Scarlet Fever and Streptococcus A Webinar 8 Dec 2022

Frequently asked questions

1. **What is Streptococcus A?**

Streptococcus A is a common bacterium which most people will encounter. It usually causes mild illnesses which can be managed at home with over-the-counter medicines. Sufferers may feel unwell but are able to carry out most activities. The same bacteria also cause impetigo, tonsilitis, pharyngitis and pneumonia.

2. **What complications which can arise?**

Scarlet Fever is caused by the toxins released by the bacteria which causes a rash and florid skin. The child should be seen by a health professional who will confirm the diagnosis and will usually prescribe antibiotics.

3. **What are the symptoms of Scarlet Fever or iGAS?**

Red rash on skin, white area on red tongue and florid cheeks. Skin will feel like sandpaper where there is a rash – face or body.

Rash will start to appear within 24-36 hours after contact.

Sufferers are noticeable unwell and may have fever, headache or sore throat and are not able to carry out normal activities.

iGAS (invasive Group A Streptococcus) is a rare complication when bacteria enter the bloodstream and causes a systemic (whole body) illness. Sufferers appear seriously unwell and may show very high fever and urgent hospital treatment is usually required.

4. **How long does a child on antibiotics need to stay away from school/setting?**

Antibiotics need a full 24hr period before starting to work so the advice is that the child stays away and takes the antibiotics for a full day before returning. This will usually mean 2 sleeps and may be up to 48hr. Children should only return if they are well enough to carry out all normal activities.

5. **How do schools/settings/settings need to report and who to?**

Notify any cases to Cheshire East so that the local situation can be monitored, local patterns identified and emerging issues can be addressed quickly. We can be contacted via the **School and setting reporting form** or **Covid19@cheshireeast.gov.uk**

Prior to the current rise in cases UKHSA wanted to be informed of all cases but they are now prioritising the complicated situations and so have asked schools/settings/settings to contact them in such cases. These are:-

- Co-circulating chickenpox or flu
- There is an outbreak in a setting supporting clinically vulnerable children
- The outbreak continues over 2 weeks
- Anyone is admitted to hospital or there is a death
- There are other issues which make it difficult to manage the cases

Any school which meets these criteria should notify UKHSA via the national helpline **03442250562** and choosing **option 9.**

6. **What information do we need to pass on to parents?**

Letter has been circulated to share with parents giving basic information and advice on when health professions should be contacted.

Good practice will be to inform parents if there are cases in school but not necessary to inform every day if there are more cases.

7. **Should we send home all cases?**

Any child who is unwell should not be in school.

8. **What about children with a fever/raised temperature but no other symptoms?**

Children should be 24hours free of fever before returning.

9. **Does the "free from fever" for 24 hours relate to nurseries too, we have lots of young children who have temperatures with teething and colds without symptoms such as rashes, sore throats etc?**

Parents should inform the setting before sending the child in, explaining that they think the fever is due to teething. If remedies such as teething gel or teething rings are alleviating the symptoms, then the child may attend.

We are currently experiencing co-circulating infections, (flu, Scarlet Fever, RSV, etc). Therefore, if there are other children in the house or setting who are unwell then the child in question should not return until they have been fever free for 24 hours without the use of Calpol (or similar).

10. **What is a child starts to show symptoms while in school?**

Remove the child away from other children. Staff supporting the child while waiting to be collected should wear single use plastic gloves/apron while looking after the child.

11. **What if child has had antibiotics prior to developing scarlet fever, e.g. Child given antibiotics for Step A but has now developed scarlet fever?**

Be cautious about child returning and ask for re-assessment by GP before returning as they could pass Scarlet Fever onto other children. Contact CE to discuss specific instances like this to get specific advice.

12. **Can vomiting be a symptom?**

Yes.

13. **Is swabbing required when antibiotics are given?**

New guidance will be given to primary care staff – threshold for swabbing may be reduced after the initial rise in cases once has been understood – it will be assumed that cases with similar symptoms has the same condition and swabbing is only required for unusual cases.

14. **Can the rash be just on the face?**

Yes.

15. **What if a child has open skin due to eczema that can’t be covered?**

Wear long sleeves and discuss with parents to see what other measures can be put in place to reduce the risk of infection.

16. **What if we have hand foot and mouth plus conjunctivitis circulating?**

Not on the UKHSA list but should inform UKHSA when there are other co-circulating infections

17. **What do schools/settings/setting need to do?**

Full COVID measures are not required.

Schools/settings have managed cases of Scarlet Fever over many years and should continue to do so.

No need to stop all activities while there are no complicated cases – risk assess and contact Cheshire East for specific advice.

18. Can we visit care homes?

Not advised as older people may be more vulnerable.

19. What about other trips and activities, e.g. performances?

Need to consider each event and not to prevent these unless necessary.

When there are uncomplicated cases, these can be risk assessed and usually go ahead but message to parents/audience is that anyone who is unwell should not attend. Contact Cheshire East for specific advice.

20. What cleaning is required?

The environment can play a significant part in transmission as Group A Strep can be found to remain in dust as well as on furniture and equipment.

Schools/settings are **not** required to close for cleaning but should follow the advice below which describes best practice for infection prevention and control.

- Cleaning of the environment, including toys and equipment, should as a minimum be carried out daily and a very thorough terminal clean should be undertaken when an outbreak is declared over.
- Touch points such as taps, toilet flush handles, and door handles, should be cleaned regularly throughout the day.
- Equipment, hard surfaces, hard toys and sleep mats should be washed with warm soapy water before disinfecting, (Hypochlorite at 1000 ppm of available chlorine)
- To allow more thorough cleaning, surfaces should be kept clear of unnecessary equipment and ornaments, especially during an outbreak.
- Carpets and soft furnishings should be vacuumed daily.
- Where soft toys cannot be avoided, they should be machine washed at the highest compatible temperature; hard surface toys are more easily washed and disinfected.

Once an outbreak is over, (at least 7 days after the last confirmed case), a thorough clean should take place. Carpets and rugs should be cleaned with a washer-extractor. Curtains, soft furnishing covers and all linen should be removed and washed at the hottest compatible temperature or steam cleaned. Soft furnishings without removable covers should be steam cleaned.

If a school/setting is working with UKHSA to manage a complicated outbreak, then further measures may be advised.

21. Which groups are vulnerable and what actions are required?

Vulnerable individuals are those who are immunocompromised, have reduced skin integrity or have long term conditions that reduce their immunity and make them clinically vulnerable.

In most cases there will be no testing or treatment for other children

There is no reported risk to pregnant staff who are contacts of Scarlet Fever or Strep A but they should inform their midwife. Schools/settings should notify UKHSA if there are any pregnant contacts of a confirmed iGAS case as further action may be advised.

22. **How should schools/settings respond to parents who choose to keep children away due to the risk of infection?**

Although there have been more cases than usual at this time of year, and parents might feel anxious, there has not been any Public Health advice to close schools/settings or to ask children not to attend. Schools/settings have been made aware of the infection prevention and control measures to be put in place which include good hygiene and cleaning. Parents and schools/settings have been informed about symptoms to look out for and what actions they should take. Parents are asked not to send their child to school if they are unwell as this will help reduce the risk of infection to others. Parents are advised to speak to school if they have particular concerns or circumstances where they feel someone is at particular risk so that any additional measures can be agreed or put in place if necessary. Where a well child does not attend and there has not been any discussion or agreement with the school it should be recorded as unauthorised.

Any will be an unauthorised absence and coded as usual

23. **Can schools/settings continue with planned trips and visits?**

Well children will be able to go on visits following the usual good hygiene measures – take hand gel if there is no access to hand washing. Emphasis is on everyone attending being well.

Schools/settings should discuss with the parents any vulnerable individuals at home (e.g. older relatives or parent undergoing cancer treatment) who may be visiting the school and how these children can be managed -

24. **Is a child with Chronic Fatigue Syndrome from previous Scarlet Fever infection more vulnerable?**

Contact Cheshire East for to discuss the case and for specific advice.

25. **Will a GP confirm to a parent if a child has Scarlet Fever, Group A Strep or if iGAS?**

Yes – GPs must report Scarlet Fever.

If iGAS then action for household contacts may be put in place e.g. antibiotics for household members

26. **How is GAS spread?**

Streptococcus bacteria survive in throats and on skin for long enough to easily spread between people through sneezing and skin contact. They can also spread in the environment in outbreaks (both in the air and on surfaces or objects, although the degree to which transmission on surfaces or objects is likely to be limited. People who are currently carrying GAS in the throat or on the skin can pass these bacteria on to others especially while in close or prolonged contact.

27. **What is Invasive Group A Streptococcus (iGAS) and what are the symptoms?**

Invasive Group A Streptococcus is a rare but severe disease. It is notifiable and requires urgent treatment and referral to secondary care and management.
The most important thing to be aware of are the early signs and symptoms These are:

- high fever
- severe muscle aches
- localised muscle tenderness
- increasing pain, swelling and redness at site of wound
- unexplained diarrhoea or vomiting

Parents and carers should be alert to signs and symptoms of sepsis. If they feel their child seems seriously unwell, they should trust their own judgment and:
Contact NHS 111 or their GP if:

- their child is getting worse.
- their child is feeding or eating much less than normal.
- their child has had a dry nappy for 12 hours or more or shows other signs of dehydration.
- their baby is under 3 months and has a temperature of 38C or is 3 to 6 months and has a temperature of 39C or higher.
- their baby feels hotter than usual when you touch their back or chest or feels sweaty.
- their child is very tired or irritable.

Call 999 or go to A&E if:
- their child is having difficulty breathing – you may notice grunting noises or their tummy sucking under their ribs.
- there are pauses when their child breathes.
- their child's skin, tongue or lips are blue.
- their child is floppy and will not wake up or stay awake.

28. What is the case definition for a confirmed iGAS case?
An individual who has an iGAS infection, which is defined as the detection of group A Streptococcus (GAS), by culture or accredited molecular methods (such as PCR), from a normally sterile body site, such as blood, cerebrospinal fluid, joint aspirate, pericardial-peritoneal-pleural fluids, bone, endometrium, deep tissue or deep abscess at operation or post-mortem.

29. What is the case definition for a probable iGAS case?
An individual who has a severe clinical presentation consistent with iGAS infection, such as STSS, necrotising fasciitis, myositis, and puerperal sepsis, in the absence of microbiological confirmation of GAS AND either:
- the clinician considers that GAS is the most likely cause, or
- there is an epidemiological link to a confirmed GAS case.

30. How common is iGas?
Notifications of invasive group A streptococcus (iGAS) disease are higher than expected for this time of year with an unusually high number of children presenting with lower respiratory tract GAS infections, including pulmonary empyema. However, iGAS disease remains rare. There are 2 to 4 cases per 100,000 population annually.

31. What is the link between Influenza and iGAS?
Influenza has been identified as a risk factor for iGAS disease amongst children. It is important to remind parents of eligible children, including those in clinical risk groups who are at increased risk of severe disease, to take up the offer of flu vaccination.
The children being offered the influenza vaccine this year, are:
- Children aged 2 and 3 on 31 August this year.
- all primary school-aged children.
- some secondary school-aged children.

Children aged 2 and 3 years will be given the vaccination at their general practice, usually by the practice nurse. School aged children should be offered a flu vaccine in school or can be vaccinated at community clinics.

32. Who is considered a close contact for GAS/iGAS infection?
A close contact is defined as those who have had prolonged contact with the case in a household-type setting during the 7 days before onset of symptoms and up to 24 hours after starting antibiotics.
Examples of such contacts would be:
- those with an overnight stay in the same household

- pupils in the same dormitory

Close contacts would **not** normally include:

- staff and children attending the same school, class or tutor group (although the risk assessment may allow you to define a group within the setting in which extensive close contact takes place)
- work colleagues
- attending the same social function
- travelling in the same plane, bus, train or car unless for prolonged periods of time (for example, a flight ≥8 hours, coach tours over a period of days)

33. When is antibiotic prophylaxis for close contacts of GAS infection recommended?

Antibiotics are not routinely recommended for close contacts of GAS infection.

34. When is antibiotic prophylaxis for close contacts of iGAS infection recommended?

Antibiotics are not routinely recommended for all close contacts of iGAS cases.
Antibiotic prophylaxis is recommended for close contacts in high-risk groups These high risk groups are:

- pregnant women from ≥37 weeks gestation.
- neonates and women within the first 28 days of delivery.
- older household contacts (≥75 years).
- individuals who develop chickenpox with active lesions either seven days prior to onset of the iGAS case or within 48 hours after commencing antibiotics by the iGAS case, if exposure is ongoing.

Antibiotic prophylaxis should be offered promptly to high-risk close contacts to commence as soon as possible (within 24 hours, and preferably the same day).

35. Does the Varicella vaccine have a role in reducing risk?

Chickenpox has been identified as a risk factor for iGAS infection in between 15% to 25% of iGAS cases. If chickenpox is co-circulating with scarlet fever in a nursery or pre-school setting, the OCT may consider use of varicella vaccine.

36. Can the flu vaccine help in a GAS/iGAS outbreak situation?

If flu is suspected or confirmed to be co-circulating in a nursery or school setting where an iGAS case has been confirmed, this provides an opportunity to remind eligible children, including those in clinical risk groups who are at increased risk of severe disease, to take up their offer of flu vaccination.
However, influenza vaccination is not routinely recommended as post-exposure precaution in this context and is unlikely to prevent secondary cases of iGAS.

37. When should a child with scarlet fever or streptococcal throat infection stay off school, nursery, and childcare settings?

Confirmed cases of scarlet fever and streptococcal throat infection (as confirmed by a clinician) should stay off school until 24 hours after starting treatment with an appropriate antibiotic.

Children can return to school after 24 hours if their fever has settled and they're feeling well enough. Education is extremely important for a child or young person's health and wellbeing and high-quality face-to-face education is always preferable where appropriate.

If antibiotics are not used, the recommendation is for a three-week exclusion period.

38. **Can a sibling of a confirmed case of GAS attend school, nursery and childcare settings?**

Yes. The sibling of a confirmed case of GAS can continue to attend, however, if the sibling of a confirmed case begins to develop symptoms, they should be assessed by a clinician and prescribed antibiotics if needed.

39. **Should schools expect a negative throat swab before allowing a child to attend a school, nursery or childcare setting?**

No, testing to attend is not required.