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The Clinical Picture

Generalized pruritus after a beach vacation

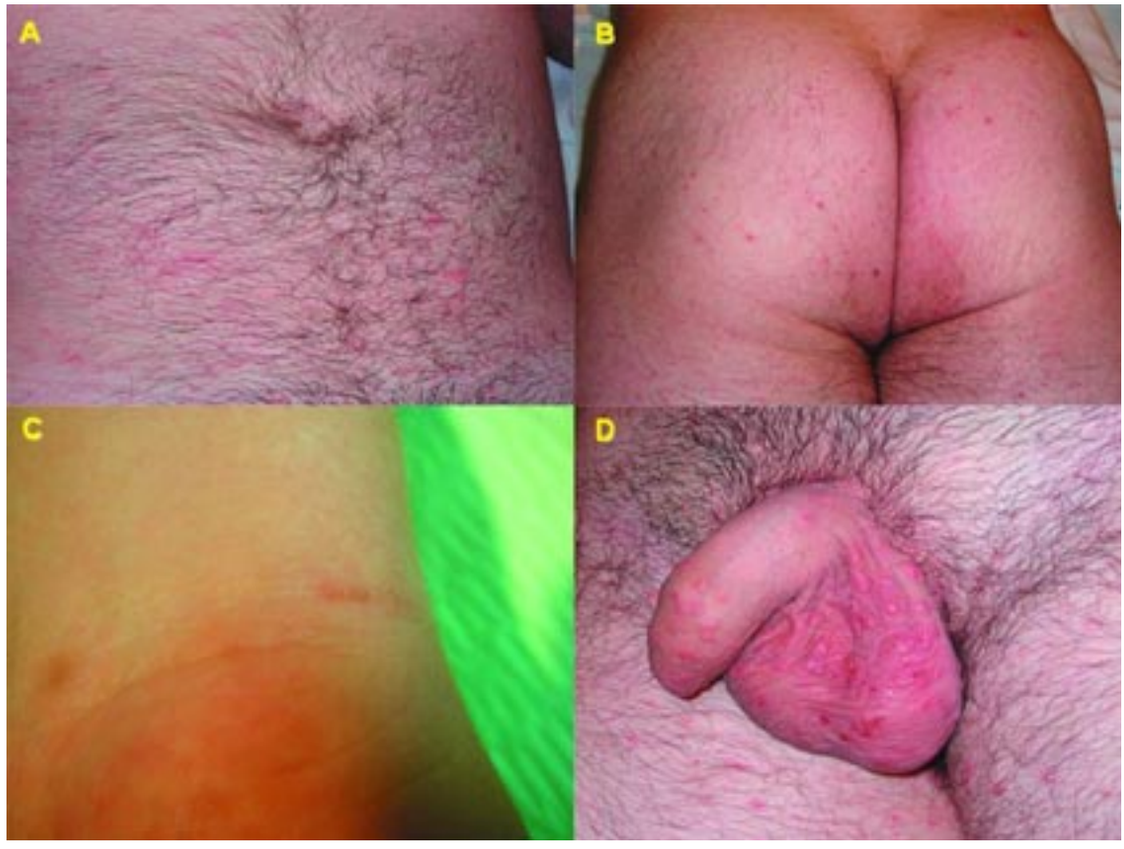

FIGURE 1

A 25-YEAR-OLD MAN PRESENTS with a 2-month history of generalized itching that began 5 weeks after returning from a trip to a beach in Brazil, during which he had sexual relations without protection. He has already been treated with topical steroids and antihistamines, with no improvement.

On physical examination, he has papules and excoriations on the abdomen (FIGURE 1A) and buttocks (FIGURE 1B), a linear grayish threadlike elevation on the flexor surface of the left wrist (FIGURE 1C), and multiple red nodules on the penis and scrotum (FIGURE 1D).

Q: What is the most likely diagnosis?

- ❑ Herpes simplex type 2
- ❑ Acute trypanosomiasis
- ❑ Syphilis
- ❑ Scabies
- ❑ Papular urticaria

A: The most likely diagnosis is scabies, an intensely pruritic skin infestation caused by

the host-specific mite *Sarcoptes scabiei* var *hominis*.[1] Herpes simplex type 2 infection presents with clustered vesicles, not nodules, on an erythematous base in the genital area, without generalized pruritus. Acute trypanosomiasis involves malaise, fever, vomiting, diarrhea, anorexia, rash, tachycardia, and even generalized lymphadenopathy and meningeal irritation, but generalized itching is not typical. The location and morphology of the patient's lesions are not consistent with syphilis. Topical steroids and oral antihistamines should have improved the pruritus of papular urticaria.

A GLOBAL PUBLIC HEALTH PROBLEM

Scabies is a worldwide public health problem, affecting people of all ages, races, and socioeconomic groups.[1] Overcrowding, delayed diagnosis and treatment, and poor public education contribute to the prevalence of scabies in both industrialized and nonindustrialized nations.[2] Prevalence rates are higher in children and people who are sexually active.[3]

Sexual transmission is by close skin-to-skin contact. Poor sensory perception in conditions such as leprosy and compromised immunity due to organ transplantation, human immunodeficiency virus infection, or old age increase the risk for the crusted variant of scabies.[2] Patients with the crusted variant tend to present with clinically atypical lesions, and because of this they are often misdiagnosed, thus delaying treatment and elevating the risk of local epidemics.

Family and close contacts must be evaluated and treated, even if they have no symptoms

CLINICAL ASPECTS

Scabies can mimic a broad range of skin diseases. Patients present with intense itching that is worse at night. The face and neck are rarely affected. The pathognomonic signs of scabies are burrows, erythematous papules, and generalized pruritus (also on non-infested skin) with nocturnal predominance.[3] Reddish to brownish extremely pruritic nodules of 2 to 20 mm in diameter may be also present on the genitalia (more commonly in males than in females), buttocks, groin, and axillary regions. Patients usually have secondary papules, pustules, vesicles, and excoriations.

DIAGNOSIS

Every patient with intense pruritus should be suspected of having scabies, but especially if a family member reports similar symptoms.[3] A diagnosis can be made clinically if a burrow is detected at a typical predilection site and if the lesion itches severely. In this case, even a single burrow is pathognomonic.[2] The diagnosis is confirmed by light-microscopic identification of mites, larvae, ova, or scybala (fecal pellets) in skin scrapings.[1]

TREATMENT

Treatment includes a scabicidal agent, an antipruritic agent such as a sedating antihistamine, and an appropriate antimicrobial agent in cases of secondary infection. Permethrin (Acticin), a 5% synthetic pyrethroid cream, is an excellent scabicide and is the preferred treatment.[1] All family members and close contacts must be evaluated and treated, even if they do not have symptoms.[1]

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