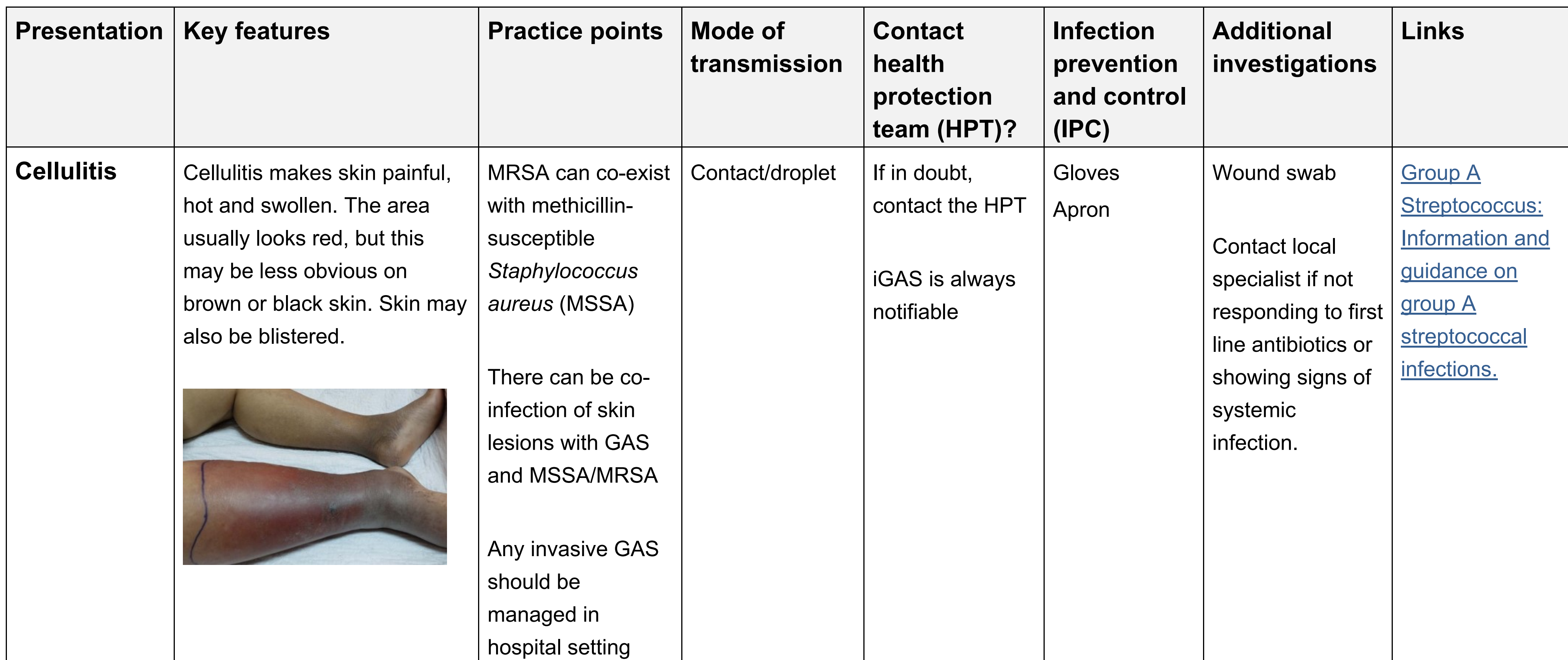
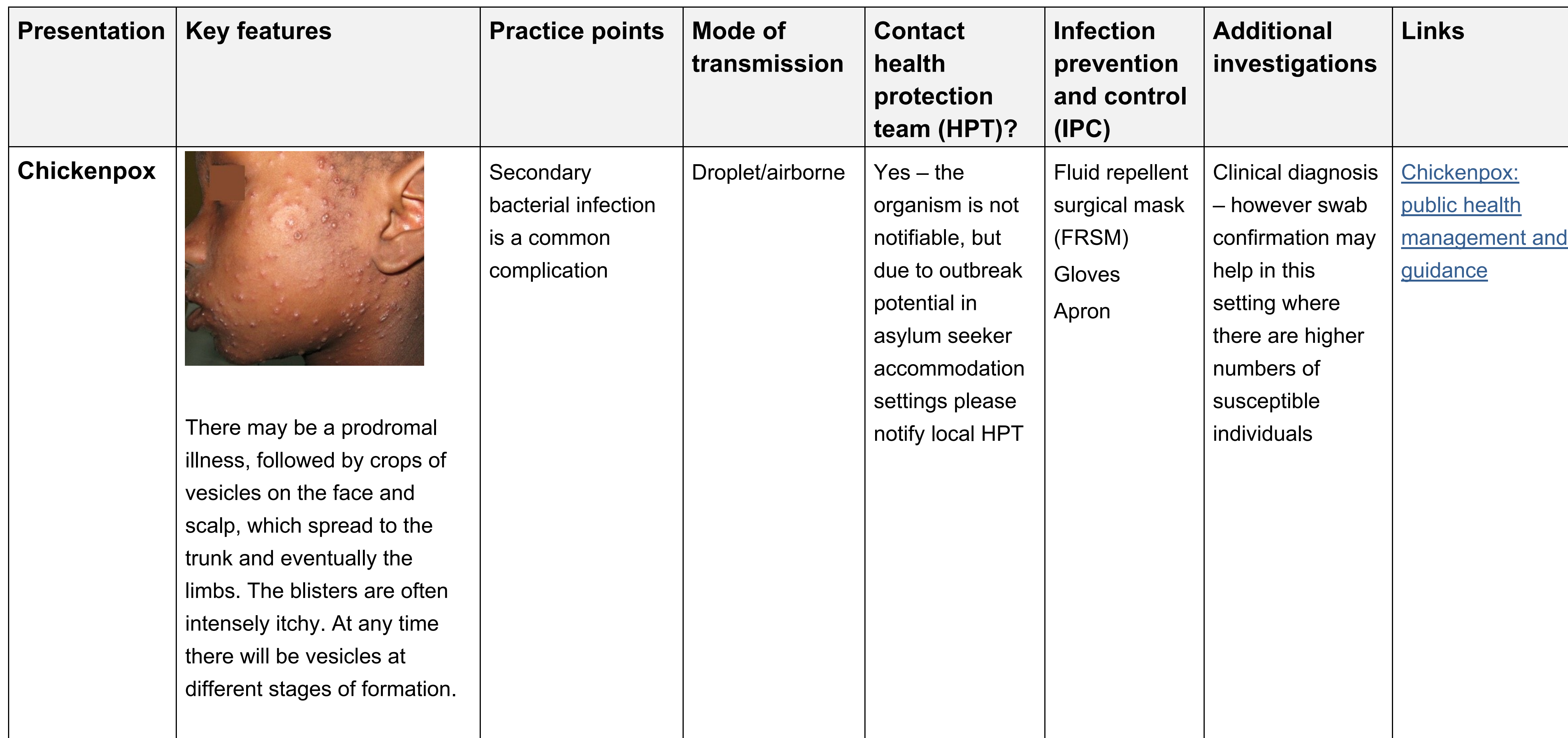
Table 1. Identification, clinical features and required actions for common pathogens causing skin lesions of public health importance[1]

IPC advice for health care settings can be found at https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

Presentation	Key features	Practice points	Mode of transmission	Contact health protection team (HPT)?	Infection prevention and control (IPC)	Additional investigations	Links
Cellulitis	Cellulitis makes skin painful, hot and swollen. The area usually looks red, but this may be less obvious on brown or black skin. Skin may also be blistered. 	MRSA can co-exist with methicillin-susceptible *Staphylococcus aureus* (MSSA) There can be co-infection of skin lesions with GAS and MSSA/MRSA Any invasive GAS should be managed in hospital setting	Contact/droplet	If in doubt, contact the HPT iGAS is always notifiable	Gloves Apron	Wound swab Contact local specialist if not responding to first line antibiotics or showing signs of systemic infection.	Group A Streptococcus: Information and guidance on group A streptococcal infections.

[1] Note: Photos are illustrative and not intended to capture all presentations.

Presentation	Key features	Practice points	Mode of transmission	Contact health protection team (HPT)?	Infection prevention and control (IPC)	Additional investigations	Links
Chickenpox	 There may be a prodromal illness, followed by crops of vesicles on the face and scalp, which spread to the trunk and eventually the limbs. The blisters are often intensely itchy. At any time there will be vesicles at different stages of formation.	Secondary bacterial infection is a common complication	Droplet/airborne	Yes – the organism is not notifiable, but due to outbreak potential in asylum seeker accommodation settings please notify local HPT	Fluid repellent surgical mask (FRSM) Gloves Apron	Clinical diagnosis – however swab confirmation may help in this setting where there are higher numbers of susceptible individuals	Chickenpox: public health management and guidance

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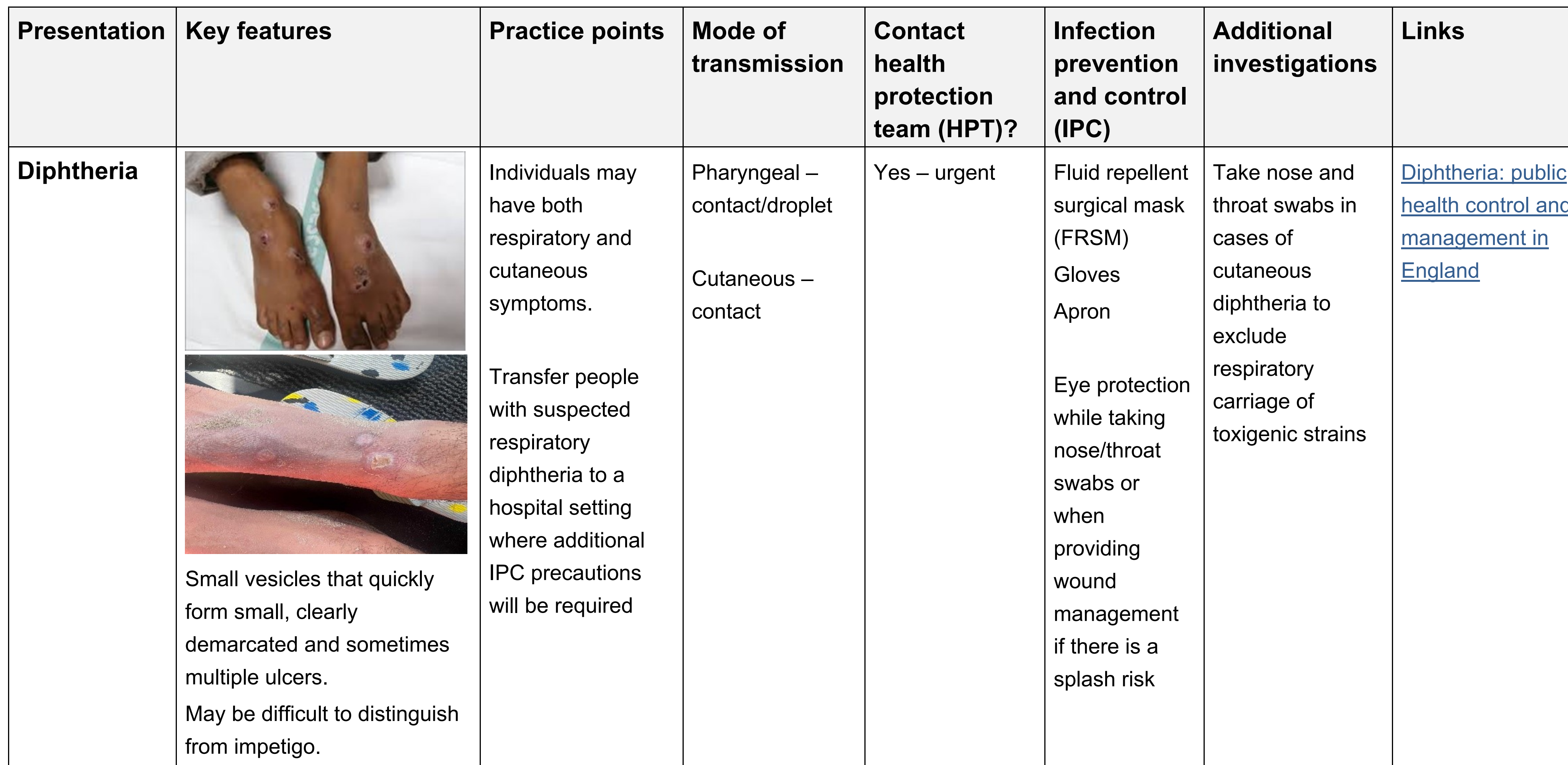
Diphtheria	 Small vesicles that quickly form small, clearly demarcated and sometimes multiple ulcers. May be difficult to distinguish from impetigo.	Individuals may have both respiratory and cutaneous symptoms. Transfer people with suspected respiratory diphtheria to a hospital setting where additional IPC precautions will be required	Pharyngeal – contact/droplet Cutaneous – contact	Yes – urgent	Fluid repellent surgical mask (FRSM) Gloves Apron Eye protection while taking nose/throat swabs or when providing wound management if there is a splash risk	Take nose and throat swabs in cases of cutaneous diphtheria to exclude respiratory carriage of toxigenic strains	Diphtheria: public health control and management in England

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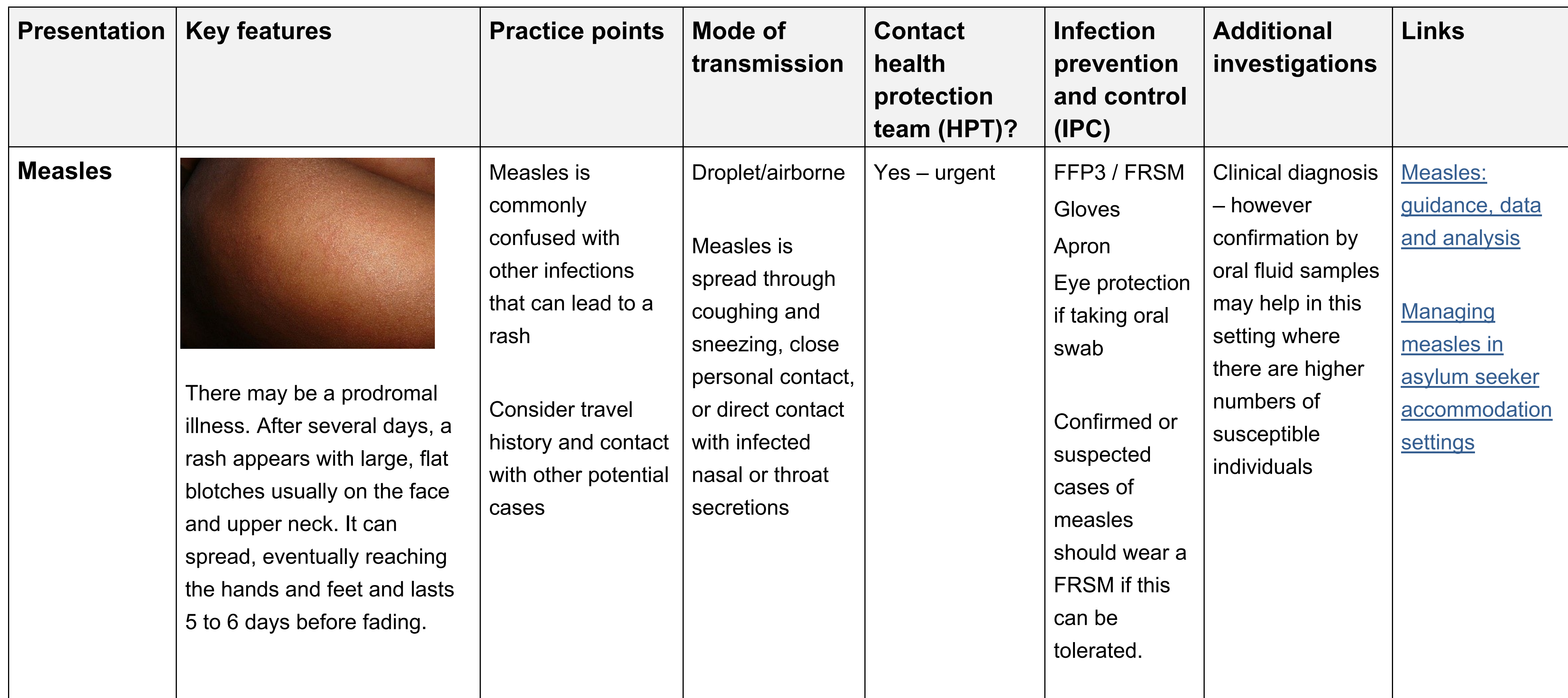
Measles	 There may be a prodromal illness. After several days, a rash appears with large, flat blotches usually on the face and upper neck. It can spread, eventually reaching the hands and feet and lasts 5 to 6 days before fading.	Measles is commonly confused with other infections that can lead to a rash Consider travel history and contact with other potential cases	Droplet/airborne Measles is spread through coughing and sneezing, close personal contact, or direct contact with infected nasal or throat secretions	Yes – urgent	FFP3 / FRSM Gloves Apron Eye protection if taking oral swab Confirmed or suspected cases of measles should wear a FRSM if this can be tolerated.	Clinical diagnosis – however confirmation by oral fluid samples may help in this setting where there are higher numbers of susceptible individuals	Measles: guidance, data and analysis Managing measles in asylum seeker accommodation settings

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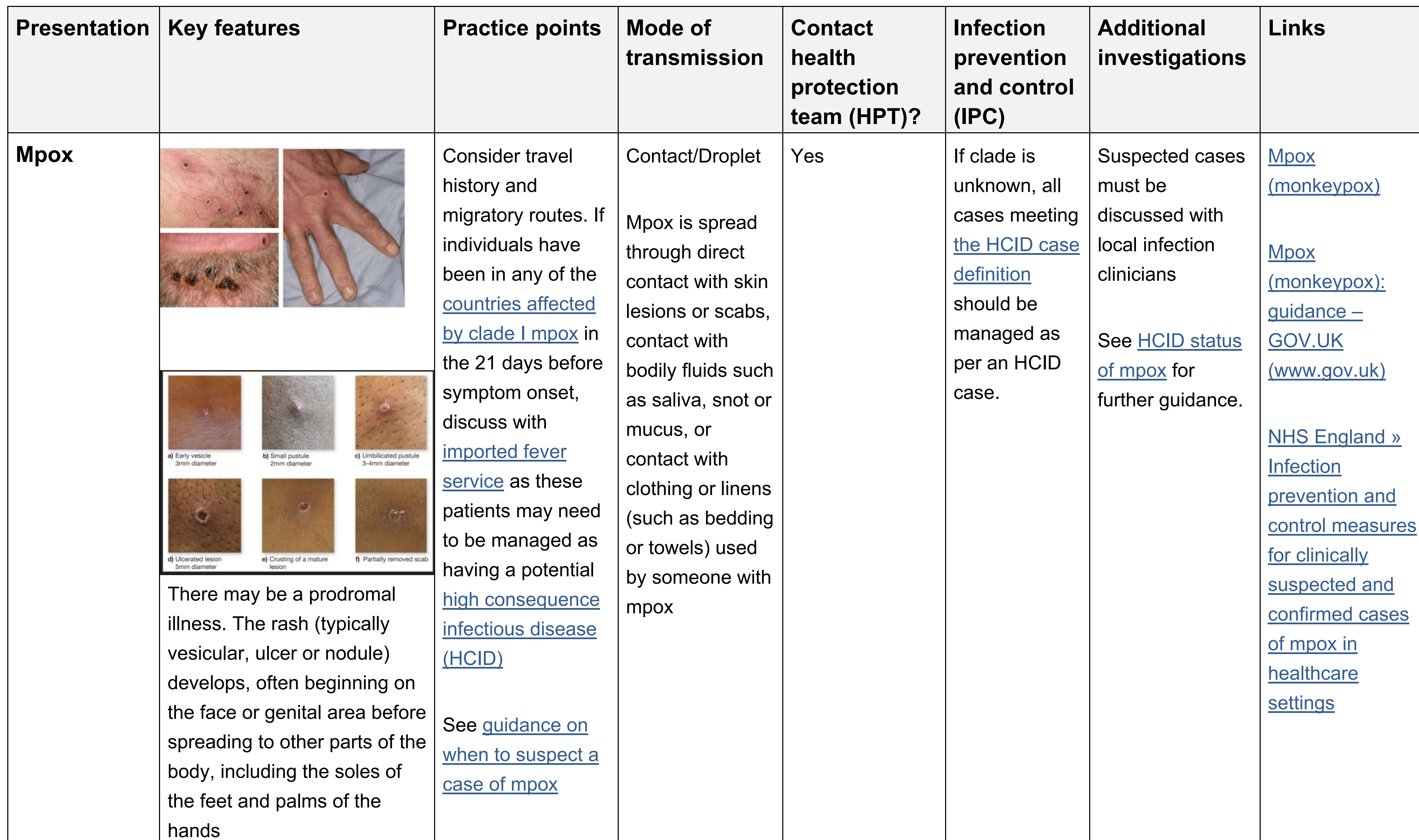
Mpox	 There may be a prodromal illness. The rash (typically vesicular, ulcer or nodule) develops, often beginning on the face or genital area before spreading to other parts of the body, including the soles of the feet and palms of the hands	Consider travel history and migratory routes. If individuals have been in any of the countries affected by clade I mpox in the 21 days before symptom onset, discuss with imported fever service as these patients may need to be managed as having a potential high consequence infectious disease (HCID) See guidance on when to suspect a case of mpox	Contact/Droplet Mpox is spread through direct contact with skin lesions or scabs, contact with bodily fluids such as saliva, snot or mucus, or contact with clothing or linens (such as bedding or towels) used by someone with mpox	Yes	If clade is unknown, all cases meeting the HCID case definition should be managed as per an HCID case.	Suspected cases must be discussed with local infection clinicians See HCID status of mpox for further guidance.	Mpox (monkeypox) Mpox (monkeypox): guidance – GOV.UK (www.gov.uk) NHS England » Infection prevention and control measures for clinically suspected and confirmed cases of mpox in healthcare settings

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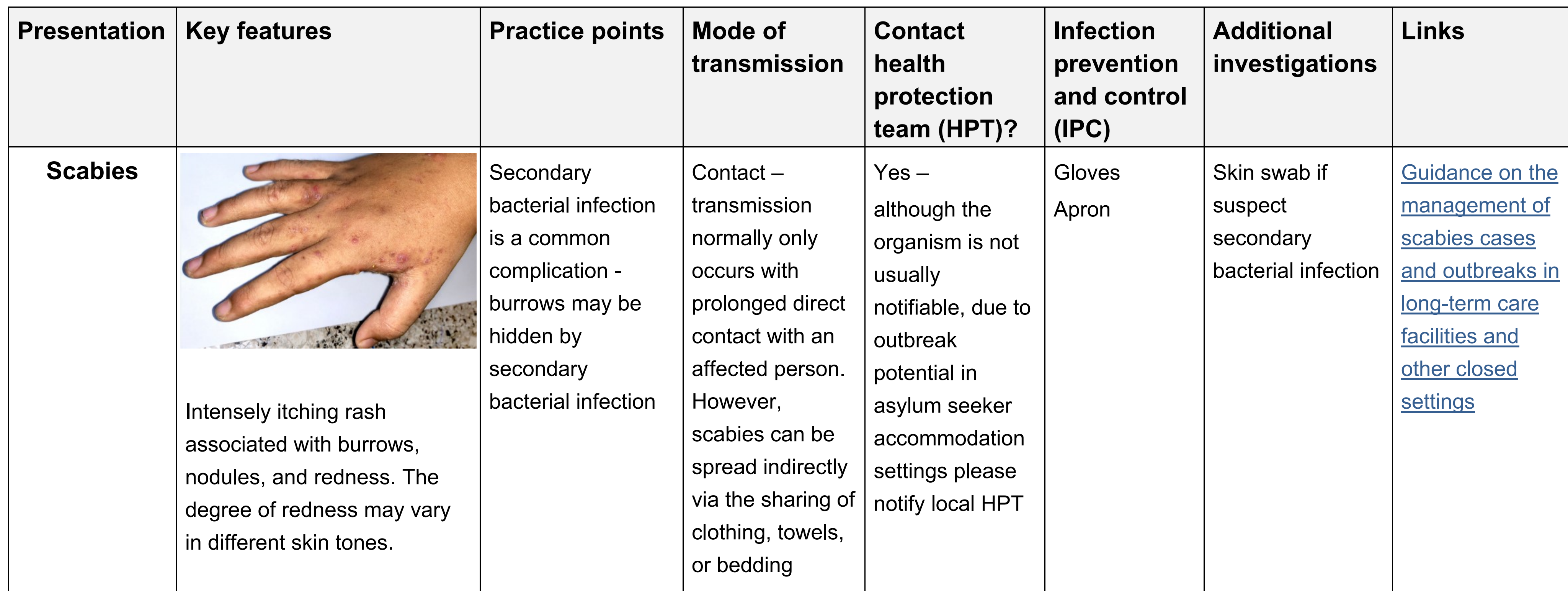
Scabies	 Intensely itching rash associated with burrows, nodules, and redness. The degree of redness may vary in different skin tones.	Secondary bacterial infection is a common complication - burrows may be hidden by secondary bacterial infection	Contact – transmission normally only occurs with prolonged direct contact with an affected person. However, scabies can be spread indirectly via the sharing of clothing, towels, or bedding	Yes – although the organism is not usually notifiable, due to outbreak potential in asylum seeker accommodation settings please notify local HPT	Gloves Apron	Skin swab if suspect secondary bacterial infection	Guidance on the management of scabies cases and outbreaks in long-term care facilities and other closed settings