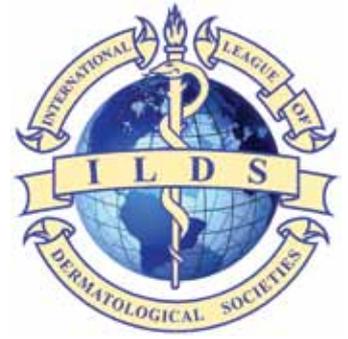


# Community Dermatology Journal



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## HIFA and Community Dermatology Journal



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### Healthcare Information for all (HIFA) links over 6,000 healthcare professionals, libraries and publishers in 167 countries.

We are pleased to announce that Community Dermatology Journal has been welcomed as a supporting organization to this global initiative, which was first established in 2006 at the 10th Congress of the Association for Health Information and Libraries in Africa, in Mombasa, Kenya. HIFA's strategy is based on a shared vision of a world where no-one dies for lack of healthcare knowledge. It aims to achieve this via three main routes;

- 1) Through dynamic global email **forums** for discussion, in collaboration with the World Health Organization and other interested parties. HIFA's five global forums (HIFA2015, CHILD2015, HIFA-Portuguese, HIFA-EVIPNet-French, and HIFA-Zambia) collaborate with WHO, International Child Health Group, International Society for Social Paediatrics and Child Health, and also with the Zambia UK Health Workforce Alliance.
- 2) Through "HIFA Voices"; a **knowledge base** that harnesses the collective intelligence of HIFA members about information needs and how to meet them. The HIFA Voices prototype has already been used to inform WHO policy guidelines and HIFA aims to launch the resource publicly later in 2013.
- 3) Through **Advocacy**. In collaboration with the New York Law School, HIFA supports the rights of health professionals and lay individuals to unrestricted access to healthcare information, by challenging governments to fulfil their legal obligation to provide access to this information for their citizens and health workers.



**Distributing Community Dermatology Journal at Dabat Health Centre, Ethiopia** Photo: Chris Lovell

The aims and objectives of HIFA are in accord with those of Community Dermatology Journal, which is distributed free of charge to healthcare workers worldwide, especially in rural communities and resource-poor settings. We encourage all readers to join: [www.hifa2015.org](http://www.hifa2015.org)

### Contents

- 1 Lead Article**  
**HIFA and Community Dermatology Journal**  
*Neil Pakenham-Walsh, Michele Murdoch, Christopher Lovell*
- 2 Recommended Treatment for Sexually Transmitted Infections, 2013** *Michael Waugh*
- 7 The Complications of Scabies** *Daniel Engelman & Andrew Steer*
- 6 Book Review - Dermatological Preparations for the Tropics** *Claire Fuller*

# Recommended Treatment for Sexually Transmitted Infections, 2013

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## AIMS

These recommendations are based on recent advice from USA CDC (Centers for Disease Control and Prevention) STD (Sexually Transmitted Disease) Treatment Guidelines, UK BASHH (British Association for Sexual Health and HIV) and IUSTI (International Union against Sexually Transmitted Infections) Guidelines. All are accessible on the Web (see end of article). The advice given is concise and the main source of reference is attributed. (e.g., CDC; IUSTI)

For treatment for HIV advice may be found on the Web. BHIVA (British HIV Association)-Clinical Guidelines are recommended, though primarily established for advice to clinicians in United Kingdom.

## GENERAL ADVICE

The oft repeated phrase, "Education, Education, Education," is the key to PREVENTION and SAFER SEX. All STDs are preventable. Preventive education needs to be continuous, assessable and aimed at specific parts of the population, mainly the sexually active young person. It needs to be understandable. It needs to tell where persons can go for advice and treatment, which in the case of STDs needs to be free. It needs to get the message across that all men for any act of sexual penetration at any casual encounter need to know how to and use a CONDOM (SAFER SEX), which also need to be freely available at any place where people have social/sexual encounters. PARTNER NOTIFICATION is necessary to prevent infection to known sexual partners.

I am going to add some tips that I have learned over 43 years of working in STDs to prevent pitfalls. These will be found throughout the text.

STDs are transmitted by the same route as HIV. For 30 years it has been realised that STD transmission facilitates HIV. At the same time as treatment for STD basic awareness needs to be given to the patient about HIV PREVENTION (SAFER SEX). Where facilities allow, HIV TESTING and SCREENING SEROLOGY for SYPHILIS should be performed.

## GONORRHOEA (Figs 1,2)

### WHY THE URGENCY FOR NEW TREATMENT ADVICE?

Simple, the resistance of *Neisseria gonorrhoeae* to antibiotics recommended for its treatment over the last 50 years has spread to all parts of the world. Resistance is found to penicillins, tetracyclines, macrolides and fluoroquinolones as well as in the last 5 years to cephalosporins (ceftriaxone and cefixime). There is a WHO Global Action Plan to control the spread and impact of antimicrobial resistance in *Neisseria gonorrhoeae* (1). Since a report from Japan in 2011 (2), resistance to ceftriaxone and cefixime has been reported from many referral centres in Europe and elsewhere.

### TREATMENT

Treatment advice abstracted from IUSTI (November 2012) is; CEFTRIAZONE 500mg intramuscularly (IM) as a single dose together with AZITHROMYCIN 2g as a single oral dose; the second antibiotic is not given to treat gonorrhoea but concomitant Chlamydial infection. It is realised there may be gastric upset. However there is realisation that AZITHROMYCIN RESISTANCE is building up in the World. So it may be more prudent to substitute DOXYCYCLINE 100 mg twice daily for 7 days.



Fig 1. Gonorrhoea in the male - urethritis Photo: Mike Waugh



Fig 2. Gonococcal cervicitis but it can have very few clinical signs Photo: Mike Waugh

Alternatives are;

1. CEFIXIME 400mg oral as a single dose together with DOXYCYCLINE 100mg twice daily for 7 days or AZITHROMYCIN 2g as a single dose. This is only to be used if Ceftriaxone is unavailable or injectable antimicrobials not possible or refused.
2. SPECTINOMYCIN 2g IM together with DOXYCYCLINE 100mg twice daily for 7 days or AZITHROMYCIN 2g orally as a single dose if resistance to cephalosporins is suspected or there is a history of penicillin anaphylaxis or cephalosporin allergy.

As co-infection with *Chlamydia trachomatis* is frequent, either DOXYCYCLINE (100mg twice daily for 7 days) or AZITHROMYCIN 2g orally should be given. But please remember growing resistance of *N.gonorrhoeae* to AZITHROMYCIN despite the ease of one-off treatment under supervision.

In Malawi, GENTAMICIN 240mg IM as a single dose with AZITHROMYCIN 2g orally or DOXYCYCLINE 100mg bd for 7 days has been used successfully for some years in syndromic management. (3)

The author realises that in many centres follow up tests of cure, as recommended at 1 week, will not be possible.

ALL KNOWN SEXUAL PARTNERS SHOULD BE TREATED AT THE SAME TIME WITH EPIDEMIOLOGICAL TREATMENT FOR GONORRHOEA, WHICH IS THE SAME AS ABOVE. Gonorrhoea and *Chlamydia trachomatis* have no or few symptoms in women before pelvic inflammatory disease (PID), salpingitis develops.

## CHLAMYDIA TRACHOMATIS (Fig 3)

This is the most frequent cause of Non Gonococcal Urethritis (NGU), or "Non Specific Genital Infection" as described in the text books of 30 years ago. It is probably more frequent in some societies in young people than gonorrhoea.

Treatment (IUSTI) is either DOXYCYCLINE 100mg bd for 7 days or AZITHROMYCIN 2g orally. REMEMBER previous notes about AZITHROMYCIN RESISTANCE. Sexual partners should be treated at the same time.

Care should be taken with pregnancy. Dental discolouration has been noted with the use of tetracyclines (which include doxycycline). The manufacturers of azithromycin state that care should be taken with its use also in pregnancy, but as there is no alternative it may be used in this case.



Fig 3. Chlamydial urethritis (NGU) Photo: Mike Waugh

## LYMPHOGRANULOMA VENEREUM (LGV) (Fig 4)

This STD is caused by *Chlamydia trachomatis* L1, L2, L3 serovars and a variant L2b, the cause of the present outbreak of proctitis and genital ulcer -adenopathy syndrome in men who have sex with men (MSM) in Europe. It is treated with DOXYCYCLINE 100mg orally bd for 21 days. (IUSTI)



Fig 4. LGV showing massive swelling and abscess formation (painless) Photo: Mike Waugh

## SYPHILIS (Fig 5-8)

This is the STD which springs to the mind of most dermatologists in the differential diagnosis of skin disease. However many parts of the spectrum of HIV skin disease must also be considered nowadays. Its course runs; early syphilis (infectious) (Figs 5-7) primary, secondary (Fig 8) and early latent; latent syphilis and sequelae, neurosyphilis, and cardiovascular syphilis; and congenital syphilis.

### TREATMENT

There has been controversy over treatment of late stages, as to whether benzathine penicillin reaches the cerebro-spinal fluid in great enough concentration to kill *Treponema pallidum*. However the CDC treatment advice below is sensible and applicable worldwide.

**Early** (Primary, Secondary and Early Latent); BENZATHINE PENICILLIN G 2.4 million (mega) units IM in a single dose.

**Latent** Syphilis, Neurosyphilis (that may well need further medical investigation), Cardiovascular syphilis; BENZATHINE PENICILLIN G 2.4 million units at 3 doses each at weekly intervals for 3 weeks to a total of 7.2 million units.

If there is allergy to penicillin, alternative treatments (but with not so much clinical evidence for efficacy) are;

DOXYCYCLINE 100mg bd for 14 days

TETRACYCLINE or OXYTETRACYCLINE 500mg (four times a day) (qds) for 14 days.



Fig 5. Penile primary chancre - syphilis Photo: Mike Waugh

**TREATMENT OF SEXUAL PARTNERS**

This is called epidemiological treatment. If they are not found to have obvious syphilis all sexual contacts of early syphilis patients within the last 90 days should be treated the same as for early syphilis.

CDC has a most useful section whose advice should be followed on all STDs in pregnancy.

**PITFALLS AND HINTS**

ALWAYS give intramuscular injections with the patient prone (lying down) and into the upper and outer quadrant of the buttock.

Healthy men are just as likely to faint as anyone else.

ALWAYS have some other member of personnel near by if giving such an injection. You may need help if the subject faints, has a procaine reaction or an anaphylactic reaction. The latter may occur if procaine or lignocaine gets into the gluteal vein and the patient, often a strong man, struggles, gets hysterical and thinks he is going to die.

There should always be (1:1000) adrenaline (epinephrine) present and, if an anaphylactic reaction, immediate subcutaneous injection of 0.5ml 1:1000adrenaline given.

JARISCH HERXHEIMER REACTION. This is an acute febrile reaction more common in the treatment of early syphilis. It usually happens within 24 hours; the patient notices an acute febrile reaction, headache and myalgia. It is treated with antipyretics and usually clears within a few hours. The patient should be told beforehand about its possibility otherwise he may think himself allergic to penicillin. It should be noted by the clinician.



Fig 6. Female primary chancre -syphilis Photo: Mike Waugh



Fig 7. Anal primary chancre painless in male who had sex with a male (MSM) – could easily be missed Photo: Mike Waugh



Fig 8. Secondary syphilis - rash Photo: Mike Waugh

**CHANCROID** (Fig 9)

This is another cause of painful genital ulceration with tender suppurative inguinal glands and is an important differential diagnosis of LGV, Granuloma Inguinale, Primary Genital Herpes and Syphilis. In countries where it occurs in Asia and Africa there will be few laboratory facilities for accurate diagnosis. Its diagnosis will thus be made syndromically.

**TREATMENT (CDC)**

AZITHROMYCIN 1g stat orally or CEFTRIAXONE 250mg IM



Fig 9. Chancroid Photo: Mike Waugh

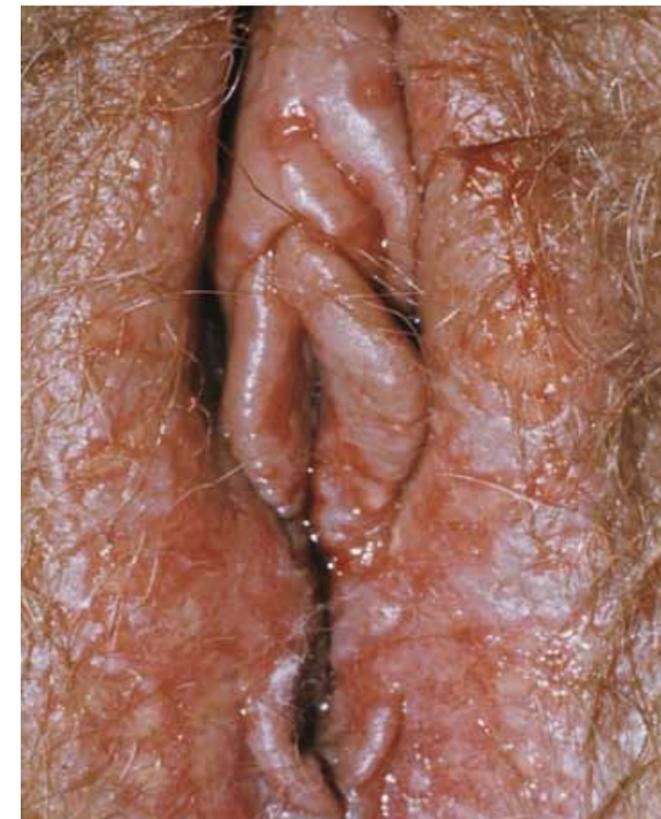


Fig 11. Female – herpes genitalis Photo: Mike Waugh

**HERPES GENITALIS** (Fig 10,11)



Fig 10. Herpes Genitalis - vesicles Photo: Mike Waugh

Advice here is given for a primary or severe attack. In countries where HIV infection is frequent that must be considered as a possible causative factor.

Recurrent attacks are common and advice is given on CDC Guidelines.

**GENERAL ADVICE**

Keep the lesion clean – bathe with saline solution.

**SPECIFIC ADVICE (after CDC)**

Aciclovir 400mg orally three times a day for 7 days

Or Aciclovir 200mg orally five times a day for 7 days.

**VAGINAL DISCHARGE**

It should always be born in mind that infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* may be present, though not the main cause of vaginal discharge. There may be occasions when it is necessary to give epidemiological treatment for those infections (see earlier in this paper).

However three conditions give frequent rise to vaginal discharge, **candidiasis, bacterial vaginosis, and trichomoniasis.**

**TREATMENT OF CANDIDIASIS**

Treatments available in industrialised counties may not be available elsewhere.

NYSTATIN pessaries have been available for at least 40 years. Gentian violet swabbing should not be used in this day and age.

Other recommendations (IUSTI) - oral preparations – FLUCONAZOLE 150 mg single dose or ITRACONAZOLE 200 mg bd for 1 day

Intravaginal –CLOTRIMAZOLE vaginal tablets, MICONAZOLE and ECONAZOLE vaginal tablets as per manufacturers' instructions, variable in different parts of the world.

**TREATMENT OF BACTERIAL VAGINOSIS and TRICHOMONIASIS**

METRONIDAZOLE 200mg orally tds or 400mg bd for 5 to 7days.

Sexual partners should be treated similarly for trichomoniasis. There is no proven reason for doing likewise for partners of bacterial vaginosis.

#### HUMAN GENITAL PAPILLOMA VIRUS INFECTION (GPVI)

It has to be remembered that this, often presenting to dermatologists, is sexually transmitted in over 60% of cases and other STDs may be present and should be diagnosed. Benign proliferative warts caused by HPV 6 and 11 are found in over 95% of lesions, while High Risk lesions with the potential for carcinogenic change (HPV 16,18 and others) are found in only a small proportion of cases. In most parts of the World there is no possibility of typing at present.

#### THERAPY (IUSTI)

Only surgical well performed therapies have primary clearance rates approaching 100%. Recurrences of all therapies are frequent. All therapies may cause local skin reactions such as itching, burning, erosions and pain. Algorithms depending on local trained clinical manpower and local therapies available within resources need to be defined.

For use at home. PODOPHYLLOTOXIN 0.15% cream or 0.5% solution. (Local extracts of podophyllin resin are difficult to ensure efficacy) or IMIQUIMOD 5% cream.

In the clinic by trained staff.

Cryotherapy,  
Trichloroacetic acid,  
Electrotherapy/scissors excision/curettage/laser.

It is not proven that interferons are of use in HPV.

#### CLINIC CONFIDENCE

All STD treatments have cost implications. Thus all staff should receive ongoing education to their use and where to get information (see list of websites).

Their security needs to be protected and in any department there should be a member of staff in charge of security, restocking, accounting and auditing their use.

Good relations and diplomacy with HEALTH and POLITICAL AUTHORITIES are constantly needed to ensure the efficacy of any STD service.

#### WEB GUIDELINES

The following websites are useful for treatment of STDs. All were visited and found open on 11.12.2012.

CDC-www.cdc.gov/std/treatment/2010 -----2010 STD TREATMENT GUIDELINES Centers for Disease Control and Prevention. USA

British Association for Sexual Health and HIV (BASHH)-www.bashh.org/guidelines

IUSTI Guidelines ---www.iusti.org/regions/Europe/euroguidelines.htm

For HIV, BHIVA Clinical Guidelines ---www.bhiva.org/ClinicalGuidelines.aspx

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Because of increasing resistance of *Neisseria gonorrhoeae* to Azithromycin, the original guidelines were altered in respect of both treatment of Gonorrhoea and *Chlamydia trachomatis* on 27th. May 2013.

### JOURNAL CLUB

#### Clays as sunscreens

(Dlova NC et al. *Photodermatol Photoimmunol Photomed* 2013; 29: 164-169).

Sunscreens are difficult to obtain and they are prohibitively expensive in the developing world. These authors have studied the in vitro photoprotective effect of riverbank clays used traditionally as a sunscreen and adornment by indigenous outdoor workers in South Africa. White and grey clays were found to contain oxides and silicates of aluminium (kaolinite) with additional iron oxide (haematite) in red clay. Although the clays afford only a modest Sun Protection Factor (3.6-4) against ultraviolet B, they also protected against longer wavelengths (ultraviolet A), which are also implicated in skin cancer and increased skin pigmentation such as melasma.

Clays are very safe, although there is a risk in some areas of contamination with arsenic. Hopefully this study will encourage others to explore freely available materials that can be used as low-cost sunscreens.

Chris Lovell

The INTERNATIONAL LYMPHOLOGY FRAMEWORK (ILF) ([www.lympho.org](http://www.lympho.org)) has recently published the 2nd edition of its "Best Practice for management of lymphoedema". This comprehensive document includes a useful review of compression therapy in Indian villages and a chapter on lymphoedema and the skin. It can be downloaded free of charge from the website (although a donation is welcomed!) Click on the icon labelled Compression Therapy on the website.

# The Complications of Scabies: importance of diagnosis and treatment

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Scabies infestation (Figs 1-5) is caused by the mite *Sarcoptes scabiei* var. *hominis*. It affects people in every country, especially tropical areas, and poverty and overcrowding are important risk factors. Vulnerable groups such as children, the elderly and those with other conditions such as disability or HIV are most commonly affected. The infestation causes profound itch which affects sleep and quality of life. Here we discuss some of the less-known complications (Fig 5) which emphasise the need for accurate diagnosis and treatment.

Scabies infestation and subsequent scratching leads to a disruption of the skin barrier, which predisposes to bacterial infections of the skin. These are most commonly due to *Streptococcus pyogenes* (group A streptococcus) and *Staphylococcus aureus*. Bacterial infections of the skin, such as impetigo, cellulitis and abscess then predispose to a range of serious infections and post-infective complications. Far from being a mere nuisance, these diseases cause severe disease and even death.

In tropical settings where scabies is endemic, complicated bacterial skin and soft-tissue infections are common, including large and multiple abscesses. Superficial infections can seed to bone and joints (osteomyelitis and septic arthritis) as well as internal organs and heart valves (infective endocarditis), or can progress to severe, deep soft tissue infection (pyomyositis and necrotising fasciitis). Blood stream infections cause severe sepsis and shock. Both *S. aureus* and *S. pyogenes* cause a range of toxin mediated disease, including toxic shock syndrome, which has a very high mortality even with prompt treatment.

Infection due to *S. pyogenes* also predisposes to "non-suppurative" or post-infectious complications. The best documented of these is acute post-streptococcal glomerulonephritis (APSGN), which presents 1-2 weeks after infection with dark "cola" urine due to blood in the urine, as well as high blood pressure and swelling around the eyes, hands and feet, and sometimes impairment of renal function. There are an estimated 470,000 cases of APSGN in tropical regions each year (1). More than 50% of these are due

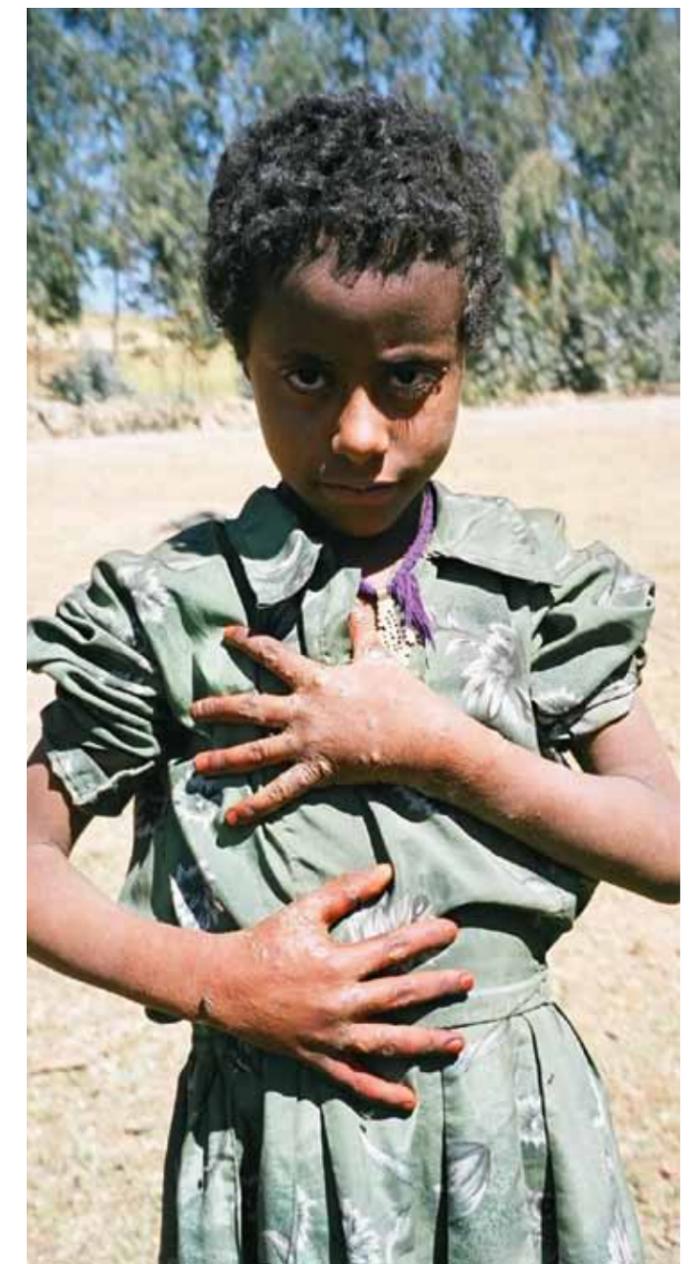


Fig 1. infected Scabies Photo: Sir Eldryd Parry

to skin infections, and outbreaks of APSGN are often associated with scabies outbreaks. Whilst many episodes of APSGN appear to resolve with supportive treatment, damage to the kidneys can lead to chronic kidney disease and renal failure in the longer term (2).

Acute rheumatic fever (ARF) is another post-infectious complication of infection with *S. pyogenes*. It mainly affects children aged 5 - 15 years, who present with clinical symptoms including, fever, swelling of the joints, and a cardiac murmur due to inflammation of the heart valves. Whilst the joint symptoms improve with rest and supportive treatment, damage to the heart valves can persist and worsen with repeated infections, causing rheumatic heart disease (RHD). RHD is the most common heart disease affecting young people worldwide, with more than 15 million cases causing more than 200,000 deaths each year (1). It was traditionally thought that only *S. pyogenes* infections of the throat could cause ARF and RHD, but epidemiological evidence from tropical regions, where rates of RHD are high but streptococcal infections more frequently involve the skin than the throat, suggests a possible role for infections of the skin, particularly infections complicating scabies infestation.

These severe complications reinforce the importance of diagnosing and correctly treating scabies. The diagnosis is usually clinical, based on the presence of itchiness, which is often severe and worse at night, and may affect multiple members of a household. Papules are seen in specific sites such as hands and wrists, feet and ankles, buttocks and back and external genitalia, but can be widespread in young children. Crusting and pus around scabies lesions suggest secondary bacterial infection.

### Management

There are a number of effective topical agents used to treat scabies (summarised in Table 1). Permethrin is the most effective, but cost and availability varies by region. Sulphur compounds and benzyl benzoate are the only agents available in many resource-poor settings, and are also effective if correctly applied. Treatment should be given to all household contacts to prevent spread and



Fig 2. Crusted scabies in a HIV positive patient, RDTC, Moshi Photo: Claire Fuller

reinfestation. All treatments applied as a single application are likely to be more effective if repeated at 7-14 days, due to the life cycle of the mite. Over-treatment should be avoided and may cause toxicity and local irritation. Scabies mites may survive for short periods off the skin, and it is generally recommended to wash linen, towels and clothing in hot water, or isolate in plastic bags for at least three days. Oral ivermectin is effective against scabies and many other parasites, and current research is investigating the role of ivermectin for scabies community control programs.

Mild cases of impetigo (less than five lesions) may be adequately managed with simple cleaning with soap and water, and local antiseptic. More significant infections require treatment with antibiotics. The choice of antibiotics will depend on local medication availability and bacterial sensitivity patterns (particularly prevalence of methicillin resistant *S. aureus* - MRSA). We recommend oral antibiotics active against *S. aureus*, such as cloxacillin or flu/dicloxacilin. Clinical review is important for all cases. Abscesses (localised collections of pus) generally require drainage, and all abscesses associated with high fever or in an unwell patient should be referred to hospital for management of presumed invasive disease. All suspected cases of glomerulonephritis or acute rheumatic fever should be referred to hospital for assessment and management. Table 2 summarises these recommendations for management and schedule of clinical review.

Current and proposed research aims to provide a better understanding of the role of scabies in these severe complications. Further studies are examining the role of mass drug administration programmes for community control of scabies. The International Alliance for the Control of Scabies (IACS) is a recently formed group from across the globe to advance the agenda of scabies control. The alliance is committed to the control of human scabies infestation, and to promote the health and wellbeing of all those living in affected communities. (3)

Scabies infestation is common in many areas of the world, and the direct effects may be less severe than many other illnesses and infections. However, diagnosis and appropriate treatment of all cases of scabies is important to prevent the serious complications of scabies and skin infection.



Fig 3. Scabies burrow Photo: Claire Fuller



Fig 4. Scabies, wrist of child Photo: Claire Fuller



Fig 5. Scabies in axilla Photo: Claire Fuller

Table 1 – Treatment options for scabies *modified from Hay et al. 2014 (4)*

DRUG	INSTRUCTIONS FOR USE	NOTES
<b>Topical</b>		
Permethrin 5%	Apply overnight (8-14 hours) then wash off.	Generally well tolerated with few side effects. Treatment failures described with use of the 1% formulation (which should be used for head lice, not scabies). Probably safe for younger children, consider a shorter application time in infants less than 2 months. Safe in pregnancy and lactation.
Benzyl benzoate 10-25%	Apply for 24 hours then wash off. Dilute for use in children and infants	Transient skin irritation after application is common. To reduce irritation, benzyl benzoate should be diluted to 12.5% for children and 6.25% for infants, but this reduces efficacy. Topical steroids (eg: 1% hydrocortisone) can also be applied to reduce irritation.
Crotamiton 10%	Apply 24 hours, then wash and reapply. Repeat applications for 3-5 days.	Safe alternative for infants, but less practical as requires multiple treatments. Safe in pregnancy and lactation.
Gamma benzene hexachloride (Lindane) 1%	Apply for 8 hours then wash off.	Should be used only if other treatments unavailable. Rare side effects: aplastic anaemia, neurological complications including convulsions, especially in infants, pregnant women and those with neurological disorders. <b>Avoid in infants, pregnant and lactating women.</b>
Malathion 0.5%	Apply 24 hours.	
Sulphur ointment 6% (2-10%)	Apply 24 hours, then wash and reapply. Repeat applications for 3 days.	Can cause skin irritation.
<b>Oral</b>		
Ivermectin	200µg/kg orally Repeat after 1-2 weeks	Will also treat many parasitic infections of skin and digestive tract. <b>Not recommended for children &lt; 15kg or pregnant women as limited safety data available.</b>

Table 2 – Management summary – scabies and skin infections *adapted from Steer et al. 2019 (5)*

SIGN	DIAGNOSIS	ACTION
Danger sign of unwell patient Extensive redness or swelling	Very severe infection	Give first dose of appropriate antibiotic Refer urgently to hospital
Localised warm, tender swelling or redness	Abscess or cellulitis	Give first dose of appropriate antibiotic Refer to hospital
Discrete sores/lesions with pus or crusts	Impetigo	Give appropriate oral antibiotic for 7 days Follow-up in 5 days
Itchiness AND papules AND lesions with pus or crusts	Infected scabies	Give appropriate oral antibiotic for 7 days Give appropriate topical scabies cream Treat the whole family with the cream Follow-up in 5 days and 2 weeks
Itchiness AND papules	Non-infected scabies	Give appropriate topical scabies cream Treat the whole family with the cream Follow-up in 2 weeks
Puffy eyes, hands and feet High blood pressure Blood in urine	Suspect APSGN	Refer to hospital
Child 5-15yo with swollen joints, fever or heart murmur	Suspect acute rheumatic fever	Refer to hospital

Fig. 6 – Complications of Scabies

- **Itch, poor sleep, decreased quality of life**
- **Stigma for individuals and families**
- **Bacterial skin infection – impetigo, cellulitis, abscess**
- **Complicated soft tissue infection – large abscess, pyomyositis**
- **Invasive disease – sepsis, bone and joint infections**
- **Toxin-mediated disease**
- **Acute post-streptococcal glomerulonephritis, progressing to Chronic Kidney Disease**
- **Possible role in Acute Rheumatic Fever, progressing to Rheumatic Heart Disease.**

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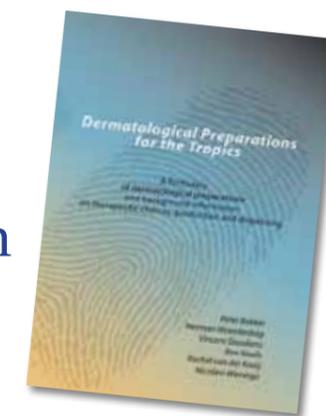
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# Book Review

## Dermatological Preparations for the Tropics

A formulary of dermatological preparations and background information on choices, production and dispensing.

(2012) Bakker, Peter; Woerdenbag, Herman; Gooskens, Vincent; Naafs, Ben; Kaaij, Rachel van der; Wieringa, Nicolien



**Claire Fuller**

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This second edition is available for free to those in developing countries either electronically or in hard copy. This represents a much needed start to provision of an evidence base for low cost medication suitable for the tropics and how to compound them from basic ingredients in a resource poor settings. Given the push to modify the WHO essential drug list taking off those therapeutic interventions with little evidence base, we are in danger of losing some of our most used and widely available weapons. This second edition as well as providing practical information and recipes on how to compound from scratch, additionally covers the basic therapeutics of a range of skin diseases. The text in "" below is extracted from the introductory information on the Gronigen University Beta Repository and summarizes the publication very well.

"This book is a formulary describing 35 preparations covering the safe treatment of a broad range of skin diseases. The formulary focuses on effective and cheap preparations, suitable for local production and use under tropical conditions.

If you want to use this book, you can either download it for free (see above), or you can order your own hard copy by sending an email to [Wewi-fwn@rug.nl](mailto:Wewi-fwn@rug.nl), mentioning your name, address, email address, occupation and intended use of the book. It will be delivered free of charge to those working as health care professionals in developing countries or regions. Others will be charged €15,- for production and shipping costs.

Skin diseases are among the most common reasons for seeking medical advice in developing countries and regions. Although skin diseases are, in general, not life threatening, they may cause considerable discomfort and often have serious social implications. The potential demand for skin preparations is very high among large sections of the world's population, which are economically disadvantaged and have little financial security.

Not much scientific work has been done to determine which effective, cheap and simple dermatological preparations are suitable for the conditions that exist in tropical environments.

This formulary is a step in that direction. The recommendations in the book are based on the most current scientific information available, our own investigations and practical experience. The formulary aims to help meet the basic dermatological needs in primary and secondary health care in developing countries and regions around the world.

The first part of the book focuses on dermatological indications, preparations and therapy. It provides background information for the preparations considering efficacy, stability, and simplicity. The second part is a practical manual for the preparation and dispensing of the proposed dermatologicals. It also includes basic pharmaceutical methods and standards of Good Manufacturing Practice. The third part contains monographs of the preparations and raw materials. Master production forms are included in the electronic version of the book and are found on the CD that comes with the book.

This book can serve many purposes. It may be used as a textbook for teaching dermatological therapy or as a manual to set up a local production unit. More specifically, it may help medical doctors, pharmacists, nurses, clinical officers and other health care workers to jointly develop local drug policies and formularies for dermatologicals, and design local production facilities.

This formulary is a publication of the Beta Science Shop of the University of Groningen, the Netherlands. The book comes with a CD containing master production forms for all preparations and a pdf file of the book itself."

I commend this practical publication to you and congratulate the authors for their efforts and mammoth contribution.

Downloadable for free from <http://irs.ub.rug.nl/dbi/4fed64994b40a>

Community Dermatology  
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# Community Dermatology Journal

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The Community Dermatology Journal brings up to date, relevant information on the diagnosis and treatment of skin disease to health workers in developing countries. It also provides information that can be used to educate health workers and the populations they serve.

**Website** [www.ifd.org](http://www.ifd.org)

This has further information about the journal and detailed Guidelines for Authors.

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The Editorial Board welcomes original articles, reports and letters. All contributions are reviewed before publication. Original articles should not exceed 1,200 words; short reports/ letters should not exceed 500 words. Contributions should follow the detailed

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Please tell your friends – it all helps to finance the journal! *Chris Lovell*

## Imrich Sarkany Non-European Memorial Scholarship

The Imrich Sarkany non-European memorial Scholarship is awarded to young dermatologists outside Europe to attend a meeting of the European society for Dermatovenereology.

**Further details on  
[www.eadv.org](http://www.eadv.org)**

## SCHOLARSHIPS and AWARDS

The **Foundation for International Dermatologic Education** ([www.fide-derm.org](http://www.fide-derm.org)) awards travel grants and scholarships to enable dermatologists from Latin America, Asia and RDTA at Moshi, Tanzania to attend international meetings.

The **American Academy of Dermatology** ([www.aad.org](http://www.aad.org)) offers financial support of between \$2,500 and \$5,000 to fund humanitarian projects as part of its Skin Care for Developing Countries Program. (Closing date 31st January 2014.) Also, the AAD awards a travel scholarship to enable a dermatologist from an developing country to present a poster at its meeting.