Management of Sex Partners and Household Contacts

Persons who have had sexual, close personal, or household contact with the patient within the month preceding scabies infestation should be examined. Those identified as being infested should be provided treatment.

Management of Outbreaks in Communities, Nursing Homes, and Other Institutional Settings

Scabies epidemics frequently occur in nursing homes, hospitals, residential facilities, and other communities (*1420*,*1421*). Control of an epidemic can only be achieved by treating the entire population at risk. Ivermectin can be considered in these settings, especially if treatment with topical scabicides fails. Mass treatment with oral ivermectin is highly effective in decreasing prevalence in settings where scabies is endemic (*1422*). Epidemics should be managed in consultation with a specialist.

Special Considerations

Infants, Young Children, and Pregnant or Lactating Women

Infants and young children should be treated with permethrin; the safety of ivermectin for children weighing <15 kg has not been determined. Infants and children aged <10 years should not be treated with lindane. Ivermectin likely poses a low risk to pregnant women and is likely compatible with breastfeeding; however, because of limited data regarding ivermectin use for pregnant and lactating women, permethrin is the preferred treatment (*431*) (see Pediculosis Pubis).

HIV Infection

Persons with HIV infection who have uncomplicated scabies should receive the same treatment regimens as those who do not have HIV. Persons with HIV infection and others who are immunosuppressed are at increased risk for crusted scabies and should be managed in consultation with a specialist.

Sexual Assault and Abuse and STIs

Adolescents and Adults

These guidelines are primarily limited to the identification, prophylaxis, and treatment of STIs and conditions among adolescent and adult female sexual assault survivors. However, some of the following guidelines might still apply to male sexual assault survivors. Documentation of findings, collection of nonmicrobiologic specimens for forensic purposes, and management of potential pregnancy or physical and psychological trauma are beyond the scope of these guidelines. Examinations of survivors of sexual assault should be conducted by an experienced clinician in a way that minimizes further trauma to the person. The decision to obtain genital or other specimens for STI diagnosis should be made on an individual basis. Care systems for survivors should be designed to ensure continuity, including timely review of test results, support adherence, and monitoring for adverse reactions to any prescribed therapeutic or prophylactic regimens. Laws in all 50 states limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STIs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment also is enforced in most states. Although it rarely occurs, STI diagnoses might later be accessed, and the survivor and clinician might opt to defer testing for this reason. Although collection of specimens at initial examination for laboratory STI diagnosis gives the survivor and clinician the option of deferring empiric prophylactic antimicrobial treatment, compliance with follow-up visits is typically poor (*1423*–*1425*). Among sexually active adults, identification of an STI might represent an infection acquired before the assault, and therefore might be more important for the medical management of the patient than for legal purposes.

Trichomoniasis, BV, gonorrhea, and chlamydia are the most frequently diagnosed infections among women who have been sexually assaulted. Such conditions are prevalent among the population, and detection of these infections after an assault does not necessarily imply acquisition during the assault. However, a postassault examination presents an important opportunity for identifying or preventing an STI. Chlamydial and gonococcal infections among women are of particular concern because of the possibility of ascending infection. In addition, HBV infection can be prevented through postexposure vaccination (see Hepatitis B Virus Infection). Because persons who have been sexually assaulted also are at risk for acquiring HPV infection, and the efficacy of the HPV vaccine is high (*1426*,*1427*), HPV vaccination is also recommended for females and males through age 26 years (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html) (*11*). Reproductive-aged female survivors should be evaluated for pregnancy and offered emergency contraception.

Evaluating Adolescents and Adults for STIs

Initial Examination

Decisions to perform the following tests should be made on an individual basis. An initial examination after a sexual assault might include the following: