



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 bacterial infection of the surface of the skin. In the UK it is the most common skin infection seen in young children.

What causes impetigo?

In the UK, impetigo is usually due to a germ known as *Staphylococcus aureus*; in hot climates it may be due to *Streptococcus pyogenes*, or to a mixture of the two. These germs pass from person to person by skin-to-skin contact or less often by bedding, clothing and towels. Impetigo can spread rapidly through families and school classes, however it can spontaneously appear with no link to where it came from.

Methicillin-resistant *S. aureus* (MRSA) can also cause impetigo; this can be hospital or community acquired.

The germs that cause impetigo can invade normal skin, but more often take advantage of skin that is already damaged by cuts or grazes, insect bites, head lice, scabies, cold sores, or eczema.

There are also other general diseases where the patients can be more susceptible to get impetigo, for example, diabetic patients, patients on medications to suppress the immune system, HIV infection, after surgery and after radiation therapy.

Impetigo is more common in warm humid weather.

Is impetigo hereditary?

No.

What are the symptoms?

Impetigo can make the skin sore and itchy, but the infection does not usually make you feel ill.

What does impetigo look like?

Impetigo can crop up anywhere, but is most common on exposed areas of skin such as the face (around the nose and mouth) and on the hands. It starts as a rash of thin-roofed pus-filled blisters, which tend to break easily to leave round oozing patches covered with yellow or brownish crusts. The patches are small at first (e.g. half a centimeter or so across), but slowly get bigger. Smaller patches can arise nearby, and may enlarge too.

Impetigo can also present with blisters that appear in normal looking skin; it is called bullous impetigo and is caused exclusively by *S. aureus*.

As the patches clear up, their crusts fall off and the areas heal without leaving scars, although there may be temporary redness.

How will impetigo be diagnosed?

Your doctor will base the diagnosis on the way the rash looks, and will check to see if it has come up on top of another skin condition, such as scabies. A swab from a crusted area may be sent to the laboratory to see which germ is causing the impetigo and which antibiotic is most likely to help; however, treatment should not wait until the results are received. If you are getting recurrent episodes of impetigo, your doctor may take a swab from your nose to see if the infective bacteria are harbouring there.

Can impetigo be cured?

Yes. Usually it clears in a few days with treatment and 2 to 3 weeks without treatment but it will not do so if it is based on an unrecognised underlying skin problem such as scabies or head lice (see above). Such additional skin problems will also need addressing and treatment.

How can impetigo be treated?

The first step is to remove the crusts gently and regularly - antibacterial soap and water is as good for this as anything else.

You can then rub an antibiotic cream, or ointment, onto the patches and the skin around them, two or three times a day, until they clear up (usually in 7 to 10 days). Mupirocin or fusidic acid are often used for impetigo, and unlike some other antibiotic creams they seldom cause allergy; however, the bacteria that cause impetigo are becoming less likely to respond to them than in the past. For that reason, creams containing antiseptics such as povidone iodine, [hydrogen peroxide](#) cream or chlorhexidine may be recommended.

Your doctor will decide whether you need a course of oral antibiotic tablets as well as the antibiotic ointment. This approach may be used if your impetigo is extensive, slow to get better with antibiotic applications alone, or keeps coming back. Flucloxacillin, erythromycin and cephalexin are all effective and are taken for at least 7 days. Penicillin can be added to the treatment if your impetigo is due to a streptococcal infection.

What can I do?

Your main aim must be to stop the impetigo spreading to other people, and especially to newborn babies:

- Do not touch patches of impetigo, and stop other people touching them too.
- Hygiene is important - always wash your hands after accidentally touching the area (and ask other people to do the same).
- Wash your hands after putting the antibiotic cream or ointment on the impetigo.
- Don't share towels, flannels etc. until the infection has cleared. Always use a clean towel each time the affected area is dried.
- To prevent the spread of germs, the patient's towels, pillowcases, and sheets should be changed and laundered (either at 60°C (140°F), or 40°C (104°F) with the addition of a bleach-based laundry product) after the first day of treatment; clothing should be changed and laundered daily (see above) for the first few days.
- Children with impetigo should be kept off school or nursery for a few days until blisters and crusting have gone.

Where can I get more information about impetigo?

Links to patient support groups:

www.prodigy.nhs.uk/guidance.asp?gt=impetigo#managementissues

Web links to detailed leaflets:

www.nlm.nih.gov/medlineplus/impetigo.html

www.dermnetnz.org/dna.impetigo/impet.html

For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

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: its contents, however, may occasionally differ from the advice given to you by your doctor.

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

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