Protocol for Management of Impetigo

The Victorian Community Pharmacist Program

December 2025

OFFICIAL

VICTORIA State Government | Department of Health

Protocol for Management of Impetigo

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1. About

This Protocol has been developed to provide pharmacists authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations) a clear framework to supply the Schedule 4 poisons documented in this Protocol for the management of Impetigo under a structured prescribing arrangement. It is a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists comply with this Protocol when supplying Schedule 4 poisons for treatment of Impetigo. It is also a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists have completed the current training requirements specified in the departmental guidance before supplying Schedule 4 poisons.

Pharmacists authorised to supply Schedule 4 poisons under the Regulations must:

- Operate at all times in accordance with the Drugs, Poisons and Controlled Substances Act 1981, the Regulations and all other applicable Victorian, Commonwealth and national laws.
- At all times act in a manner consistent with the Pharmacy Board of Australia's (the Board) Code of Conduct and in keeping with other professional guidelines and policies as set out by the Board as applicable.

Pharmacists are also expected to exercise professional judgment in adapting treatment guidelines to presenting circumstances.

1.1 Definitions and acronyms

APSGN: Acute post streptococcal glomerulonephritis

ARF: Acute rheumatic fever

HCP: Healthcare practitioner

HPI-I: Healthcare Provider Identifier-Individual number

HSV: Herpes Simplex Virus

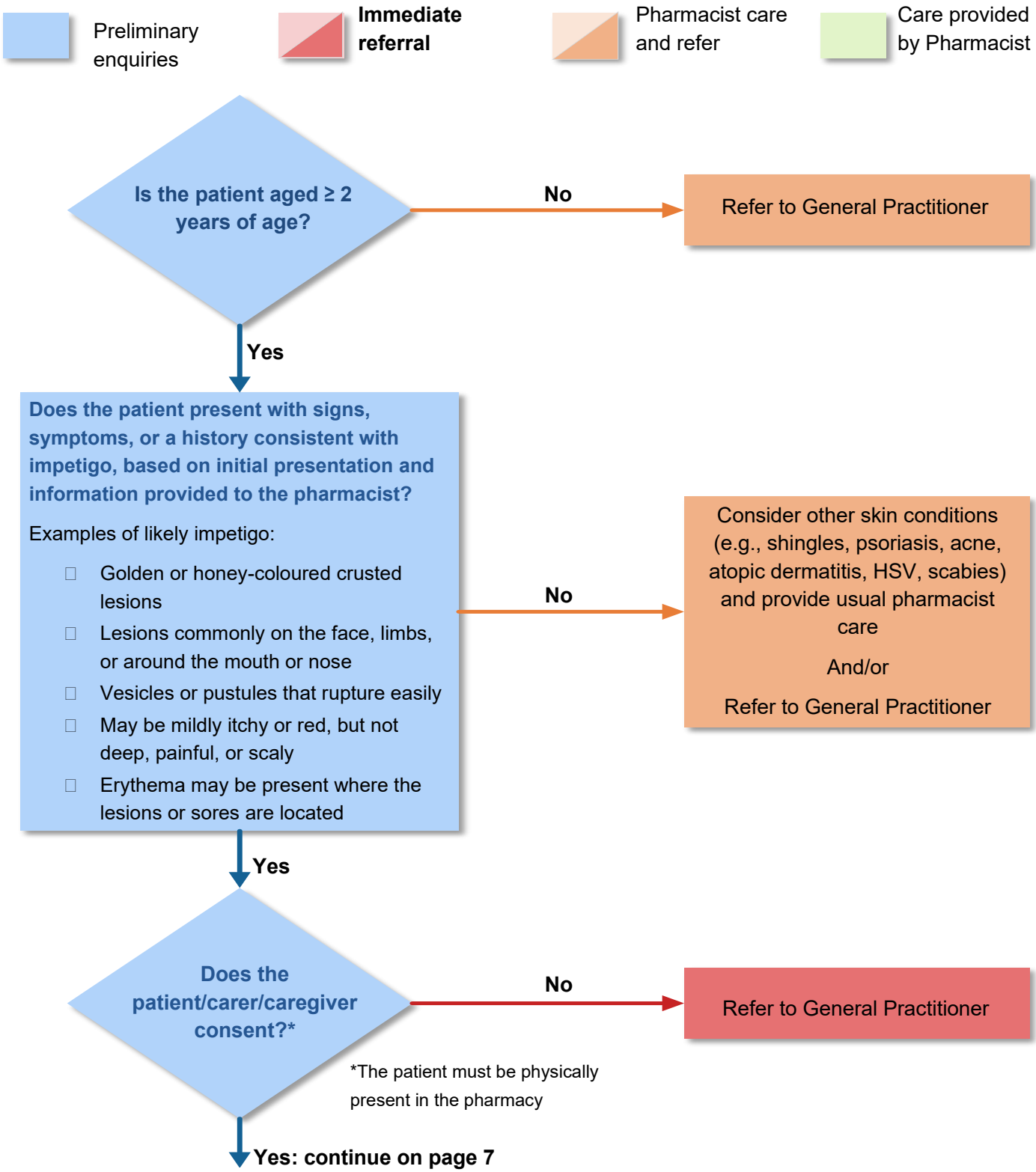
MHR: My Health Record

RHD: Rheumatic Heart Disease

2. Protocol for Management of Impetigo

2.1 Key to colours used in this protocol

Where the protocol indicates to "Refer to General Practitioner", the Pharmacist may refer to a medical practitioner or other authorised prescribing health practitioner as clinically appropriate. If timely access to a GP is not available, referral to the Victorian Virtual Emergency Department (VVED) or an urgent care clinic may be considered as an alternative pathway.



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Assess:

Patient history

- Onset, duration, nature, location, severity and extent of lesions
- History of previous impetigo or skin infections, especially if lesions persist, or recur shortly after previous treatment completion
- Risk factors: recent skin or throat infections, trauma, immunosuppression, ARF risk factors (Refer to **Table 2: People considered at high risk of developing ARF**)
- Lifestyle factors: most recent place of residence or recent travel, recent contact with others with similar symptoms
- Comorbidities: diabetes, renal/hepatic impairment, overweight etc.
- Current medications
- Medication allergies and/or adverse effects
  - Contraindications
  - Medication interactions
  - Pregnancy and lactation

Does the patient report/present with any of the following?

- The patient is identified with or at risk of recurrent impetigo (e.g., symptoms have not resolved after the first course of antibiotic treatment, symptoms significantly or rapidly worsen, if impetigo infection reoccurs frequently)
- The patient is immunocompromised
- The patient is at high risk of complications of impetigo, including patients at high risk of ARF (Refer to **Table 2: People considered at high risk of developing ARF**)

Yes → Refer to General Practitioner

No

Conduct clinical review

Examination

Confirm presenting signs and symptoms indicative of impetigo by performing a skin assessment (Refer to supplementary notes including **Table 1**: **Types of impetigo**)

- When examining patients, standard and contact precautions apply for cases of localised impetigo
- Personal protective equipment (PPE) including gloves should be used, and surfaces should be cleaned with neutral detergent and disinfectant after examination
- Ensure hand hygiene is performed

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Does the patient report/present with any of the following red flag criteria?

- Widespread, painful rash that may be erythematous
- Non-blanching purple rash
- Blistering of the skin and/or mucous membranes (that may include mouth and eyes)
- Signs and symptoms of serious and/or systemic illness (e.g., complicated cellulitis, severe ecthyma, acute ARF) including fever, lethargy, headache, rash, nausea and vomiting, severe pain, sore and swollen joints, food/drinking aversion in a child
- Generalised erythema that covers 90% or more of the skin surface, especially when associated with systemic symptoms

Yes → **Refer to the Emergency Department immediately**

No

Does the patient report/present with any of the following?

- Signs of bullous impetigo (large, flaccid blisters)
- Signs that impetigo is widespread, severe and/or has ecthyma (ulceration, induration) present
- Chronic sores or ulcers
- The patient presents with generalised erythema that covers 90% or more of the skin surface, but the patient is otherwise well, with no systemic features.
- A clear diagnosis of impetigo cannot be made (i.e. uncertain diagnosis of uncomplicated non-bullous impetigo), and/or other/co-occurring secondary conditions are suspected that cannot be treated in the community pharmacy setting, e.g., Infected atopic or discoid eczema, herpes simplex virus (HSV-1), varicella (chickenpox), herpes zoster (shingles), cellulitis, scabies, psoriasis, folliculitis or acne, contact dermatitis, dermatophytosis (tinea), candidiasis, thermal burns, and molluscum contagiosum.

Yes → Refer to General Practitioner

No

Does the patient present with a clear presentation of non-bullous impetigo?

Key Features of non-bullous impetigo (eligible for pharmacist treatment)

- Honey-coloured crusts, typically on face/extremities
- Vesicles/pustules that rupture easily
- Mild itch, minimal pain
- No systemic symptoms

Note: Pharmacists should treat only clearly eligible low-risk cases and refer to a GP for swabbing or further review if the diagnosis is uncertain, recurrent, or not improving.

No → Refer to General Practitioner

Yes: continue page 9

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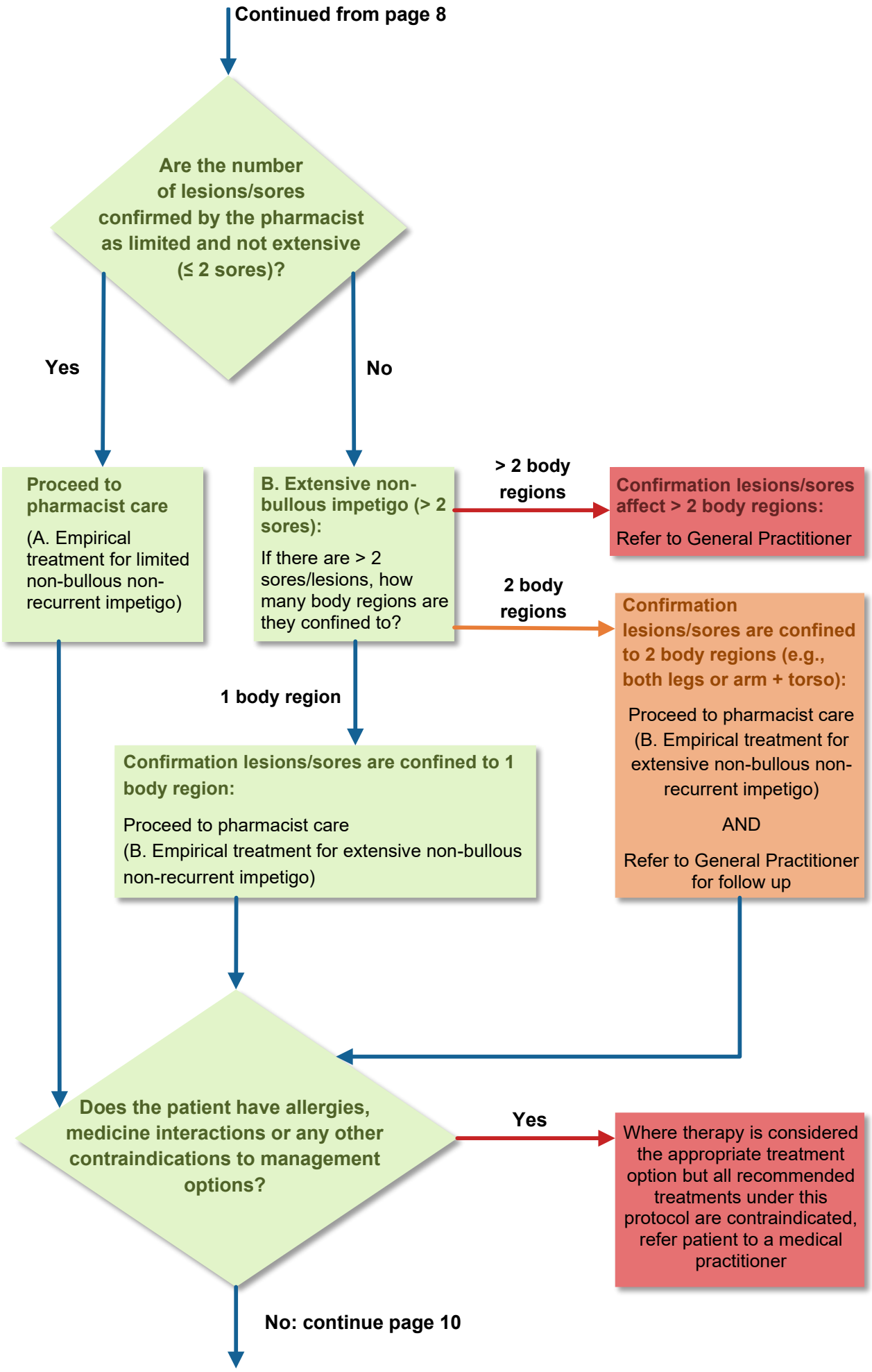

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The management of impetigo consists of pharmacotherapy in addition to general measures for the patient, family and community to reduce spread.

For pharmacotherapy, provide treatment where indicated in line with the Therapeutic Guidelines.

A. Empirical treatment for limited non-bullous non-recurrent impetigo

1. Mupirocin 2% ointment or cream topically to crusted areas, every 8 hours for 5 days
2. Hydrogen peroxide 1% cream topically to crusted areas, every 8 hours for 5 days

B. Empirical treatment for extensive non-bullous non-recurrent impetigo

1. Dicloxacillin 500mg (child: 12.5 mg/kg up to 500 mg) orally, every 6 hours for 5 days (Stop at 3 days if resolved)
1. Flucloxacillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally every 6 hours for 5 days (Stop at 3 days if resolved)
2. Cefalexin 1 g (child: 25 mg/kg up to 1000 mg) orally, every 12 hours for 5 days (Stop at 3 days if resolved)*
3. Trimethoprim + Sulfamethoxazole 160+800 mg (child: 4+20 mg/kg up to 160+800 mg) orally, 12-hourly for 3 days
3. Trimethoprim + Sulfamethoxazole 320+1600 mg (child: 8+40 mg/kg up to 320+1600 mg) orally, once daily for 5 days

* Cefalexin may be preferred in children, because it is dosed less frequently and the liquid formulation is better tolerated.

Note: Patients should be referred to a medical practitioner where treatment with intramuscular (IM) benzylpenicillin is considered the most appropriate treatment option (e.g., There is a concern the patient being able to finish their course of treatment)

Dispense medications via pharmacy dispensing software and label according to the legislative requirements outlined in the Drugs, Poisons and Controlled substances Regulation 2017

Provide non-pharmacological and self-care advice

1. Provide patient with Consumer Medicines Information and/or a Self-Care Fact card to help patients control their impetigo

2. Provide advice on non-pharmacological, general and preventative measures

- For detailed hygiene and household prevention tips, refer to the Royal Children's Hospital Impetigo Fact Sheet.
- For information on reducing the spread of impetigo, refer to the Therapeutic Guidelines - Figure 2.85 Patient information: Advice for reducing the spread of impetigo

Treatment of co-occurring skin conditions (e.g., dermatitis, head lice or tinea) with standard pharmacist care

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Confirm management plan is appropriate with regards to contraindications, precautions, interactions, pregnancy and lactation status.

Communicate agreed treatment plan to patient and other healthcare professionals:

- Dispense medications via pharmacy dispensing program
- Counselling for topical or oral anti-infectives (e.g., dose, duration, application advice if applicable), including adverse effects and how to manage them
- Duration of treatment and expectations around resolution of symptoms
- Offer infection control advice and supply appropriate dressings where required
- Advise when to seek further care e.g., If signs and symptoms do not improve within 5 days of commencing treatment or worsen at any point in time

Document the consultation and share a record of the service with the patient, patient's usual treating GP or medical practice where the patient has one

3. Clinical Documentation Requirements

The pharmacist must document a clinical record of the consultation that contains:

- Sufficient information to identify the patient (Medicare number and date of birth are usually recorded when dispensing prescriptions)
- Date of treatment
- Name of the pharmacist who undertook the consultation and their Healthcare Provider Identifier Individual (HPI-I) number
- Consent given by the patient regarding: program participation, costs, pharmacist communication with other healthcare practitioners (e.g., patient's usual treating GP) and access to the patient's My Health Record for the purpose of checking inclusion/exclusion criteria and uploading information relating to the consultation as required
- Any information known to the pharmacist that is relevant to the patient's diagnosis or treatment (e.g., number of sores/lesions and sites affected) and any observations and assessments including allergies and adverse medicine reactions
- Any clinical opinion reached by the pharmacist
- Actions taken by the pharmacist (including any medications supplied or referrals made to a medical practitioner)
- Particulars of any medications supplied to the patient (such as form, strength and amount)
- Information or advice given to the patient in relation to any treatment proposed by the pharmacist who is treating the patient

The pharmacist must share a copy of the record of the service to the patient and with the patient's usual treating medical practitioner or medical practice, where the patient has one.

The pharmacist must make a record in the pharmacy software and an IT system approved by the Victorian Department of Health, regarding the supply.

Supplementary information

The supplementary information provided below has been included to assist Victorian pharmacists participating in the Community Pharmacist Program (the Program). It is intended to be used together with the guidelines and other resources referred to here to assist pharmacists in adhering to the management protocol and facilitate delivery of a safe and high-quality service to the community for the management of impetigo.

4. Gather information and assess patient's needs

4.1 Patient history

Sufficient information must be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines for the patient.

Consider:

- age (patients < 2 years of age are NOT eligible for treatment and must be referred to a medical practitioner)
- weight (if a child)
- pregnancy and lactation status, including patients planning pregnancy (if applicable)
- most recent place of residence/community and/or recent travel to a place where impetigo or ARF may be endemic (In Australia, ARF is generally considered to be endemic in Far North Queensland and North Queensland, the Northern Territory, and the Pilbara and Kimberley regions of Western Australia)
- onset, duration, nature, location, severity and extent of lesions
- recent skin and throat infections and treatment received
- other signs and symptoms e.g., pain, lymphadenopathy, signs of sepsis or other complications including APSGN and ARF such as fever, confusion, tachycardia, hypotension or hypertension, clammy skin, vomiting and diarrhoea, facial or peripheral oedema, severe headache, joint pain and/or hot swollen joints
- potential source of infection e.g., skin trauma, contact with people with similar symptoms
- co-existing and underlying medical conditions, including skin conditions or immunosuppression that may lead to complications (e.g., atopic dermatitis, discoid eczema, scabies, herpes simplex)
- current, recently commenced or recently ceased medications (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines) and topical treatments
- medicine allergies/adverse effects
- other risk factors including day care settings, crowding and malnutrition

The patient's My Health Record can be used to access a range of clinical information including details about current and past medication history, allergies and current medical conditions.

4.2 Examination

Prior to commencing patient examination, pharmacists should consider implementing infection control steps in line with the Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019 to their specific setting and circumstances. Pharmacists must also ensure that patient privacy is maintained throughout the examination and consultation.

Assessment and management of impetigo includes consideration of the patient's risk of complications including patients with a high risk of ARF, the nature (non-bullous or bullous), duration and number of sores, and whether the infection is recurrent.

Only patients with clearly identified non-recurrent, non-bullous impetigo, limited to no more than two body regions, with no signs of other complications, who are not at high risk of developing ARF

(Refer to **Table 2: People considered at high risk of developing ARF**), are eligible for treatment under this protocol. All other cases must be referred to a GP or other medical professional.

Where the diagnosis is uncertain, the condition is severe or recurrent, or symptoms do not improve with appropriate empirical treatment, patients should be referred to a medical practitioner for review and swab collection.

Pharmacists may refer to the following guidance to support a focused patient examination and clinical assessment.

A. Lesion Characteristics

Impetigo is a contagious skin infection that most often affects children, though it can occur at any age. It usually develops on skin that is already damaged by cuts, insect bites, or conditions like eczema — this is called secondary impetigo and is the most common form. Less commonly, it occurs on intact skin, known as primary impetigo. The main types of impetigo — non-bullous, bullous, and ecthyma — are described in **Table 1: Types of impetigo**. Further information and images of impetigo can be found at: https://dermnetnz.org/topics/impetigo

Table 1: Types of impetigo

Type	Description
Non-bullous (crusted)	• Present as thin-walled pustules or vesicles that rupture quickly, forming honey-coloured crusts; usually itchy, not painful, with minimal or no surrounding erythema. • Often begins as a single vesicle that spreads via self-inoculation, especially on the face and extremities (although any body part can be affected). • Patients are generally well, though may present with regional lymphadenopathy. • The condition is typically self-limiting; lesions may resolve spontaneously within 2-4 weeks without treatment and heal without scarring. • Caused by *Streptococcus pyogenes* (GAS), *Staphylococcus aureus*, or both.
Bullous	• Present as irritating fluid-filled flaccid vesicles or bullae (diameter often > 1 cm) that rupture, forming thin yellow-brown crusts and erosions with scaling at the edge (collarette). • Typically affects moist intertriginous areas (e.g., nappy area, axillae, neck) as well as face, trunk, and extremities. • Patients with bullous impetigo are more likely to experience systemic symptoms including fever, malaise and lymphadenopathy. • Lesions typically heal without scarring, resolving within 2–4 weeks if untreated. • Typically caused by *Staphylococcus aureus*.
Ecthyma (deep impetigo)	• Characterised by yellowish crusted sores with underlying ulcers, typically with purplish borders; if the crust is removed, an indurated ulcer will appear red, swollen and oozing. • Most commonly affects the buttocks, thighs, legs, ankles and feet.

	• People more likely to develop ecthyma include children, immunocompromised people, people with untreated impetigo and people living in crowded conditions. • Ecthyma is a deeper infection than non-bullous impetigo, with higher risk of scarring, systemic involvement, and may present with lymphadenopathy. • Lesions resolve slowly, sometimes spontaneously without treatment.

B. Red flag signs or patient ineligibility criteria i.e. patient to be referred to another authorised prescriber (medical or nurse practitioner)

Pharmacists must refer patients to the Emergency Department immediately if:

- The patient presents with any of the following:
    - Widespread, painful rash that may be erythematous
    - Raised purple rash that doesn't blanch
    - Blistering of the skin and/or mucous membranes (that may include mouth and eyes)
    - Signs and symptoms of serious and/or systemic illness (e.g., complicated cellulitis, severe ecthyma, acute ARF) including fever, lethargy, headache, rash, nausea and vomiting, sore and swollen joints, food/drinking aversion in a child
    - Generalised erythema that covers 90% or more of the skin surface, especially when associated with systemic symptoms

Pharmacists must refer patients to a medical practitioner immediately if:

- The patient is below the age of 2 years old
- The patient is immunocompromised
- The patient is at high risk of complications of impetigo, including patients at high risk of ARF (Refer to **Table 2: People considered at high risk of developing ARF**)
- A clear diagnosis of impetigo cannot be made or other/co-occurring conditions are suspected that cannot be treated in the community pharmacy setting, e.g., viral infection eczema herpeticum or contact dermatitis
- The patient presents with generalised erythema that covers 90% or more of the skin surface, but the patient is otherwise well, with no systemic features.
- The impetigo is widespread, severe and/or has ecthyma (ulceration) present
- Chronic sores or ulcers
- Symptoms have not resolved after the first course of antibiotic treatment, symptoms significantly or rapidly worsen, if impetigo infection reoccurs frequently

Pharmacists must refer patients to a medical practitioner but may also provide treatment if:

- Vesicles present in more than one but limited to a maximum of two locations (e.g., face plus arms), indicating moderate infection. Noting that multiple vesicles can be present in a single location (e.g., multiple vesicles near/around the mouth are considered as one location)

C. Differential Diagnosis (refer if suspected)

Impetigo may present similarly to, or co-exist with, other skin conditions including:

- Infected atopic or discoid eczema: Chronic itchy, inflamed patches; may develop secondary golden crusting when infected
- Herpes simplex virus (HSV-1): Grouped painful vesicles, often recur in same site; tingling/burning prodrome
- Varicella (chickenpox): Crops of vesicles at different stages, often starting on trunk
- Herpes zoster (shingles): Dermatomal distribution of vesicles, painful/burning prodrome
- Cellulitis: Diffuse redness, warmth, swelling, tenderness of skin; usually painful, often with systemic features (fever, malaise)
- Scabies: Intense itch, especially at night; burrows in web spaces, wrist, axillae.
- Psoriasis: Well-demarcated plaques with silvery scale, commonly on scalp, elbows, knees; chronic/recurrent
- Folliculitis: Small pustules or papules centred on hair follicles; may be itchy or tender
- Acne: Comedones (blackheads/whiteheads), papules, pustules; face, chest, back
- Contact dermatitis: Localised itchy erythematous rash at site of exposure; vesicles possible; resolves with avoidance
- Dermatophytosis (tinea): Ring-shaped, scaly, expanding border
- Candidiasis: Bright red, moist rash with satellite pustules; often in skin folds
- Thermal burns: Painful erythema or blistering consistent with recent heat/exposure
- Molluscum contagiosum: Dome-shaped, umbilicated, not crusting

D. Risk of the individual developing complications

As impetigo is contagious and most commonly in children, pharmacists should assess patients for the risk of developing complications.

Complications of impetigo, although rare, are more often associated with bullous impetigo and ecthyma, and may include:

- Lymphangitis or lymphadenitis
- Widespread infection, cellulitis, gangrene and bacteraemia
- Permanent scarring

Group A streptococcal infections (more common in endemic areas) may lead to:

- ARF (Refer if at high risk of developing ARF)
    - Immune-mediated disease caused by S. *pyogenes*
    - Presents with sore/swollen joints, fever, malaise and weakness
    - Affects the heart, joints, nervous system and skin
    - Onset: 1-5 weeks after strep infection, often with repeated strep throat or skin infections
    - Most commonly in children 5-14 years

Table 2: People considered at high risk of developing ARF

Individuals at high risk of developing ARF
• Aboriginal and Torres Strait Islander people residing in a rural or remote area, or living in a household affected by household overcrowding (> 2 people per bedroom) or experiencing socioeconomic disadvantage. • Māori and/or Pacific Islander person living in a household affected by overcrowding (> 2 people per bedroom) or experiencing socioeconomic disadvantage. • A person with a personal history of ARF or RHD. • A person with a family or household member with a recent history of ARF or RHD.
Additional risk factors for individuals aged ≤ 40 years (particularly between 5-20 years)
• People living in a household affected by household overcrowding (> 2 people per bedroom) or experiencing socioeconomic disadvantage. • People with current or prior residence in (or frequent or recent travel to) an area with a high rate of ARF e.g., refugees and migrants from low-middle income countries, rural and remote communities.

- APSGN
    - Immune-mediated kidney disease caused by nephritogenic S. *pyogenes*
    - Features: facial/eye swelling (especially morning), high blood pressure, proteinuria, dark urine, lethargy
    - Onset: 2-3 weeks after strep skin or throat infection
    - Most common in children 12 months to 17 years
- Sepsis
- Osteomyelitis

4.3 Investigations

Patients with impetigo do not require an initial skin swab before starting empirical therapy unless the diagnosis is uncertain or impetigo is recurrent. A skin swab for culture and susceptibility testing is recommended for patients with impetigo that is not responding to appropriate empirical therapy.

Where referral is required (e.g., for recurrent, severe, or uncertain cases), pharmacists should direct patients to their general practitioner or another appropriate health service. If timely access to a GP is not available, referral to the Victorian Virtual Emergency Department (VVED) may be considered as an alternative pathway to ensure timely care.

5. Management and treatment plan

Uncomplicated impetigo is generally mild, and treatment of impetigo reduces the duration of the illness, the spread of lesions, and decreases the risk of complications.

Pharmacist management of impetigo can involve:

- General and preventative measures
- Provide the patient/parent/caregiver with advice and education to help reduce the spread of impetigo. For example, the Royal Children's Hospital Melbourne Impetigo fact sheet or the Better Health Channel Impetigo fact sheet or the Therapeutic Guidelines Patient information leaflet: Advice for reducing the spread of impetigo.

Treatment of co-occurring skin conditions

- Provide standard pharmacist care or refer to a medical practitioner as appropriate.

Pharmacotherapy

- As per this protocol and in line with the Therapeutic Guidelines: Antibiotic - Impetigo including:
    - **Empirical topical anti-infectives** – for patients with non-recurrent limited non-bullous impetigo (up to 2 sores) who are not at high risk of ARF
    - **Empirical oral antibiotics** – for patients with non-recurrent extensive non-bullous impetigo limited to no more than 2 sites who are not at high risk of ARF.

NB1: Topical antibiotics are considered sufficient treatment for the majority of patients. However, they are not appropriate if the infection is widespread or multiple family/community members are infected, due to the risk of rapid resistance. Oral antibiotics may be prescribed if appropriate.

NB2: The correct use of antibiotics is essential; extended or incorrect use may increase the risk of antimicrobial resistance, particularly for topical antibiotics. Discussing the treatment regime with patients/parents/caregivers reduces the risk that antibiotics will be incorrectly used. Where the patient or caregiver's ability and/or motivation to correctly use topical treatment is in doubt e.g., when there are multiple sores, oral antibiotics should be considered, or referral to a medical practitioner for IM benzathine benzylpenicillin.

5.1 Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references to confirm the management is appropriate, including for:

- Contraindications and precautions
- Medicine interactions
- Pregnancy and lactation

Note: There is no requirement to report cases of impetigo to the Department of Health in Victoria.

6. Medicines list

The Program authorises the supply of certain anti-infectives for the treatment of impetigo where these are indicated. These include:

Empirical therapy for limited non-bullous impetigo (≤ 2 sores, non-recurrent, not at high risk of ARF)

Generic name	Preparation	Dose	Duration
Mupirocin (1st line)	Cream 2% or Ointment 2%	Apply to crusted areas every 8 hours	5 days
Hydrogen peroxide (2nd line)	Cream 1% *Unscheduled and available over the counter	Apply to crusted areas every 8 hours	5 days

Empirical therapy for extensive non-bullous impetigo (non-recurrent, limited to no more than 2 sites, not at high risk of ARF)

Generic name	Preparation	Dose	Duration
Dicloxacillin (1st line)	Capsule 250mg or 500 mg	500 mg (child: 12.5 mg/kg up to 500 mg) orally every 6 hours	5 days (stop at 3 days if resolved)
Flucloxacillin (1st line)	Capsule 250mg or 500 mg, Oral liquid 50 mg/mL or 25 mg/mL	500 mg (child: 12.5 mg/kg up to 500 mg) orally every 6 hours	5 days (stop at 3 days if resolved)
Cefalexin (2nd line)	Capsule 250mg or 500 mg, Oral liquid 25mg/mL or 50 mg/mL	1 g (child: 25 mg/kg up to 1000mg) orally, every 12 hours	5 days (stop at 3 days if resolved)
Trimethoprim + Sulfamethoxazole (3rd line)	Oral liquid 8+40 mg/mL or Tablet 160+800 mg	160+800 mg (child: 4+20 mg/kg up to 160+800 mg) orally, every 12 hours	3 days
		320+1600 mg (child: 8+40 mg/kg up to 320+1600 mg) orally, once daily	5 days

Guidance and Special Considerations

Penicillin Hypersensitivity

- For patients who have had a non-severe (immediate or delayed) hypersensitivity reaction to a penicillin, use the cefalexin regimen above. Cefalexin may be used in patients who have had a non-severe (immediate or delayed) reaction to amoxicillin or ampicillin. However, because cross-reactivity between these drugs is possible, consideration should be given to the extent of the reaction, patient acceptability, and the suitability of non–beta-lactam options

For patients who have had a severe (immediate or delayed) hypersensitivity reaction to a penicillin use one of the trimethoprim + sulfamethoxazole regimens above.

Oral antibiotic considerations

- Cefalexin is often preferred in children due to better-tolerated oral liquid formulations and twice daily dosing
- Consider trimethoprim + sulfamethoxazole for patients with true beta-lactam allergy or where dosing convenience (e.g., once-daily) is important

7. Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) as per the Australian Medicines Handbook and other relevant references should be provided to the patient/parent/caregiver regarding:

- Individual product and medication use including dosing, duration and application tips where indicated.
- Non-pharmacological, general and preventative measures. For detailed hygiene and household prevention tips, refer to the Royal Children's Hospital Impetigo Fact Sheet.
    - Patients should be advised to gently soak and clean affected areas, including removal of crusts (e.g., with a soft, wet disposable cloth).
    - Dilute bleach baths may help reduce bacterial load and support healing. Pharmacists may advise families on the safe use of bleach baths in line with the Royal Children's hospital guidance: Skin infections: bleach baths. Bleach baths may be used as an adjunct to, not a replacement for, topical or oral therapy.
- How to manage adverse effects of treatment.
- When to seek further care and/or treatment, including recognising complications of impetigo, particularly ARF and APSGN.

7.1 General advice

The patient/parent/caregiver(s) should be provided with clear and simple advice to support healing and reduce the risk of transmission.

Key points include:

- Impetigo is highly contagious and spreads easily between children.
- Avoid scratching or picking at sores; keep fingernails short and lesions covered with watertight dressings.
- Complete the full treatment course until all sores are healed.
    - Patients recommended topical treatments or oral trimethoprim-sulfamethoxazole on once daily dosing should complete 5 days of treatment
    - Patients recommended first-line oral antibiotics (dicloxacillin or flucloxacillin), cefalexin or trimethoprim-sulfamethoxazole on twice daily dosing may stop treatment after 3 days if signs of infection have resolved.
- Children may return to school or childcare after 24 hours of treatment if all sores are fully covered. Pharmacists should advise that sores be gently cleaned and de-crusted before covering. Appropriate dressings (e.g., waterproof or non-stick types) may be supplied or recommended for dry or minimally weeping lesions, particularly on exposed areas to prevent the spread of infection. If lesions are heavily weeping, focus on cleaning and de-crusting, as dressings may worsen maceration.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients, and to ensure compliance with all copyright conditions.

The agreed management plan should be shared with the patient's multidisciplinary healthcare team, with the patient's consent.

Patients/parents/caregivers should be advised to see a medical practitioner if:

- the condition does not improve within 5-10 days of starting treatment

- the patient's condition worsens, including developing systemic signs and symptoms
- the condition recurs after treatment course is completed
- adverse effects of treatment cannot be managed in the pharmacy setting

8. Follow up / clinical review

Clinical review with the pharmacist is generally not required. If the condition does not improve or resolve, the patient should be advised to see a medical practitioner for further investigation.

9. Resources for pharmacists

9.1 Pharmacist resources

- Therapeutic Guidelines
  - Antibiotic – Impetigo
- Australian Medicines Handbook
  - Antibacterials (skin)
  - Antibacterials
  - Skin and soft tissue infections
- Rheumatic Heart Disease Australia – ARF RHD Guideline
- MSD Manual Professional Edition - Impetigo and Ecthyma
- Royal Children's Hospital Melbourne
  - Clinical Practice Guidelines: Cellulitis and other bacterial skin infections
  - Clinical Practice Guidelines: Antimicrobial guidelines
- DermNet NZ
  - Impetigo (school sores, skin infections): Images, Causes, and Symptoms — DermNet
- Australian College of Dermatologists
  - ACD A-Z of Skin - Impetigo

9.2 Patient resources

- Royal Children's Hospital Melbourne
  - Kids Health Info: Impetigo (school sores)
  - Kids Health Info: Staphylococcal infections
  - Kids Health Info: Skin infections – bleach baths
- Better Health Channel
  - Impetigo - school sores - Better Health Channel
- Raising Children's Network: The Australian Parenting Website
  - Impetigo or school sores
- Victorian Department of Health
  - Impetigo (school sores)
- Health Direct
  - Impetigo - treatments, symptoms and causes