

The Hots, Snots and Trots:

The Most Frequent Questions for School Nurses of Tots.

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Introduction

The Hots

Fevers in Children:

What is your trigger point?

What is the definition of a fever?

“How hot is too hot?”

Viruses and Upper Airway Infections: The Common Cold

How many are expected?

To treat or not to treat.

Eye Infections: “Oh, Why Do You Think My Eye Is Pink?”

Ear Infections: “Oh Dear, I Fear It Is My Ear!”

Sore Throats: To Strep or Not To Strep

The Snots

Sinus Anatomy: Complicated.

Sinus Infections: “It’s Not Easy Being Green!” (Kermit the Frog)

The Trots

Diarrhea: What is it?

Causes: Viral vs. Bacterial

How Many Poops Get You Sent Home?

FEVERS (HOTS):

When do you get nervous?

Definition of a FEVER: (Nelson's Textbook of Pediatrics.)

“Fever is an elevation of body temperature mediated by an increase of the hypothalamic regulatory set-point...Fever is one manifestation of the inflammatory response produced by cytokine-mediated host defense mechanisms.”

NORMAL core body temperature: 37° C (98.6° F)

Axillary is usually 1° C lower.

Don't add or subtract: Where was it taken? What did the thermometer say?

Body temps have a circadian rhythm, being lowest in early morning.

The body makes endogenous pyrogens that raise the set-point.

Where do you take it? With what kind of thermometer do you use?

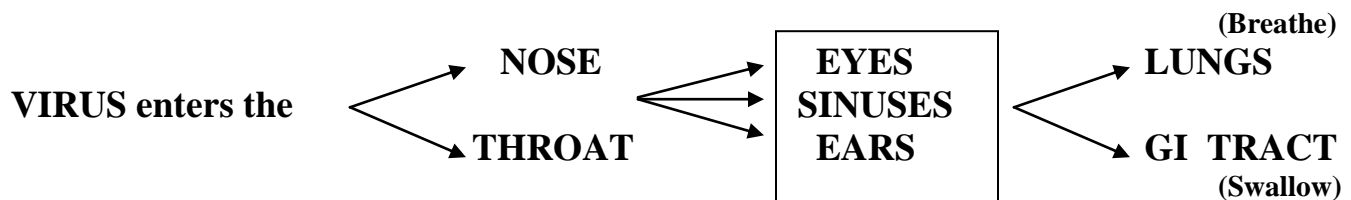
Appearance vs. Temperature: To treat or not to Treat and Fever Phobia

Who **MUST** have a work-up when they have a fever?

- 1. Infants under 56 days (8 weeks) of age.**
- 2. Anyone who is immunocompromised.**
- 3. Anyone with an implant, such as VP-shunts.**

URI: The Upper respiratory Infection

- The most common infectious condition of children!
- Expect about 12-15 in the 1st year of life.
- Last 5-7 days and are usually improving by the 10th day.
- Everything is interconnected:



Secretions are everywhere:

The smaller the structure, the more easily it gets blocked.

Symptoms: Nasal discharge or stuffiness, cough, fever, otalgia, excessive crying.

Most symptoms are nonspecific.

Treatment:

Supportive. Saline and Suction when possible!

Watch for side effects of cold medications!

Antibiotics don't kill viruses.

EYES: “PINK EYES” can be from:
Allergies; Viruses; Bacteria; Irritation; Abrasion; Fungus; Other.

Treatment:

Antibiotics when bacterial infection is highly suspected.

Antihistamine: For allergic symptoms or when itchy.

Cool Compress: To help with discomfort.

EXCLUDE from school: For purulent drainage!

Corneal abrasions can be seen with fluorescein and a blue light.

Tip/Trick: The blue light on the ophthalmoscope works great!

EARS:

OUTER EAR INFECTIONS: Swimmer’s Ear

- Infection of the outer ear canal
- Swelling of the canal
- Pain with moving the ear or tragus

Treatment: Antibiotic drops, usually with a steroid

MIDDLE EAR INFECTIONS: Otitis Media (OM)

- The second most common infectious condition of children!
- The 3rd most common reason to see provider (1st = Well Child Care; 2nd = URI)
- The most common reason antibiotics are prescribed for children.
- Come up the Eustachian tube, not from the outside.
- Infant Anatomy: Tube is shorter and at a flatter angle.
- 1st year of life: ~1/3 have no OM.
~1/3 have >3 episodes of OM.

Symptoms:

Infant: Irritable, won’t sleep +/- pulling or rubbing on ears

Older child: Pain, fever

There may be no symptoms at all!

Can go from **NORMAL** to **RUPTURED** in as little as 4 hours.

Definition of an Acute Otitis Media:

1. **MEE (Middle Ear Effusion):** Fluid present in the middle ear.
2. **OME (Otitis media with effusion):** Fluid in the ear with NO evidence of inflammation.
3. **AOM (Acute Otitis Media):** Needs to meet all 3 Criteria:
 1. **Rapid onset.**
 2. **Fluid in the middle ear (MEE), TM is full or bulging and is not mobile.**
 3. **Signs and symptoms of middle ear inflammation.**

Crying can make the TM pink, but this goes away as child calms down.

Inflammation causes bright red TMs, especially if individual swollen blood vessels can be seen. The edema of the TM makes it cloudy or opacified. The TM is no longer translucent.

4. BULLOUS MYRINGITIS: Blisters are present on the TM. These are very painful and are prone to rupture. When an ear drum or blister ruptures, the pain often improves because the pressure has been relieved.

Treatment for Acute Otitis Media:

Treat pain: Treat the pain whether or not antibiotics are started.

Wait and Watch: 75% of acute ear infections go away on their own.

- Parents must have phone or means of communication.
- Provider may write a prescription that the family can fill if the pain and symptoms are not improved in 48 to 72 hours. This is called a SNAP Rx (Safety Net Antibiotic Prescription) and should only be valid for 3 days.
- Pain should be controlled with analgesics.
- Should not be done with infants less than 6 months, or children over 6 months with severe symptoms.

Give antibiotics: 90% go away.

- Pain may go away in 1 day rather than 2 days.
- Amoxicillin is still the first-line therapy.
- Save the “big-guns” for treatment failures.

Recheck: Only if symptoms persist.

40% will have fluid present for 4 weeks.

10% will have fluid for 3 months!

It may take 12 weeks for all the fluid to go away.

Complications:

Mastoiditis: Rarely seen any more.

Chronic hearing loss.

Speech delays.

NOSE:

- Olfaction: to smell.
- Warms and humidifies the air.
- Hairs in the nose trap large particles.
- Ciliated cells and mucous layer trap smaller particles.
- Thick green buggers do not automatically mean there is an infection!

SINUSES:

Air-filled spaces in the facial bones.

- Decrease the weight of the bones.
- Help with phonation of sounds.
- Lined with ciliated, mucous-producing epithelium to clean out debris.
- Produce lysozyme and secretory IgA which have antimicrobial activities.
- The openings, called “ostia”, drain into the nose.
- Under normal circumstances the paranasal sinuses are considered sterile.
But they are very close to where there are a lot of germs!
- There is no direct blood flow into the air spaces, only into the lining.
So, medications, such as antibiotics are hard to concentrate in the space where the buggers are hiding out.

Sinus Development:

Paranasal sinuses development continues through adolescence.

Maxillary and Ethmoid:

- Development starts at 3-5 months of gestation.
- In neonate: can be seen on high resolution CT scans.
- Cannot be seen on plain radiographs until about 1-2 years of age.

Frontal and Sphenoid:

- 2 years old: Start to form in the frontal bone
- Cannot be seen on plain radiographs until 5-6 years of age.

SINUSITIS (The SNOTS):

Definitions: (SOURCE: AMERICAN ACADEMY OF PEDIATRICS CLINICAL PRACTICE GUIDELINE: MANAGEMENT OF SINUSITIS)

Acute Bacterial Sinusitis: Bacterial infection of the paranasal sinuses lasting less than 30 days in which the symptoms resolve completely.

Recurrent Acute Bacterial Sinusitis: Bacterial infection of the paranasal sinuses, each lasting less than 30 days and separated by intervals of at least 10 days during which the patient was asymptomatic. Defined as having 3 episodes of acute bacterial sinusitis in 6 months or 4 episodes in 12 months.

Chronic Sinusitis: Episodes of inflammation of the paranasal sinuses lasting more than 90 days. Patients have residual respiratory symptoms such as cough, rhinorrhea or nasal obstruction.

Acute Bacterial Sinusitis Superimposed on Chronic Sinusitis: Patients with residual respiratory symptoms develop new respiratory symptoms. When treated with antibiotics, these new symptoms resolve, but the underlying residual symptoms do not.

Symptoms: Persistence of respiratory symptoms after 10 days *without* evidence that they are improving. Fever, facial pain and headache are variable. A severe infection generally presents with high fever and 3-4 consecutive days of purulent discharge.

Nasal Drainage:

CLEAR → WHITE → YELLOW → GREEN → YELLOW → WHITE → CLEAR

What does **GREEN** mean? **Maybe not much!**

If the nasal drainage “gets stuck” at green or was getting better and goes back to green, then there is usually bacterial infection, especially if a fever is present.

Treatment:

Wait and Watch: If symptoms are mild, less than 10 days and there is no fever.

Give antibiotics: Will help give a more rapid clinical cure.

Imaging: Such as CT scans are reserved for complications or failure to cure.

Decongestants and antihistamines: Have not been proven to be helpful.

Intranasal steroids: Have not been proven to be helpful.

Nasal Irrigation and Flushing: Not clinically proven, but can be very helpful especially if secretions are thick.

CHECK for a Foreign Body (FB): Be suspicious when there is:

- Smelly breath or bad halitosis.
- Purulent drainage from one nostril.
- A history that “something” went up there.

For mouth ulcers, canker sores or painful oral lesions:

Magic Mouthwash can be very helpful:

Calculate the diphenhydramine dose based on weight (1 mg/kg/dose).

(Tip: Often 12.5 mg of diphenhydramine is plenty to help the oral pain.)

To make, mix 1:1 diphenhydramine liquid (such as Benadryl) with antacid liquid (such as Mylanta). For example, mix 5 mL of each to make 10 mL of magic mouthwash.

The mixture should be swished around the mouth or put on open sores in the mouth.

It can be swallowed, but most children get sleepy with diphenhydramine.

To be less sleepy, swish or gargle and then spit it out.

THROAT:

Tonsils and adenoids: Garbage Disposal Functions

PHARYNGITIS: 85% Viral vs. 15 % Strep**Comparing Viral and Strep Pharyngitis Signs and Symptoms:**

VIRAL PHARYNGITIS	STREP PHARYNGITIS	
Gradual onset Early fever Anorexia Moderate throat pain May have cough, runny nose, conjunctivitis Small cervical nodes Ulcers may be present	Can have sudden onset Fever can be high (40°), can last for 1-4 days Difficulty swallowing Early sore throat, may be severe Usually no cough, runny nose, conjunctivitis May have large nodes, often tender nodes Can present with abdominal pain, vomiting	
Pharynx does not usually look bad Tonsils may have small exudates Hoarse voice	1/3 of Patients Big, red, tonsils Large exudates, pus Mash potato voice	2/3 of Patients Small tonsils No exudates Normal voice
Can last 24 hours to 5 days	May be sick for 2 weeks, but usually better quickly with antibiotics	
Few complications	Complications: Rheumatic fever, Rheumatic Heart Disease (valvular heart disease), post-streptococcal glomerulonephritis	
TX: Supportive	TX: Antibiotics prevent complications	

Strep can present with:

Headache,
 Neck ache,
 Backache,
 Stomach ache,
 Vomiting,
 Fever,
 Rash and/or
 A sore throat.

LARYNX:

Has 4 cartilages:

- Thyroid; cricoids; arytenoids and epiglottic.
- The cricoid goes completely around the airway just below the vocal cords.
- Is the narrowest portion of the airway in pediatric patient.

CROUP:

- An acute upper airway obstruction, with inflammation of the larynx, trachea and bronchi. The narrowest portion of the airway is just below the vocal cords.
- Cough is barky and worse in the night/early am hours.
- Mostly caused by viruses, especially parainfluenza.
- Lasts a few days: a “warm-up” then a “bad night” then a “warm-down”.
- Moisture is very helpful:
 - Warm, steamy bathroom or warm moist night outside.
 - Cold mist, opening the freezer door.

EPIGLOTTITIS:

- Has been nearly eliminated with the *H. influenzae* type B vaccine.
- Rapid course of high fever, sore throat, dyspnea and rapidly progressive airway obstruction. Respiratory distress may be the first symptom.
- Rose-sniffing position: Sitting, leaning forward, mouth open and protruding tongue.

INHALING VIRUSES INTO THE LUNGS:

Can trigger an asthma attack!

ASTHMA:

ASTHMA: Acute, reversible airway bronchospasm

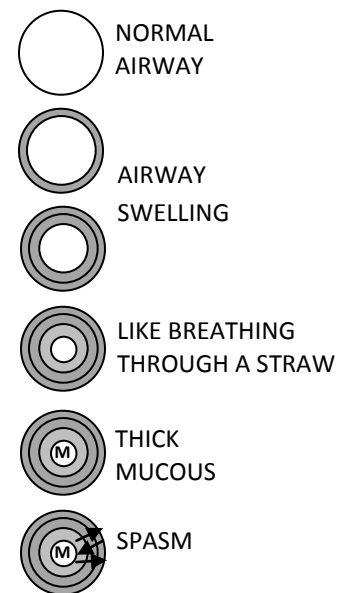
Three issues: **Airway edema (swelling)**
 Thick secretions (mucous)
 Bronchospasm (wheezing)

TREATMENT:

SWELLING: Steroids or Non-steroidal (montelukast)

MUCOUS: Drink extra fluids and coughing it out

SPASM: Albuterol and ipratropium



Microlide antibiotics: Are **OVERPRESCRIBED** because they also have antimicrobial [plus anti-inflammatory properties. Parents treated for “bronchitis” are sure their children need to be treated as well.

STOOL: To Err is Human...To Poop is Divine. And it should be easy

Type 1	Small balls (rabbit pellets). Each stool is a separate hard lump.	Very Constipated
Type 2	Log or sausage shaped. Lumpy balls stuck together.	Constipated
Type 3	More like a sausage but with cracks on the surface.	Normal
Type 4	Soft log that is smooth and soft and easy to pass.	Normal
Type 5	Soft pieces of stool with well-defined edges.	Not enough fiber
Type 6	Mushy stool, ragged-edged pieces with some form.	Inflammation
Type 7	Liquid, watery stool with no formed pieces.	Inflammation

SWALLOWING VIRUSES INTO THE GI TRACT:

DIARRHEA (The TROTS):

Definition of diarrhea: An increase in the frequency, fluidity and volume of stool.

The weight of the stool is increased because of additional water. With diarrhea, there is usually 10 oz or 300 grams of stool.

For a child who usually has 3 stools per day, diarrhea would occur when there are more stools that watery, bigger and more frequent.

- Most are caused by a viral infection and resolve on their own in 72 hours.
- Often come as seasonal epidemics, especially with rotavirus.
- Rotavirus: 2/3 of patients have preceding or concurrent respiratory illness with runny nose, cough, red throat and otitis.
- Bacterial diarrhea often associated with:
 - Abdominal Pain, fever $> 38.5^{\circ} \text{C}$, $> 8 \text{ BM}$ in 24 hours and weight loss.
- Stool color: Brown, Yellow and Green is related to transit speed.

Other terms:

- **Hyper-defecation:** an increased number of stools (above the person's normal).
- **Incontinence:** involuntary passing of stool, an "accident")
- **Acute diarrhea:** lasts less than 2 weeks.
- **Chronic diarrhea:** lasts longer than 3 weeks.

How many Poops are Too Many? The answer is not straight forward!

SEND HOME: A child whose stooling frequency and volume exceeds the rules at your school, or who has a fever, blood in the stool or who is getting dehydrated.

Bacterial and Viral Causes of Gastroenteritis*

	Bacterial	Viral
Fever >38.5° C	Yes	Unusual
Abdominal pain	Yes	Unusual
> 8 BM/24 hours	Yes	Unusual
Vomiting	Unusual	Yes
Duration > 5 days	Yes	No
WBC elevated	Elevated	No
Stool leukocytes and mucous present	Yes (<i>Shigella, Salmonelle, Yersinia, Camphylobacter, invasive Escherichia coli</i>)	No
No stool leukocytes: Secretory diarrhea	Yes (<i>Vibrio Cholerae, toxigenic E. Coli</i>)	No
Blood in stool	Yes (<i>Shigella, Salmonelle, Yersinia, Camphylobacter, enterohemorrhagic Escherichia coli, pseudomembranous colitis due to Clostridium difficile</i>)	No (Except rotavirus in a preterm infant)
Shellfish consumption	Yes (<i>E coli, V cholera, Champhylobacter, V. parahaemolyticus</i>)	Yes (Norwalk agent)
Traveler's diarrhea	Yes (<i>toxigenic E. coli, Salmonella, Shigella,</i>)	Unusual (Norwalk virus and rotavirus)
Single-source outbreak	Yes (<i>Salmonella, Shigella, Streptococcus aureus, Bacillus cereus, Clostridium perfringens, Yersinia, E. coli</i>)	Yes (Norwalk agent)
Seasonal epidemics	Unusual Yes (<i>Champhylobacter</i>)	Yes (rotavirus)

(*Adapted from Infectious Disease: Disorders Caused by a Variety of Infectious Agents Ralph D. Feigin, Marshall L. Stoller)

Treatment: Stay hydrated. Race to get more fluids in than come out!

Fluid changes: Pedialyte[®] or Enfalyte[®], Liquilytes[®] or generic electrolyte solution.
Low Sugar Gatorade[®] (G2) or Sports drinks (not red); Jell-O[®]; Popsicles[®];
Caffeine-free white soda such as Sprite[®], 7Up[®], or ginger ale; Soup broth;
Apple juice that is mixed with an equal amount of water or Pedialyte[®].

Diet Changes: Ripe or strained banana; Pretzels; Canned fruit in heavy syrup; Plain rice;
Plain toast; Soda crackers; Plain noodles; Yogurt;
Dry unsweetened cereal such as Cheerios[®] or Kix[®];
Cooked refined cereal (no sugar added) like Cream of Wheat[®], Cream of Rice[®]

Need to be seen if dehydrated. Watch for: tears, spit and pee!

Constipation: Health Fact (<http://www.chw.org/teaching-sheets/2014/09/constipation/>)

Constipation means the stools are hard and dry. This makes having a bowel more difficult than normal. Constipation may be caused by lack of exercise, low water intake, stress, recent illness, changes in daily routine or a low fiber intake. It may also be caused by some medicines.

To help with constipation:

- Get more exercise each day.
- Limit foods low in fiber that may increase the risk for constipation. These foods include:
 - Milk. Have no more than 16 to 20 ounces a day. Limit other dairy foods like cheese and ice cream.
 - Foods or snacks made from white sugar and white flour such as cookies, cake and white bread.
 - Sugar-coated cereals.
 - Unripe bananas.
 - Candy including chocolate.
 - Deep-fried foods.
- After each meal, sit on the toilet for five minutes. A timer may be helpful. To help with pooping, the feet should be on the floor. Sometimes a small stool is needed to help make sitting more comfortable. This time should be made as pleasant as possible. Punishing or threatening will make the situation worse.

It is very important to get enough fiber and drink enough water:

- Eat foods that are high in fiber.
- Use this formula to figure out how much fiber is needed every day:

Age in years + 5 = grams of fiber needed per day.

_____ years old + 5 = _____ grams of fiber is needed every day.

- Drink more fluids, especially water, every day. (This does not apply to infants <1 year old.)

Weight is _____ pounds.

Drink _____ ounces of fluids/day.

Other helpful teaching sheets:

<http://www.chw.org/teaching-sheets>

- #1471 Increasing Fiber in your Child's Diet
- # 1069 Fiber Chart

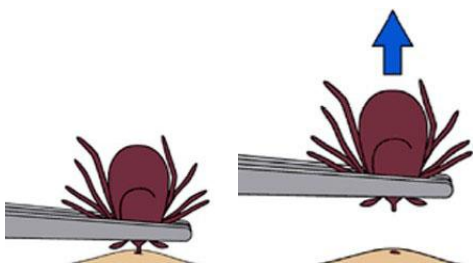
Weight in Pounds	Fluids per day
10 pounds	16 ounces (2 cups)
20 pounds	30 ounces (3-3/4 cups)
30 pounds	40 ounces (5 cups)
40 pounds	48 ounces (6 cups)
50 pounds	52 ounces (6 1/2 cups)
60 pounds	55 ounces (7 cups)
80 pounds	60 ounces (7 1/2 cups)
100 pounds	70 ounces (8 1/4 cups)
120 pounds	75 ounces (9 cups)
140 pounds	80 ounces (10 cups)
150 pounds	85 ounces (10 1/4 cups)

SCHOOL NURSES: ADDITIONAL TIPS AND TRICKS

How To Kill Head Lice: Too Many Choices?

A Summary of Pediculocidal Drugs:		
Drug:	How it Kills:	Comments:
Pyrethroids: Permethrin (Nix, A-200 1% [OTC]) (Elimite 5% [Rx] used off-label)	Neurotoxic	Rinse off in 10 minutes. Pruritis, erythema, edema. Residue kills nymphs.
Pyrethroids: Pyrethins with piperonyl butoxide (RID [OTC])	Neurotoxic	Rinse off in 10 minutes. Made from chrysanthemum. 20-30% of eggs viable.
Malathion (Ovide [Rx])	Neurotoxic	Prolonged application time 8-12 hours, malodorous and highly flammable. Don't blow dry hair or smoke. Reapply day 9 if live lice.
Spinosad: (Natroba [Rx])	Paralysis	Many patients do not need 2 nd application.
Ivermectin Topical (Sklice [Rx]) "One Tube. One Time" (75% lice-free at 14 days)	Paralysis	Rinse off in 10 minutes. Pediculocidal and ovicidal. Eye irritation, dry scalp, burning sensation.
Ivermectin (Stromectol PO [Rx])	Paralysis	Oral dose 200 mcg/kg, repeat on day 10. May cross blood-brain barrier in kids.
Benzyl Alcohol 5% (Ulesfia [Rx])	Asphyxiation	Rinse off in 10 minutes. Pruritis, erythema, eye irritation and pyoderma, numbness. Not ovicidal.
Lindane (Kwell [Rx]) (No longer recommended by AAP) (Banned from use in California.)	Inhibits Neurotransmission	CNS toxicity in humans and can cause severe seizures. 30-50% of eggs viable. Remove in less than 4 minutes
Nuvo Method	DSP (Dry-On Suffocation-based Pediculoside	Cetaphil® Cleanser and a blow drier are used to "shrink-wrap" the lice and eggs, plugging their breathing holes to suffocate them. Repeat for 3 applications. No neurotoxins or potentially hazardous chemicals. Nit removal or extensive house cleaning is NOT required. http://www.nuvoforheadlice.com/method_explained.htm .

How to Remove A Tick:



(http://www.cdc.gov/ticks/removing_a_tick.html)

1. Use fine-tipped tweezers to grasp the tick as close to the skin's surface as possible.
2. Pull upward with steady, even pressure. Don't twist or jerk the tick; this can cause the mouth-parts to break off and remain in the skin. If this happens, remove the mouth-parts with tweezers. If you are unable to remove the mouth easily with clean tweezers, leave it alone and let the skin heal.
3. After removing the tick, thoroughly clean the bite area and your hands with rubbing alcohol, an iodine scrub, or soap and water.

How to Help Students Who Have Atopic Dermatitis:

ATOPIC DERMATITIS: PRODUCT LIST (SOURCE: Children's Hospital of Wisconsin Health Facts)

Always read ingredients on the label. Products can change over time.

Be sure that products are **fragrance-free**.

- Avoid products that have “fragrance” as one of the ingredients. Products that are unscented may still have fragrance added. They may have a “masking” chemical to take the smell away. This chemical can be very irritating to the skin.
- Avoid products with added ingredients: Vitamin E, witch hazel, menthol, and acids.
- If you use other products, be sure to read the ingredient label.

Note: These lists are suggestions for fragrance-free products.

Moisturizers: Use them two times a day, even if skin does not feel dry.

Ointments (Best)

- Aquaphor Healing Ointment®
- Petroleum Jelly®
- Vaseline®
- Petrolatum
- White petrolatum
- Vaniply Ointment

Creams (Good)

- Aveeno® Eczema Therapy Moisturizing Cream
- Eucerin® Original Moisturizing Crème
- CeraVe Moisturizing Cream
- Cetaphil® Moisturizing Cream
- Vanicream Cream®

Do not use **lotions**. They have alcohol and a lot of water in them.

Skin cleansers: Use only on areas that need to be cleaned.

- Dove® Sensitive Skin Beauty Bar
- Aveeno®: Skin Relief Body Wash
- Aquaphor Gentle Wash and Shampoo
- CeraVe Hydrating Cleanser
- Vanicream® Cleansing Bar
- Cetaphil® Gentle Skin Cleanser
- Cetaphil® Gentle Cleansing Bar

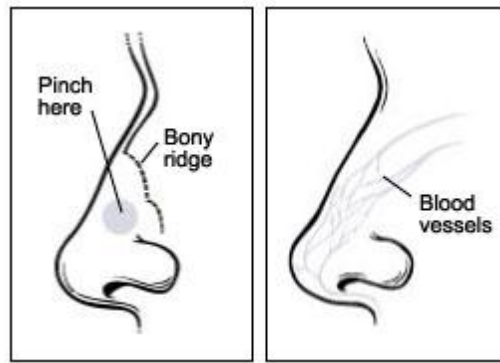
Laundry detergent:

- All® Free Clear
- Tide® Free & Gentle Liquid
- Arm & Hammer® Perfume and Dye Free Liquid
- Cheer® Free & Gentle
- Purex® Free & Clear

Do not use Ivory® or Dreft® laundry soap. These both have fragrance in them.

Do not use fabric softeners. The liquid type and fabric sheets have fragrance in them. There are fragrance-free sheets for the dryer, but they are expensive.

How to stop a nosebleed:



(SOURCE: Children's Hospital of Wisconsin: <http://www.chw.org/teaching-sheets/publication-search-results/?keyword=1524>)

- Have the child sit down and lean forward. Do not tip the head backwards or lie down as this may cause the child to swallow too much blood and vomit.
- Using your thumb and first finger, apply pressure just under the bony ridge of the nose for at least 10 minutes. **Do not let go to see if the bleeding has stopped.**
- If the bleeding does not stop after 10 minutes, press the nostrils for another 5 to 10 minutes.
- The child should not blow their nose for at least 2 hours after the bleeding has stopped.
- To help heal the scab, put Vaseline[®] inside the nostrils two times a day for 5 to 7 days. Use a Q-tip[®] to put the Vaseline[®] inside the nostrils.

How to Learn How To Swallow Pills: Practice with Tic Tacs

Step 1: Tell your brain you can do it! If you think you can't, you can't.

Step 2: Put Tic Tac in mouth, as far back as you can.

Step 3: Fill mouth with water, tip head back, and swallow water. Don't think about Tic Tac[®].

Step 4: If step 3 didn't work, try drinking water through a straw. Don't think about Tic Tac.

Step 5: Keep practicing.

How to Help Prevent Getting and Spreading MRSA:

Patient Education: Critical Component of Management

1. Wash hands regularly and immediately after touching infected skin or items.
2. Keep draining wounds covered with clean, dry bandages.
3. Maintain good general hygiene with regular bathing.
4. Do not share potentially contaminated items (towels, clothing, bedding, bar soaps, razors and athletic equipment).
5. Launder clothing that was contact wound drainage after each use and dry thoroughly.
6. If wound cannot be kept covered, do not participate in activities that may involve skin contact until the wound is healed.
7. Clean equipment and other environmental surfaces with an OTC detergent/disinfectant that specifies *Staphylococcus aureus* on the label and is suitable for the surface to be cleaned.

Adapted from Gorwitz R, et al. Strategies for Clinical Management of MRSA in the Community: Summary of an Experts' Meeting Convened by the Centers for Disease Control and Prevention. March, 2006.