04 March 2019

Dear colleagues,

Re: Increase in scarlet fever notifications

We are writing to inform you of a sixth consecutive season [national/local] of elevated scarlet fever activity since 2014. Scarlet fever is a notifiable disease, and we would like to take this opportunity to remind practitioners of the signs and symptoms and the actions to be taken if you see a case.

Signs and symptoms of scarlet fever
Scarlet fever is a common childhood infection caused by Streptococcus pyogenes, or group A streptococcus (GAS). The symptoms are non-specific in early illness and may include sore throat, headache, fever, nausea and vomiting. After 12 to 48 hours the characteristic red, generalised pinhead rash develops, typically first appearing on the chest and stomach, rapidly spreading to other parts of the body, giving the skin a sandpaper-like texture. On more darkly-pigmented skin, the scarlet rash may be harder to spot, although the ‘sandpaper’ feel should be present. Patients typically have flushed cheeks and pallor around the mouth. This may be accompanied by a ‘strawberry tongue’. During convalescence desquamation of the skin occurs at the tips of fingers and toes, less often over wide areas of the trunk and limbs.

The differential diagnosis will include measles, glandular fever and slapped cheek infections.

Complications of scarlet fever
Although scarlet fever is usually a mild illness, patients can develop complications such as an ear infection, throat abscess, pneumonia, sinusitis or meningitis in the early stages and acute glomerulonephritis and acute rheumatic fever at a later stage. Patients, or their parents, should keep an eye out for any symptoms which might suggest these complications and if concerned advised to seek medical help immediately.

Recommended actions
Suspected scarlet fever can be confirmed by taking a throat swab for culture of Group A streptococcus, although a negative throat swab does not exclude the diagnosis. Consider taking a throat swab to:

i) assist with differential diagnosis,
ii) if you suspect that the patient may be part of an outbreak
iii) if the patient is allergic to penicillin or
iv) in regular contact with vulnerable individuals (e.g. healthcare worker)

1- Prescribe antibiotics without waiting for the culture result if scarlet fever is clinically suspected:
*For children who are unable to swallow tablets, or where compliance to Penicillin V is a concern, Amoxicillin 50 mg/kg once daily (max = 1000 mg) or 25 mg/kg (max = 500 mg) twice daily may be used as an alternative
**if allergic to penicillin
***unlicensed indication

2- Advise exclusion from nursery / school / work for 24 hours after the commencement of appropriate antibiotic treatment
3- Notify your Health Protection Team, including information on the school/nursery attended if relevant.

Clinicians should be mindful of a potential increase in invasive GAS (iGAS) infection which can follow trends in scarlet fever. It is important to maintain a high index of suspicion, especially in relevant patients (such as those with chickenpox, and women in the puerperal period). Early recognition and prompt initiation of specific and supportive therapy for patients with iGAS infection can be lifesaving.

Yours sincerely,
Bayad

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