuitable or ineffective, a short course of topical antibiotics should be offered such as fusidic acid 2% cream or mupirocin 2% cream/ointment. Those who are systemically unwell or at high risk of complications and patients with bullous impetigo should be offered a short course of oral antibiotics (flucloxacillin, clarithromycin or erythromycin) initially.

In frequently recurring impetigo skin and nasal swabs should

be sent for microbiological testing. If carriage is confirmed, a decolonisation regimen is recommended. Patients with symptoms and signs of a complicating condition, such as cellulitis or sepsis, immunocompromised patients with widespread impetigo, and those failing to respond to treatment should be referred. Referral should also be considered for bullous impetigo, particularly in babies, frequently recurring impetigo, patients who are systemically unwell, and those at high risk of complications.