



MANAGEMENT OF SCABIES IN THE UK

EXPERT CONSENSUS GUIDANCE

September 2026

BACKGROUND

Scabies is a mite infestation which often causes an itchy rash and is passed between people by skin-to-skin contact. Prompt treatment of all those affected, and any possible contact, is required to manage symptoms and prevent complications and spread.

There are increasing reports of patients presenting to primary care, dermatology and sexual health departments with scabies, many of whom have difficult-to-treat infestations, although the data are limited. This is having a huge impact on patients as it can be such a distressing condition and is still unnecessarily stigmatised.

Currently, the reasons for poor treatment responses are unclear. It may reflect an increased burden of infestation and inadequate/incorrect use of topical treatments. There is ongoing research on possible resistance to treatments as a potential cause of increased rates of problematic infestations.

The most common cause of issues is likely to be re-infestation, post-scabetic nodules and/or dermatitis (from inflammation, scratching and/or scabies treatments causing irritation). Skin inflammation is to be expected alongside scabies infestation – see section following advice on scabies treatment to address this.

A diagnosis of scabies can be made according to the International Alliance for the Control of Scabies (IACS) criteria by the typical history of itching and itchy contacts, and evidence of a rash, commonly small erythematous/red spots on hands and genitals, evidence of burrows, visualisation of mites or mite eggs, or parts on dermoscopy or **direct microscopic examination** of skin scrapings. Confirmation of the diagnosis using microscopy is particularly important for crusted scabies, as typical skin lesions may not be visible.

Scabies is best managed in primary care, with treatments as below, and all relevant contacts must be treated. Waiting for dermatology review can lead to delay in treatment. Dermatology referral should be considered if there are diagnostic uncertainty or concerns.

MANAGEMENT

Treatments for scabies include topical preparations and oral ivermectin. The best way to treat scabies and avoid recurrence is to ensure that both those with infestation and **ALL** relevant contacts (see below) are treated correctly **at the same time**.

In most cases, the mites will not survive for long on bed linen, towels and clothes. Washing these at 50 °C is recommended at the same time as treatment. Any item that cannot be washed at this temperature should be placed in sealed bags for 3 days.

Itching may last for up to 6 weeks, even if treatment has been successful in eliminating the infestation. If scabies is ongoing or recurrent, then all cases and all relevant contacts will need further treatment.

Who should be considered a 'contact'?

Scabies can spread easily through skin-to-skin contact with other people. Contacts will likely include all household members and sexual partners. It could also include individuals who do not live in an

affected household but provide care, e.g. visiting family members, child minders and adult day care providers and any other skin contacts such as members of sports teams. Not all individuals with scabies have itch and rash. Asymptomatic people will re-infest their contacts if they are not treated concurrently. It is important to recognise that some will feel shame or guilt, which may have an impact on use of treatments, however, in reality, anyone can be infested by scabies. Informing and reassuring relevant contacts so that they can receive effective treatments is vital to stop the spread of scabies.

Topical treatments (advised as first-line)

Effective topical treatment options include permethrin 5% cream, malathion 0.5% liquid and benzoyl benzoate emulsion. Topical treatments for scabies can be prescribed or purchased without a prescription. Information on the correct application and treatment of close contacts are essential to ensure highest chance of effectiveness.

Advice for application of topical treatments

The mites may be anywhere on the skin, so the treatment must be applied to **ALL** areas of the skin, and not just to the itchy parts. Treatment is best applied at night – see below for tips on how to use:

- Remove all clothes.
- Wash before treatment with cool (not hot) water, ensuring the skin creases and areas under nails are cleaned thoroughly. It is best to cut nails short.
- Apply treatment to clean, cool and dry skin.
- Apply to **ALL areas of the skin**, including all of the body, neck, scalp and face (only avoiding areas around the eyes). The product advice may suggest not treating the scalp and face, but it is best that all these areas are treated.
- Certain areas of skin need particular attention for treatment to be successful – ensure the product is applied generously to:
 - skin between fingers and toes
 - genital skin (e.g. underneath the foreskin)
 - skin behind ears
 - nipples
 - under finger and toenails (use of a soft toothbrush can help with this).
- Ideally, remove all jewellery or make sure to apply to the skin under jewellery.
- Apply the product to soles of feet last.
- If any skin is washed during this time (most likely to be the hands), the product should be reapplied.

Once applied, leave 10-15 minutes for the product to dry before dressing. Treatment should be left on the skin for **at least 12 hours**.

To ensure effective treatment, consider a further application 12 hours later

This will ensure the medication is on their skin for 24 hours. The product should be washed off without soap initially, i.e. just water. Once completely showered, soap and/or moisturisers or emollients can be used. Once treatment has been used you can return to all normal activities.

As treatment does not kill scabies eggs, they should be repeated as above, 7 days later, to ensure newly hatched scabies mites are destroyed.

Potential resistance to topical treatments

This is an area of current investigation. Topical treatments are effective; however, there is some evidence of altered strains of mite which are tolerant of pyrethroids (permethrin). Alternatives such as malathion or benzoyl benzoate should be considered, as required.

Oral treatment

Ivermectin is licensed in the UK for scabies, and available in 3 mg tablets. The dose for scabies treatment is 200 µg/kg, taken in a single dose with food. For example, 15 mg (5 tablets) for a 70 kg person.

Ivermectin is not ovicidal, so a second dose should be given 7 days later to kill recently hatched mites, to ensure effectiveness. Oral ivermectin may be considered:

- if topical treatments have not resolved the symptoms and there is evidence of ongoing infestation with the presence of burrows, etc.
- if topical treatments are difficult to access or are unavailable
- in conditions where topical treatments may be difficult to apply effectively, e.g. in care home settings, and where treatment of large numbers of persons is required
- for concurrent administration with topical treatments in certain cases
- for crusted scabies.

Scabies in children

Permethrin 5% cream is recommended first-line. It can be used in children aged >2 months. Standard topical permethrin regimens should be applied on day 1 and then a repeat application on day 7 (see application guidance in children).

If scabies infestation persists following a standard permethrin regimen at day 1 and day 7, then enhanced application regimens can be considered. These may include an additional day of application, or longer application times.

It is not uncommon to get irritated skin with permethrin use. Please see information below on skin irritation and inflammation for all ages.

Application guidance in children and infants

- Infants or children should be bathed or showered before application
- Ensure children's nails are cut short prior to application (as mites can hide under nail sites)
- Topical treatments (cream, lotions, etc.) should be applied to ALL areas of skin, including face, neck, scalp and ears
- Pay particular attention to skin folds (including nappy area), palms of hands and soles of feet (these areas may have more mite activity, and more likely to rub off, especially in children)
- Apply generously between fingers and toes
- Apply to external genitalia as well as buttocks, including creases
- Apply to armpits

The best time to apply topical treatments is at nighttime after bathing or showering and patting dry. Following application, leave on for 15 minutes before putting into bedtime clothing. If children have washed their hands after applying the topical treatments or rubbed their hands or other parts of the body, then advise reapplying topical treatments to those sites.

Leave on for **12 hours minimum** before washing off the next day.

For infants that may repeatedly touch their mouths, mittens can be used overnight as these can prevent topical treatments from entering the mouth. ALL household contacts/close contacts should receive treatment at the same time, even those who have no symptoms. If following two courses of topical permethrin has been ineffective, then consult specialist advice.

Ivermectin for children

For children aged <2 years, use permethrin 5% cream.

Ivermectin is given as a single dose, taken on an empty stomach. If a child weighs >15 kg, a 3 mg dose is suitable; a further dose will be required after 7 days. If <15 kg the suggested dosing is 200 micrograms/kg for one dose (in consultation with dermatology).

For younger children, tablets can be crushed before swallowing; these can be given in water or fruit squash (not food or milk).

Scabies and pregnancy

There are no specific studies on the use of topical agents in women who are pregnant or breastfeeding, or for babies. These patients, or their carers, are advised to seek advice on their use from a doctor.

Permethrin and malathion are both used to treat scabies in pregnancy and not known to have adverse events. Permethrin is advised as first-line, although studies of scabies medications are not well reported or studied.

If a pregnant person needs treatment at the same time as other scabies cases, then it is advisable that they wear gloves and avoid unnecessary exposure.

Scabies treatment with these topical treatments are not expected to harm or affect an unborn baby.

Skin irritation and inflammation

Skin irritation and eczema can commonly be seen alongside scabies, sometimes leading to diagnostic uncertainty. During active infestation, scratching can cause a secondary dermatitis. All topical preparations to treat scabies are likely to cause skin irritation leading to eczema/dermatitis, especially if used repeatedly. This can result in ongoing skin issues even when infestation has been successfully eliminated; post-scabies itch may persist, as may areas of dermatitis and inflammatory nodules.

People with a known background of dry skin or eczema are likely to be particularly affected; however, associated or secondary eczema is likely in all people.

Management with emollients (as wash products and leave-on moisturisers) may be sufficient. However, topical anti-inflammatory treatments may be needed, and prescribed as necessary to manage any inflamed skin/dermatitis or inflammatory nodules. Topical corticosteroids of appropriate potency may be given. Topical mometasone or topical tacrolimus 0.1% are useful for post-scabetic nodules. Topical corticosteroids have more benefits than harms when used correctly and are vital to reduce inflammation and itch in eczema.

INFORMATION

<https://www.bad.org.uk/pils/scabies/>

<https://www.pcds.org.uk/clinical-guidance/scabies>

<https://www.gov.uk/government/publications/scabies-management-advice-for-health-professionals/ukhsa-guidance-on-the-management-of-scabies-cases-and-outbreaks-in-long-term-care-facilities-and-other-closed-setting>

RELEVANT PUBLICATIONS

- Engelman D, Yoshizumi J, Hay RJ et al. The 2020 International Alliance for the Control of Scabies Consensus Criteria for the Diagnosis of Scabies. *Br J Dermatol* 2020; **183**: 808-20.
- Riebenbauer K, Purkhauer K, Walochnik J et al. Detection of a knockdown mutation in the voltage-sensitive sodium channel associated with permethrin tolerance in *Sarcoptes scabiei* var. *hominis* mites. *J Eur Acad Dermatol Venereol* 2023; **37**: 2355-61.
- Sunderkötter C, Wohlrab J, Hamm H. Scabies: Epidemiology, Diagnosis, and Treatment. *Dtsch Arztebl Int* 2021; **118**: 695-704.

- Rosumeck S, Nast A, Dressler C. Ivermectin and permethrin for treating scabies. *Cochrane Database Syst Rev* 2018; **4**: Cd012994.
- Ranjkesh MR, Naghili B, Goldust M, Rezaee E. The efficacy of permethrin 5% vs. oral ivermectin for the treatment of scabies. *Ann Parasitol* 2013; **59**: 189-94.
- Salavastru CM, Chosidow O, Boffa MJ et al. European guideline for the management of scabies. *J Eur Acad Dermatol Venereol* 2017; **31**: 1248-53.
- Ivermectin: new indication. Oral treatment of scabies: simple and effective. *Prescrire Int* 2002; **11**: 137-40.
- Panahi Y, Poursaleh Z, Goldust M. The efficacy of topical and oral ivermectin in the treatment of human scabies. *Ann Parasitol* 2015; **61**: 11-6.
- Levy M, Martin L, Bursztejn AC et al. Ivermectin safety in infants and children under 15 kg treated for scabies: a multicentric observational study. *Br J Dermatol* 2020; **182**: 1003-6.
- Richards RN. Scabies: Diagnostic and Therapeutic Update. *J Cutan Med Surg* 2021; **25**: 95-101.
- Mbuagbaw L, Sadeghirad B, Morgan RL, et al. Failure of scabies treatment: a systematic review and meta-analysis. *Br J Dermatol* 2024; **190**: 163-73.
- Optimising treatment options in scabies. *Drug Ther Bull* 2026; **28**: 64: 92.
- Boralevi F, Simon G, Bernigaud C. et al. Oral ivermectin versus 5% permethrin cream to treat children and adults with classic scabies: multicentre, assessor blinded, cluster randomised clinical trial. *BMJ* 2026; **392**: e086277. Erratum in: *BMJ* 2026; **393**: s587.
- Bernigaud C, Fernando DD, Lu H, et al. How to eliminate scabies parasites from fomites: A high-throughput ex vivo experimental study. *J Am Acad Dermatol* 2020; **83**: 241-5.
- Bernigaud C, Do-Pham G, Guichard E, et al. Combined Oral Ivermectin and 5% Permethrin Cream to Treat Severe Scabies. *N Engl J Med* 2026; **394**: 1814-23.