Dear Editor,

The COVID-19 pandemic had a monumental impact on the practice of medicine, and 2020 saw a shift towards virtual consulting and changes in the range of conditions presenting to dermatology, from those directly COVID-related (e.g. chilblains, viral eruptions) to consequences of our work (e.g. personal protective equipment-related dermatosis, hand dermatitis, mask acne). We report an additional significant change in our practice during this pandemic, a rise in ‘difficult-to-treat’ scabies.

Scabies is a highly contagious skin infestation caused by the mite Sarcoptes scabiei var. hominis. In developed countries, scabies is usually observed sporadically or in the form of institutional outbreaks, such as in hospitals or group facilities or among displaced persons. It is commonly encountered in primary care, and a small fraction of cases present to dermatology. In the UK and Ireland, the usual treatment is two applications of topical permethrin 5% (or malathion 0.5% as second-line treatment) applied 1 week apart, with simultaneous treatment of close contacts. Correctly applied, this treatment is usually effective.1,2 Oral ivermectin is occasionally used off-licence in cases that have failed topical therapy or in case of crusted scabies.2 However, we observed a significant increase in scabies requiring systemic ivermectin in our region from March 2020 to July 2021, compared with the average for the same period over the previous 4 years. This prompted a retrospective review of our patient records for oral ivermectin prescriptions in order to identify trends.

Our department operates an urgent primary care referral pathway, with access for general practitioners via telephone and email. This continued throughout the pandemic. Prior to March 2020, scabies requiring treatment with systemic ivermectin occurred on average once yearly (mean annual incidence rate 1.09); however, this rose to an annual rate of 7.50 during the period of our review (Table 1). Both groups had used a similar number of permethrin applications prior to review (5.75 vs. 6.40), and none of the patients had received prior ivermectin therapy. Both groups had high numbers of reported symptomatic close contacts (83% vs. 100%). Interestingly, those seen during confinement had a shorter mean duration of symptoms (8.14 vs. 11.25 months) and were three times more likely to have complications (hospital admission, biopsies or crusted scabies).

The policy within our department is to repeat topical therapy with concomitant treatment of close contacts and advice on washing clothing/bedding, is usually successful and in line with best practice.1,2 We reserve systemic therapy for those who, despite this, have evidence of new burrows (i.e. not persistent itch). Confinement and COVID-19 has changed how and where people spend their time. More households are sharing spaces for long periods, and despite lifting of lockdown restrictions, many people continue to work from home. This probably increases the risk of transmitting the parasite through direct contact or by fomites, and similar observations have been reported from Spain.3 Scabies is also more commonly observed during the winter months.4 The shorter duration of symptoms may reflect the increased efficiency of our telephone referral advice, in response to reduced access to in-person appointments during the pandemic and is something to consider for the future.

This was a small retrospective study, and therefore makes generalizations difficult. Nevertheless, our centre has noticed significant changes in presentation of Sarcoptes to secondary care during the pandemic, with higher requirement for systemic ivermectin therapy, which must be balanced with the potential risks of this off-licence treatment.5

Table 1 Comparison of demographic, clinical and therapeutic data between scabies cases requiring systemic ivermectin therapy diagnosed during the months of ‘confinement’ and ‘non-confinement’.

|                         | Confinementa | Non-confinemb |
|-------------------------|--------------|--------------|
| Total cases, n          | 10           | 7            |
| Rate per month          | 0.63         | 0.09         |
| Rate per year           | 7.50         | 1.09         |
| Age, years; mean (median) [range] | 33.7 (27) [0.3-80] | 23.3 (21) [9-53] |
| Complicated cases, n    | 3            | 0            |
| Mean symptom duration, months | 8.14          | 11.25       |
| Mean permethrin application, n | 5.75         | 6.40         |
| Cases with known clustered contacts, % | 83           | 100          |

aConfinement: period March 2020 to July 2021 (16 months); bno confinement: period July 2016 to March 2020 (44 months); ctwo complicated cases were admitted: one had crusted scabies, the other required skin biopsy.
A 52-year-old Chinese man presented with a 4-week history of blisters on the left side of his chest and back, distributed along the intercostal nerves, with significant pain. He had been seen previously at a local dermatology clinic, where he was diagnosed with herpes zoster, and prescribed systemic antiviral therapy (aciclovir), systemic neurotrophic therapy (vitamins B1 and B12) and topical medication (antiviral ointment). After about 2 weeks of that treatment, the lesions had improved significantly and all blisters disappeared, leaving slight residual hyperpigmentation, but the localized pain persisted. He then underwent fire needle therapy, a traditional Chinese medicine treatment that involves repeatedly stabbing the painful area with a red-hot needle. Two days later, many circular crusts and small vesicles appeared in the treated area, similar to a tattoo pattern (Fig. 1).

Traditional Chinese medical theory holds that fire acupuncture can relieve neuropathic pain, and in many Asian countries, acupuncture has been used as one of the methods to relieve herpes zoster nerve pain.1,2 However, the patterns left on the skin by the needles may lead to diagnostic confusion.

Data availability

The data that support the findings of this study are available on request from the corresponding author.

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References

1 Wang J, Wang X, Xia H. An update of fire needle acupuncture for acute herpes zoster and prevention of...