



Norwegian Crusted Scabies: An Unusual Case Presentation

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ABSTRACT

Scabies is a contagious condition that is transmitted through direct contact with an infected person and has been frequently associated with institutional and healthcare-facility outbreaks. The subtype Norwegian crusted scabies can masquerade as other dermatologic diseases owing to the heavy plaque formation. Successful treatment has been documented in published reports, including oral ivermectin and topical permethrin. Few case studies documenting the treatment of Norwegian crusted scabies have reported the use of surgical debridement as an aid to topical and/or oral treatment when severe plaque formation has been noted. A nursing home patient was admitted to the hospital for severe plaque formation of both feet. A superficial biopsy was negative for both fungus and scabies because of the severity of the plaque formation on both feet. The patient underwent a surgical, diagnostic biopsy of both feet, leading to the diagnosis of Norwegian crusted scabies. A second surgical debridement was then performed to remove the extensive plaque formation and aid the oral ivermectin and topical permethrin treatment. The patient subsequently made a full recovery and was discharged back to the nursing home. At 2 and 6 months after treatment, the patient remained free of scabies infestation, and the surgical wound had healed uneventfully. The present case presentation has demonstrated that surgical debridement can be complementary to the standard topical and oral medications in the treatment of those with Norwegian crusted scabies infestation.

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Sarcoptes scabiei var *hominis*, or crusted Norwegian scabies, is a rare, atypical, and highly infectious variant of *Sarcoptes scabiei* (1). Clinically, this condition visually presents as a dermatitis and causes extensive hyperkeratotic lesions, nail thickening, and dystrophy (2). Patients characteristically complain of generalized pruritus, erythematous papules, and signs of scabies burrows (1,2). Newly infected patients might not experience symptoms of infection for up to 3 weeks, owing to a delayed type IV hypersensitivity reaction to the mite and its saliva, eggs, and excrement (3,4). Treatment for this condition has included both topical and systemic therapy, most commonly with oral ivermectin (5) and topical permethrin (6). Norwegian crusted scabies is an extremely contagious condition transmitted through direct contact with an infected person and has been associated with institutional and healthcare facility outbreaks (7,8).

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In the present case description, we report a unique case of Norwegian crusted scabies with severe dystrophic and deforming plaque formation of both feet. Treatment had been delayed for 3 months, and the diagnosis was derived from inspection of a full-thickness biopsy in the operating room. Subsequent surgical debridement was performed to allow for improved penetration of topical permethrin. The treatment was successful, and the patient subsequently had a full recovery from the infestation.

Case Report

A 60-year-old, nondiabetic, male nursing home patient presented to the emergency department with a 3-month history of an abnormal growth on both feet. The patient related that the abnormal growths had initially presented on the right foot and had rapidly spread to the left. The patient had increased pain in both feet on weightbearing and ambulation. He denied itching, fever, chills, nausea, vomiting, and other constitutional signs of infection. He had a medical history positive for bipolar disorder, schizoaffective disorder, hypertension, hepatitis C, and peripheral neuropathy secondary to alcoholism.



Fig. 1. View of plantar surface of foot at initial presentation.

The physical examination revealed thick, brown plaques encompassing all the toes and most of the plantar surface of both feet (Figs. 1 and 2). The plaques were rigid, not freely moveable, and extended the entirety of the length of the toes. No purulence, no malodor, and no periwound or ascending erythema was noted. No open lesions were noted on either foot. The skin on the dorsum of the foot proximal to the Lisfranc joint was free of pathologic changes. The patient experienced pain with palpation and passive range of motion in the areas of the foot affected by plaque formation. Pedal pulses were palpable +2/4,



Fig. 2. View of dorsum surface of foot at initial presentation.



Fig. 3. Radiograph of foot at initial presentation.

bilateral. The capillary refill time was unable to be evaluated owing to the severity of the plaque formation. Protective sensation was diminished distal to the level of the malleoli, bilateral, using the 5.07/10-g Semmes-Weinstein monofilament test. The patient was admitted to the hospital and started intravenous (IV) vancomycin, with IV fluconazole (Diflucan) and topical ketoconazole 2% cream.

Radiographs revealed multiple, condensed soft tissue lesions throughout both feet. This was most notable at the level of the digits and on the plantar surface of both feet. Chronic erosive changes were present at the level of the middle and distal phalanges. No radiographic evidence was found of a periosteal reaction (Figs. 3 and 4).



Fig. 4. Lateral radiograph at initial presentation.

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