this method has low sensitivity and is time consuming (*1403*). Alternatively, noninvasive examination of the affected skin by using videodermatoscopy, videomicroscopy, or dermoscopy can be used, each of which has high sensitivity and specificity, particularly when performed by experienced operators (*1404*). Low-technology strategies include the burrow ink test and the adhesive tape test.

Treatment

Recommended Regimens for Scabies
Permethrin 5% cream applied to all areas of the body from the neck down and washed off after 8–14 hours *or* **Ivermectin** 200 ug/kg body weight orally, repeated in 14 days* *or* **Ivermectin 1% lotion** applied to all areas of the body from the neck down and washed off after 8–14 hours; repeat treatment in 1 week if symptoms persist
* Oral ivermectin has limited ovicidal activity; a second dose is required for eradication.

Alternative Regimen
Lindane 1% 1 oz of lotion or 30 g of cream applied in a thin layer to all areas of the body from the neck down and thoroughly washed off after 8 hours*
* Infants and children aged <10 years should not be treated with lindane.

Topical permethrin and oral and topical ivermectin have similar efficacy for cure of scabies (*1405–1410*). Choice of treatment might be based on patient preference for topical versus oral therapy, drug interactions with ivermectin (e.g., azithromycin, trimethoprim/sulfamethoxazole [Bactrim], or cetirizine [Zytrec]), and cost. Permethrin is safe and effective with a single application (*1411*). Ivermectin has limited ovicidal activity and might not prevent recurrences of eggs at the time of treatment; therefore, a second dose of ivermectin should be administered 14 days after the first dose (*1412*). Ivermectin should be taken with food because bioavailability is increased, thereby increasing penetration of the drug into the epidermis. Adjustments to ivermectin dosing are not required for patients with renal impairment; however, the safety of multiple doses among patients with severe liver disease is unknown.

Lindane is an alternative regimen because it can cause toxicity (*1413*); it should be used only if the patient cannot tolerate the recommended therapies or if these therapies have failed (*1414–1416*). Lindane is not recommended for pregnant and breastfeeding women, children aged <10 years, and persons with extensive dermatitis. Seizures have occurred when lindane was applied after a bath or used by patients who had extensive dermatitis. Aplastic anemia after lindane use also has been reported (*1413*). Lindane resistance has been reported in some areas of the world, including parts of the United States (*1413*).

Other Management Considerations

Bedding and clothing should be decontaminated (i.e., either machine washed and dried by using the heat cycle or dry cleaned) or removed from body contact for >72 hours. Fumigation of living areas is unnecessary. Persons with scabies should be advised to keep fingernails closely trimmed to reduce injury from excessive scratching (*1417*).

Crusted Scabies

Crusted scabies is an aggressive infestation that usually occurs among immunodeficient, debilitated, or malnourished persons, including persons receiving systemic or potent topical glucocorticoids, organ transplant recipients, persons with HIV infection or human T-lymphotrophic virus-1 infection, and persons with hematologic malignancies. Crusted scabies is transmitted more easily than scabies (*1418*). No controlled therapeutic studies for crusted scabies have been conducted, and a recommended treatment remains unclear. Substantial treatment failure might occur with a single-dose topical scabicide or with oral ivermectin treatment. Combination treatment is recommended with a topical scabicide, either 5% topical permethrin cream (full-body application to be repeated daily for 7 days then 2 times/week until cure) or 25% topical benzyl benzoate, and oral ivermectin 200 *u*g/kg body weight on days 1, 2, 8, 9, and 15. Additional ivermectin treatment on days 22 and 29 might be required for severe cases (*1419*). Lindane should be avoided because of the risks for neurotoxicity with heavy applications on denuded skin.

Follow-Up

The rash and pruritus of scabies might persist for <2 weeks after treatment. Symptoms or signs persisting for >2 weeks can be attributed to multiple factors. Treatment failure can occur as a result of resistance to medication or faulty application of topical scabicides. These medications do not easily penetrate into thick, scaly skin of persons with crusted scabies, perpetuating the harboring of mites in these difficult-to-penetrate layers. In the absence of recommended contact treatment and decontamination of bedding and clothing, persisting symptoms can be attributed to reinfection by family members or fomites. Finally, other household mites can cause symptoms to persist as a result of cross-reactivity between antigens. Even when treatment is successful, reinfection is avoided, and cross-reactivity does not occur, symptoms can persist or worsen as a result of allergic dermatitis.

Retreatment 2 weeks after the initial treatment regimen can be considered for those persons who are still symptomatic or when live mites are observed. Use of an alternative regimen is recommended for those persons who do not respond initially to the recommended treatment.