

Case Blog

Title: Impetigo

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An 8-year-old boy presents with an erythematous plaque on the lateral aspect of the left leg with some peripheral crusting. The lesion begins 10 days ago as a small erythematous macule that later becomes excoriated and has been enlarging. The lesion is mildly pruritic and tender.

Impetigo is a superficial, highly contagious, bacterial infection of the skin, caused mainly by *Staphylococcus aureus* and group A β -hemolytic streptococci. The disease is transmitted from person to person mainly by direct contact or to oneself by autoinoculation; it can also spread by fomites. Predisposing factors include poor hygiene, crowded living conditions, skin abrasions, minor trauma, insect bites, burns, atopic dermatitis, diabetes mellitus, intravenous drug abusers, and immunodeficiency.

Impetigo typically begins as a small, 2 to 4 mm erythematous macule that soon becomes vesicular. The vesicle then ruptures, leaving an exudate with a characteristic yellowish-brown or honey-colored 'stuck-on' crust over the superficial erosion. Removal of the crust results in the reaccumulation of fresh exudate. Satellite lesions typically appear in the vicinity as a result of spread by autoinoculation. Coalescence of lesions produces wider area of involvement. Nonbullous impetigo most commonly occurs on the face, followed by the extremities. Constitutional symptoms such as fever, malaise, and anorexia are generally absent. Mild pruritus or pain may be noted. Regional lymphadenopathy may be present.

Treatment consists of topical application of antibiotics such as mupirocin, fusidic acid, and retapamulin. For severe, widespread, or recurrent infections, oral antimicrobials effective against *Staphylococcus aureus* and group A β -hemolytic streptococci should be used. The medications of choice include dicloxacillin, amoxicillin/clavulanic acid, clarithromycin, azithromycin, and cephalosporins such as cephalexin. Addition of a mild steroid to the antibiotic can be beneficial as well.

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