Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy

Common Conditions Service Protocol

Impetigo (Final)

V1.2 26/09/2025

This protocol does not impede the sale and supply of medicines
'over the counter' where this legal route of supply is relevant

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1. Critical Elements

1.1 Protocol Version
Version 1.2
1.2 Protocol Authors
Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy (See Appendix A for membership)
• Pharmacists wishing to deliver this service must: 1. Complete the mandatory Common Conditions Service training. Training can be accessed on the Irish Institute of Pharmacy website. 2. Adhere to the information and recommendations included in the Clinical Protocol for this common condition, and always ensure that they are following the current version of the protocol. Current versions of the Clinical Protocols can be accessed on the HSE website. 3. Comply with legislation in place that relates to delivery of the service and any associated guidance from the PSI. • NOTE: Locum pharmacists employed on a temporary basis who have successfully completed the training may be authorised to provide the service. They must be able to produce a record of their training upon request.

2. Clinical Criteria

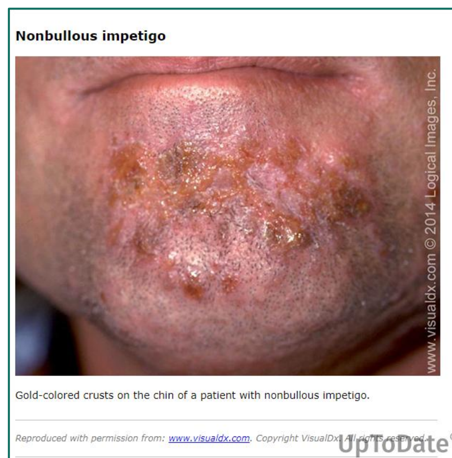
2.1 Clinical condition for use of the protocol and differential diagnosis

Localised lesions of Non-Bullous Impetigo (≤3 lesions)

Background
Impetigo is a bacterial skin infection that is highly contagious but not usually serious. It is caused by the bacteria *Staphylococcus aureus* and *Streptococcus pyogenes*. There are two types of impetigo: bullous and non-bullous. Symptoms usually resolve in seven to ten days if the individual receives treatment or two to three weeks without treatment. This can present in individuals of any age, however it is very common in young children.

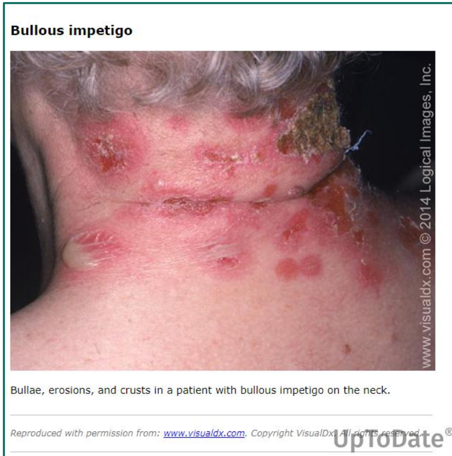
Signs and Symptoms
The management of localised non-bullous impetigo is dependent on recognising the type of impetigo which presents and differentiating from other conditions which may have a similar presentation.

Non-bullous impetigo
Non-bullous impetigo is the most common form of impetigo. It usually presents around the nose and mouth but may affect other extremities including the limbs and flexures. The symptoms of non-bullous impetigo begin with the appearance of small erythematous macule (a flat, discoloured area of skin). Vesicles (blisters) then appear as fluid filled lesions (less than 0.5cm in diameter). The blisters burst leaving behind thick, honey-coloured crusts typically around 2cm in diameter. Once the crusts dry, they leave a red mark which usually disappears within a few days or weeks, without leaving a scar. These lesions are not painful. There may be some itching in the area and individuals should be counselled to avoid scratching or touching the areas as they may spread the infection to other parts of the body (autoinoculation), and to other people. In more severe cases of infection symptoms may include swollen glands and fever.

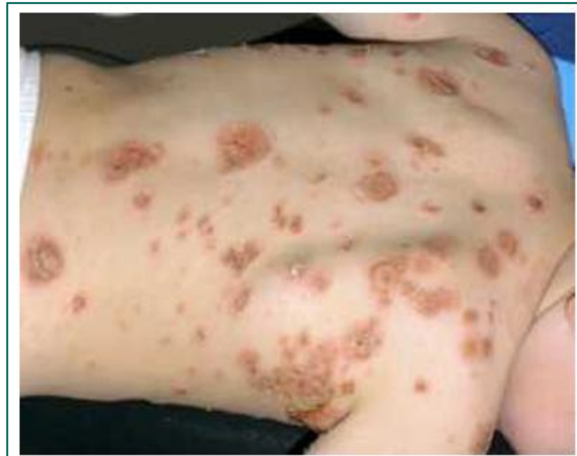


Non-bullous impetigo (UpToDate ®)

Differential Diagnosis:
Bullous impetigo
In bullous impetigo, symptoms begin with the appearance of the bullae (large, flaccid, fluid filled blisters) which are usually 1cm to 2cm in diameter. These blisters are filled with yellow/clear fluid, spread rapidly, and may present with pain and itching in the affected area(s). It most commonly affects the trunk, neck, arms, and legs. Individuals are more likely to present with fever or swollen glands with this type of impetigo. Once the blisters burst, they leave a yellow crust which typically heals without scarring over days and weeks. Individuals should be counselled to avoid touching the affected area.



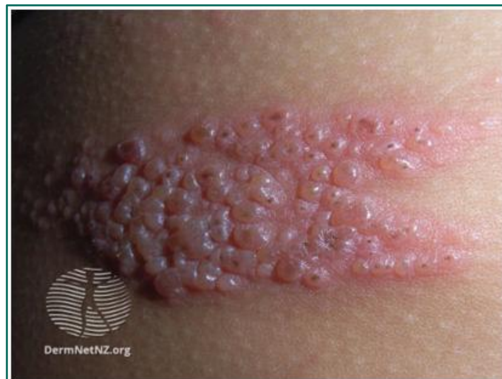
Bullous impetigo (UpToDate ®)



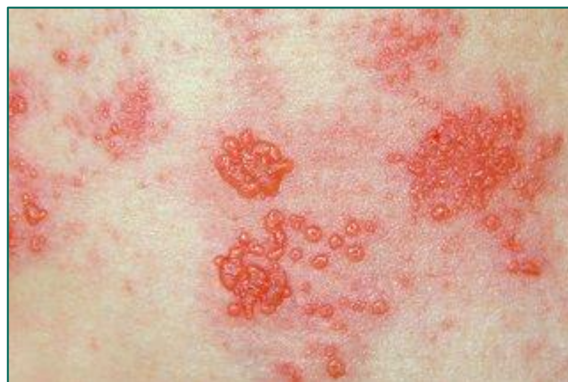
Widespread bullous impetigo over the back (HSE Antibiotic Prescribing)

Shingles (*Herpes Zoster*)

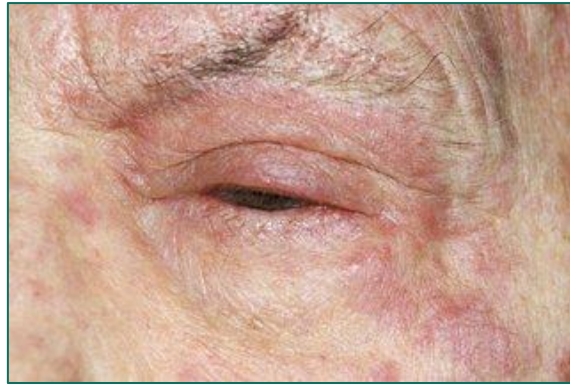
Herpes zoster infection is due to reactivation of the latent varicella zoster virus. Individuals will have been previously infected with the primary infection of varicella (chickenpox). The virus remains dormant in the sensory dorsal root ganglia for years before it is reactivated. The reactivated virus travels down sensory nerves to the skin and is usually localised to a specific nerve distribution. The shingles rash manifests in the dermatome, which is the area of skin innervated from the affected dorsal root ganglia. Herpes zoster can occur at any age but is usually more common in older people or individuals who are immunocompromised.



Close-up of Herpes Zoster blisters (HSE Antibiotic Prescribing, Source: DermNetNZ.org)



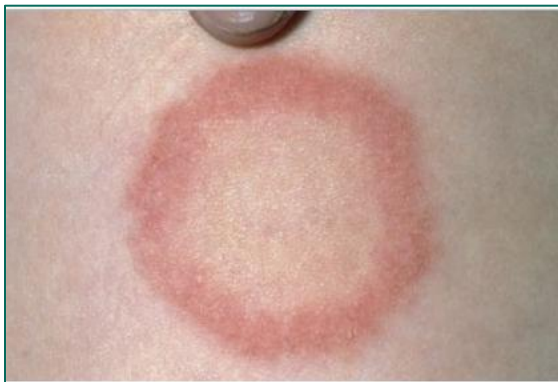
The blotches become itchy blisters that ooze fluid. A few days later, the blisters dry out and crust over (HSE A-Z)



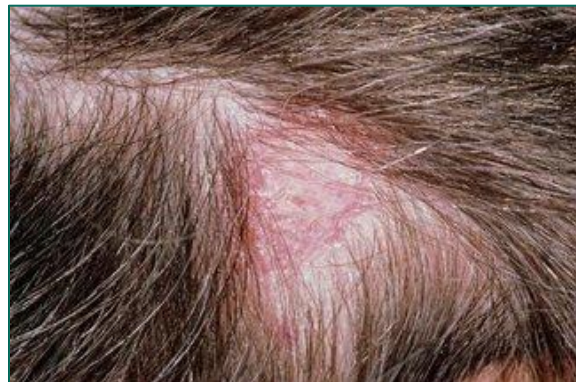
Shingles affecting the eye (HSE A-Z)

Dermatophytosis

Dermatophytosis is a fungal infection of the skin, hair, and nails. It is acquired through direct contact with the causative organism e.g. person-to-person contact or animal to person contact. It leads to a variety of clinical manifestations including Tinea Corporis, Tinea Capitis, Tinea Cruris, and Tinea Pedis. Individuals who are immunosuppressed are at an increased risk of developing a clinical infection. Complications of the infection may include a dermatophytid reaction which is a secondary reaction to the inflammatory fungal condition. This presents as an itchy rash with bumps or blisters, at a site distant from the initial infection. It will usually resolve once the initial infection is treated.



Typical ringworm presentation (HSE A-Z)



Tinea Capitis (HSE A-Z)

Tinea corporis

This annular lesion with a raised erythematous border, central clearing, and slight scale was consistent with tinea corporis.

Reproduced with permission from: Fleisher GR, Ludwig S, Baskin MN. Atlas of Pediatric Emergency Medicine, Lippincott Williams & Wilkins, Philadelphia 2004. Copyright © 2004 Lippincott Williams & Wilkins.

UpToDate®

Tinea corporis (UpToDate ®)

Tinea capitis

A scaly plaque with associated hair loss is present on the scalp.

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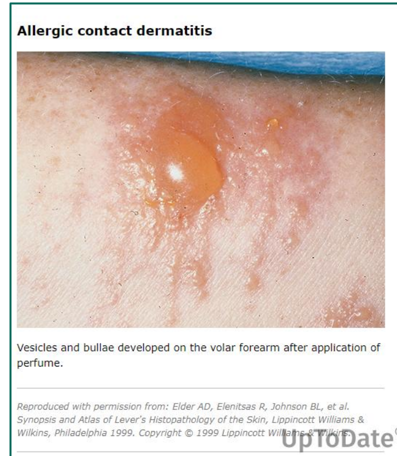
UpToDate®

Tinea capitis (UpToDate ®)

Contact dermatitis

Contact dermatitis can be caused by contact with irritants or allergens. Symptoms are usually localised to the area of exposure and may include red irritated, itching, stinging or blistered skin in the area exposed to the allergen or irritant. The reaction usually occurs within a few hours or days of exposure to the allergen or irritant.

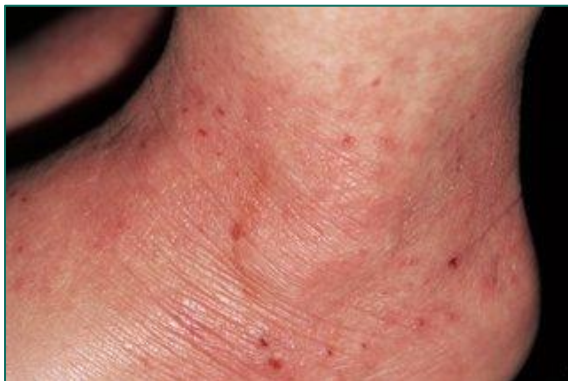
Allergic contact dermatitis (UpToDate ®)



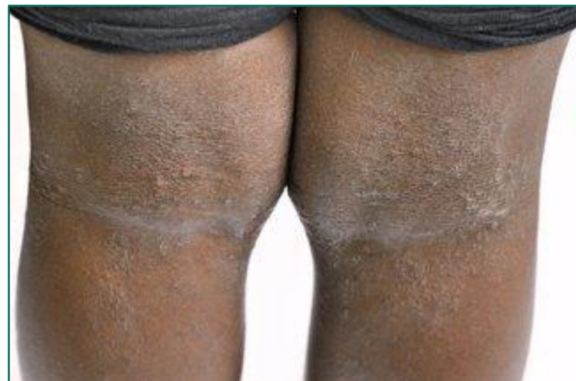
Allergic contact dermatitis (UpToDate ®)

Atopic Dermatitis (Eczema)

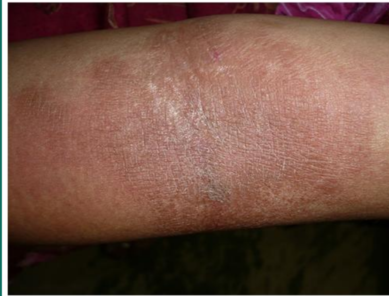
Atopic dermatitis (eczema) is an inflammatory skin condition which affects 1 in 5 children and 1 in 10 adults. Atopic dermatitis can be associated with development of other atopic diseases including allergic rhinitis, asthma, and food allergy. Individuals affected by atopic dermatitis usually have a family history. It is characterised by dryness, redness (inflammation), and itching and can be described as acute (flare-up of symptoms) or chronic.



Eczema on the ankle (HSE A-Z)

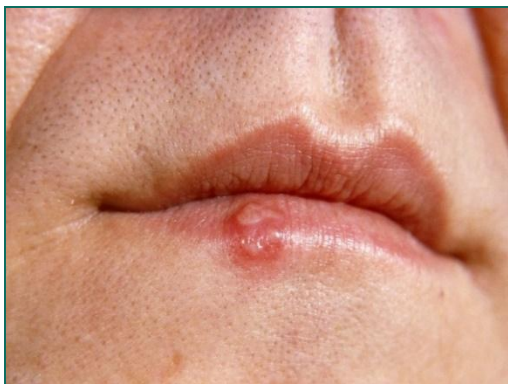


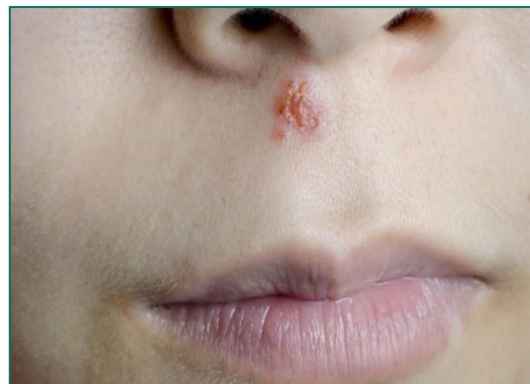
Eczema on the back of the knees (HSE A-Z)



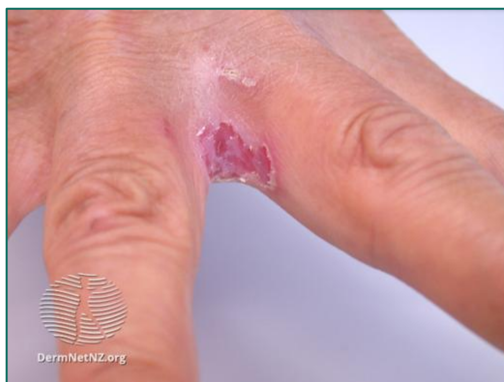
Adult chronic atopic dermatitis (UpToDate ®)

Cold Sores – Herpes Simplex Virus (HSV)
Small, fluid-filled blisters are the main HSV symptom in adults and children. Cold sores usually start with a tingling, itching or burning feeling (prodromal phase). Over 48 hours, blisters may appear, weep and usually crust over into a scab. Lymph nodes may be swollen and tender.


Small fluid-filled blisters appear (HSE A-Z)


The blisters can appear anywhere on the face (HSE A-Z)

Candidal skin
Cutaneous *Candida* infection is a fungal infection that commonly infects the skin and requires topical therapy. It commonly affects genital and nappy areas, skin folds, oral, and nail area. It can also present as a secondary infection, particularly in individuals with existing skin conditions such as psoriasis.



Cutaneous candidiasis (HSE Antibiotic Prescribing, Source DermNetNZ.org)

Cutaneous candidiasis (HSE Antibiotic Prescribing, Source DermNetNZ.org)

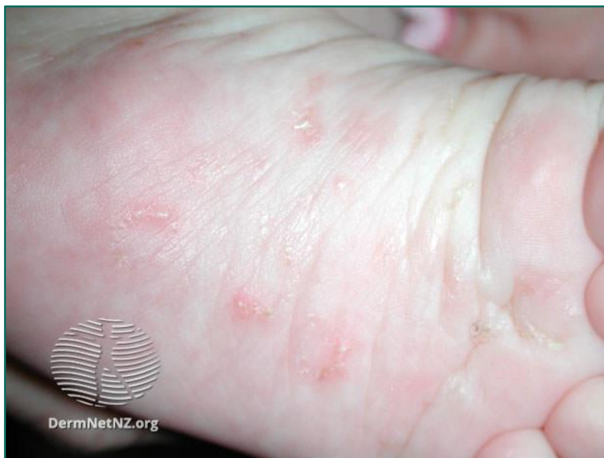
Guttate Psoriasis

Psoriasis is a common inflammatory skin condition, there are several clinical manifestations. Guttate psoriasis causes small, drop shaped spots which occur on the chest, legs, arms and scalp. It is more common in children and teenagers and is often preceded by a history of a streptococcal infection (e.g. throat infection). It usually resolves over a couple of weeks but in some instances, it can develop into plaque psoriasis.

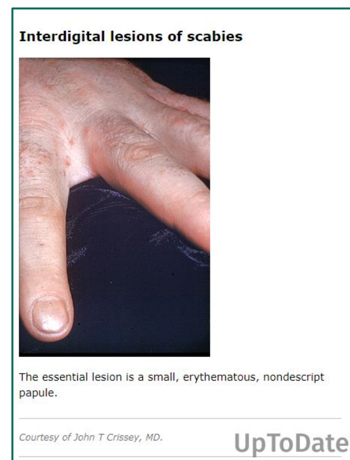
Guttate psoriasis (UpToDate ®)

Scabies

Scabies is a skin condition caused by the *Sarcoptes scabiei* mite which gets under the skin and lays eggs. It results in an intensely itchy skin eruption which characteristically presents in the web spaces between the fingers, wrists, feet, axilla, umbilicus, nipples, or genitals. It can also affect other extremities and appear on the palms and soles in infants. The rash may be worse at night or after a bath. It is transmitted by skin-to-skin or sexual contact with a person who has scabies. Household contacts may also report itch or rash. As scabies are easily spread, particularly in residential settings, it should be treated quickly.



Scabies (sarcoptes scabiei) (HSE Antibiotic Prescribing, Source DermNetNZ.org)



Interdigital lesions of scabies (UpToDate ®)

Complications of Impetigo

Some *Staphylococcus aureus* infections are associated with a toxin called Panton-Valentine Leukocidin (PVL). This may cause persistent, recurrent pustules and carbuncles, or cellulitis. Individuals presenting with these symptoms should be signposted

to their GP as swabs may be required for culture sensitivity in these clinical scenarios to determine best course of action and treatment.

2.2 Summary of Clinical Features

- Non-bullous impetigo usually presents around the nose and mouth but may affect other extremities including the limbs and flexures.
- It is highly contagious.
- The symptoms begin with the appearance of small erythematous macule (a flat, discoloured area of skin).
- Vesicles (blisters) then appear as fluid filled lesions (less than 0.5cm in diameter). The blisters burst leaving behind thick, honey-coloured crusts typically around 2cm in diameter.
- Once the crusts dry, they leave a red mark which usually disappears within a few days or weeks, without leaving a scar.
- These lesions are not painful.
- There may be some itching in the area and individuals should be counselled to avoid scratching or touching the areas as they may spread the infection to other parts of the body (autoinoculation), and to other people.
- In more severe cases of infection symptoms may include swollen glands and fever.

2.3 Inclusion criteria

2.3.1 CRITERIA FOR INCLUSION

- Informed consent given by an individual or parent/legal guardian for a child aged under 16 years.
- Individuals aged 2 months and over (corrected age for infants who are pre-term. The corrected age is the age based on the date they should have been born e.g. if a 10-month-old baby was born 2 months early, their corrected age is 8 months old).
- Localised lesions of Non-Bullous Impetigo (≤3 lesions).
- Pharmacists can **consider prescribing an initial supply of treatment <u>if clinically appropriate</u>**, while referring individuals who meet the criteria set out in **Section 2.4.4**.

2.4 Exclusion criteria and Referral Pathways

2.4.1 CRITERIA REQUIRING EMERGENCY REFERRAL TO HOSPITAL EMERGENCY DEPARTMENT/CONTACTING EMERGENCY SERVICES

- Individual is systemically very unwell, or showing symptoms of severe/life-threatening infection, or systemic sepsis: **Refer urgently to Emergency Department via ambulance.**

2.4.2 CRITERIA REQUIRING URGENT MEDICAL ASSESSMENT (TREATING SERVICE/GENERAL PRACTITIONER/GENERAL PRACTITIONER OUT OF HOURS/HOSPITAL EMERGENCY DEPARTMENT)

- Signs and symptoms of a more serious condition or illness e.g. affected area appears swollen and red, spreading redness, purple patches on the skin, pain, pus, area is warm to touch, or large blisters forming.
- Individual has moderate to severe immunocompromise due to underlying medical conditions or treatments.
- Complications suspected, for example secondary infections of wounds, cellulitis or deeper soft tissue infection, scarlet fever.

2.4.3 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER

Note: Pharmacist prescribing not permitted

- Individuals under 2 months of age (corrected age for infants who are pre-term).
- Contraindications as specified in the medication Summary of Product Characteristics.
- Currently breastfeeding with impetigo lesion(s) present on the breast.
- Bullous impetigo.
- Widespread non-bullous impetigo – four or more lesions/clusters present.
- Recurrent impetigo – two or more prior episodes in the previous 12 months.
- Currently active underlying skin condition e.g. Contact Dermatitis, Atopic Dermatitis, Scabies.

- Any open wounds affecting the topical treatment application area or the immediate vicinity.
- Failed previous topical or oral treatment (including antimicrobials) for this episode of impetigo.
- Extended, recurrent or use of fusidic acid within the previous 12 months – due to an increased risk of developing antibiotic resistance.
- The affected area(s) cannot be protected from open or naked flames (e.g. smokers) – risk of burns.
- Known hypersensitivity or adverse reaction to medication treatment options as included in Section 3.1, or any of the components within the formulation.

2.4.4 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER – INITIAL LIMITED SUPPLY*

***Pharmacists can consider prescribing an initial limited supply of treatment if clinically appropriate to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.**

- Individual is immunocompromised due to underlying medical conditions or treatments (excluding those with moderate to severe immunocompromise: see Section 2.4.2).

2.5 Action to be taken where individual meets exclusion criteria, or treatment is not indicated, or if the individual/parent/legal guardian declines treatment

- If individual meets exclusion criteria, they should be referred or signposted as per the protocol (see Section 2.4).
- Advise individual/parent/legal guardian to seek medical advice if symptoms deteriorate.
- Signpost to available resources on HSE A-Z and the HSE app if appropriate.
- Follow record keeping procedures.

3. Details of medication

3.1 Name of medication, dose, and duration

Treatment Options & Formulary

If an individual has already been prescribed oral antibiotics for this episode of Impetigo, the combined use of topical and oral antibiotics should be avoided.

Topical antibiotics are reserved for very localised lesions (≤3 lesions).

Prior to application of topical antibiotics, soak off crusts with petroleum jelly (Vaseline®) and gently remove with a warm, damp facecloth to increase absorption. Facecloths should not be shared or reused and should be washed at a high temperature after use.

Topical Treatment for Non-Bullous Impetigo – ≤3 lesions

Drug	Children's Dose	Adult Dose	Duration	Notes
Fusidic Acid 20mg/g cream **OR** Sodium Fusidate 20mg/g ointment	Topically to affected areas every 8 hours	Topically to affected areas every 8 hours	5-7 days	15g tube to be supplied* *30g tube may be supplied, only if the 15g tube is unavailable

3.2 Summary of Product Characteristics including warnings, cautions, contraindications, interactions and side effects.

Visit the Health Products Regulatory Authority (HPRA) website for detailed drug information (summary of product characteristics and patient information leaflets). Dosing details, contraindications and drug interactions can also be found in the Irish Medicines Formulary (IMF) or other reference sources such as British National Formulary (BNF) / BNF for children (BNFC).

3.3 Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, website: www.hpra.ie

3.4 Procedure for the reporting and documentation of errors and near misses involving the medication including open disclosure.

PSI Advice on Medication Error Management:
https://www.psi.ie/practice-supports/practice-updates-and-learnings/advice-medication-error-management
PSI Open Disclosure:
Open Disclosure | PSI

3.5 Resources and equipment necessary for care under the protocol to be specified. This is dependent on the assessment requirements and best practice guidelines identified for the clinical condition.

- HSE National Consent Policy
- Chaperone Policy
- Patient Consultation Area
- Infection Prevention Control Measures
- Protecting Staff – Occupational Health

4. Patient/service-user care information

4.1 General Advice for Self-Care and Safety Netting

Symptoms usually resolve in seven to ten days if the individual receives treatment or two to three weeks without treatment.

Individuals should be advised if symptoms do not improve within 72 hours of commencing treatment to seek further advice from a GP or other relevant medical practitioner.

Impetigo is highly contagious and can spread to other parts of the body or other people until it stops being contagious.

It **STOPS** being contagious:

- 24 hours after the individual starts using the prescribed treatment.
    - If lesions are not yet healed after 24 hours of treatment, then they should be covered, e.g. with gauze and tape, until crusted and healed.
- When the patches dry out and crust over - if the individuals does not get treatment.

To help stop impetigo spreading or getting worse while it's contagious:

- **Do**:
    - Stay at home.
    - Keep sores, blisters and crusty patches clean and dry.
    - Cover them with loose clothing or gauze bandages.
    - Wash hands frequently. Avoid touching the affected area and wash hands with soap and water if it has been touched or cream/ointment applied.
    - Ensure household contacts wash hands regularly/use alcohol hand gel.
    - Wash face cloths, sheets and towels at a high temperature.
    - Wash or wipe down toys with soap and warm water if children have impetigo.
    - Inform school or childcare facilities if applicable – usual guidance is to stay home until lesions have crusted over, or until 24 hours after individuals have started treatment.

- **Don't:**
    - Touch or scratch sores, blisters or crusty patches - this also helps stop scarring.
    - Have close contact with children, or individuals with diabetes or a weakened immune system.
    - Share face cloths, sheets or towels.
    - Prepare food for other people.
    - Go to the gym.
    - Play contact sports.

4.2 Medication information to be provided to the individual/parent/legal guardian using the authorised patient information leaflet if one is available.

- Signpost to available resources on HSE A-Z and the HSE app.
- Medication Patient Information Leaflets (PILs).

Key References

- HPRA https://www.hpra.ie/
- HPSC https://www.hpsc.ie/a-z/lifestages/schoolhealth/File,14304,en.pdf
- HSE Antibiotic Prescribing https://www.hse.ie/eng/services/list/2/gp/antibiotic-prescribing/
- HSE A-Z https://www2.hse.ie/conditions/
- NIAC Immunisation Guidelines https://www.rcpi.ie/Healthcare-Leadership/NIAC/Immunisation-Guidelines-for-Ireland
- UpToDate Impetigo and related images https://www.uptodate.com/contents/impetigo
- DermNet DermNetNZ.org (Images as identified)

Appendix A – Clinical Sub-Group Membership

Core Membership

- Dr. Siobhán Ní Bhriain - HSE National Clinical Director Integrated Care (Chair)
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Linda Fitzharris - HSE PCRS Head of Pharmacy
- Dr. Diarmuid Quinlan - Medical Director ICGP & GP
- Ms. Elaine Dobell - HSE General Manager, Office of National Clinical Director Integrated Care
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist
- Dr. Clíona Murphy – National Women and Infants Health Programme
- Ms. Sarah Clarke - Medicines Management Programme

General Membership as needed

- Ms. Aoife Doyle - HSE National Clinical Lead for Ophthalmology
- Prof. Anne Marie Tobin - HSE National Clinical Lead for Dermatology
- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. Seán O'Dowd - HSE National Clinical Lead for National Dementia Office representing National Clinical Programme for Neurology on behalf of Prof. Sinéad Murphy
- Ms. Ruth Hoban - HSE West Assistant Director of Nursing and Midwifery for Nurse Prescribing on behalf of Dr. Geraldine Shaw
- Prof. Fiona Lyons - HSE National Clinical Lead for Sexual Health
- Ms. Caoimhe Gleeson - HSE National Office for Human Rights and Equality Policy
- Dr. Andrew Bolas - Assistant National Oral Health Lead
- Dr. Myra Herlihy - Assistant National Oral Health Lead Special Care and Training

Impetigo CSG Working Group

- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Ms. Áine McCabe - Community Pharmacist