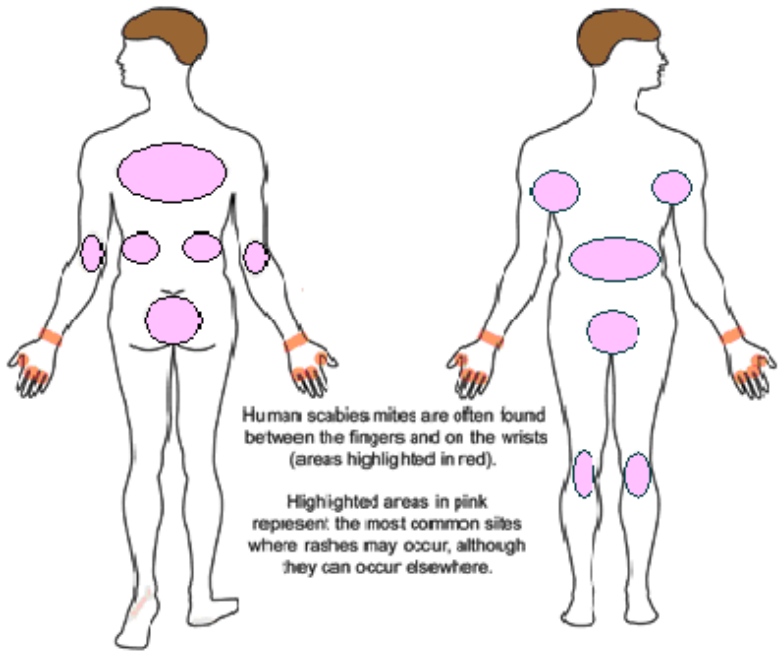
Although the major symptoms are dermal, it should be remembered that they are produced by systemic involvement, and presentation depends on the immune status of the patient.

Classical Scabies
In the so-called classical form of the disease the itch, rash and papules are often the only symptoms. These eruptions may be easily obscured by the patient's frequent need to scratch, resulting in excoriation, eczematisation and ultimately lichenification of affected areas if left untreated for long enough. Mites are normally found on the hands, particularly the insides and webs of fingers, wrists, elbows, feet, male genitalia, buttocks and axillae, in descending order of frequency.

In contrast, the allergic rash occurs around the midriff, insides of the thighs, axillae, buttocks, lower arms and legs. The rash may not appear in all these areas at once, but it is always bilaterally symmetrical, affecting both sides of the body.



Diagnoses
The identification of a burrow with the mite at one end is diagnostic. This usually requires the assistance of a hand lens magnified eight or 10 times and a good light. In practice, the burrows are hard to find. The distribution of the rash and a history of intense itching, particularly at night, are usually indicative of classical scabies, making this type the easiest to diagnose.

Crusted (or Norwegian) Scabies
Less commonly, especially if there is any degree of immune debility, the infection may changes presentation. In some patients, the keratinised layers of the skin become thickened and hyperkeratotic. This may appear icthyosiform or merely crusty in patches, but under the surface of the thickening the mites survive in greater than normal numbers. Any crusts that dislodge will be full of mites that may

be contagious to other people. Most outbreaks of scabies in psychiatric hospitals, nursing homes and other long-stay facilities can be traced to one or more undiagnosed cases of crusted scabies.

Patients most likely to develop the crusted form of the disease include the elderly, alcoholics, those with Down's syndrome, those undergoing transplant or other immunosuppressive therapy, and those with AIDS.

Treatment
Permethrin is commonly recommended for treatment of scabies. Malathion may also be used.

Treatment is also recommended for all household family contacts and all who have had skin contact with someone with scabies for more than 5 to 10 minutes, e.g. partner, boyfriend, girlfriend, children etc.

For classical scabies two treatments are recommended, one week apart

Asymptomatic contacts, as outlined above, should receive at least 1 application of treatment.

Patients with crusted scabies may require 2 or 3 applications of treatment on consecutive days to ensure that enough penetrates the skin crusts to kill all the mites.

For details of cautions, side effects and recommended application time for each product please refer to the specific product information.

Even with fastidious treatment, the cure rate is not 100%. Most apparent failures are due to either inadequate application of the cream/lotion or failure to identify a contact.

Patient and contacts should be treated at the same time.

Sufficient cream/lotion must be given to treat each patient and contact. Larger adults may require two packs.

Written instructions should be provided on how to apply the treatment. See "Patient Information Leaflet Scabies: How is it treated".

The itch of scabies persists for some weeks after the infestation has been eliminated and antipruritic treatment may be required. Application of crotamiton can be used to control itching after treatment but caution is necessary if the skin is excoriated. Oral administration of a sedating antihistamine at night may also be useful.