

CLINICALJUDGE[™] · NGN NCLEX 2026 INFOGRAPHIC LIBRARY

INTEGUMENTARY INFESTATIONS & SCALP CONDITIONS

SKIN
SERIES

INTEGUMENTARY · COMMUNITY HEALTH

PEDICULOSIS CAPITIS · PEDICULOSIS CORPORIS · DANDRUFF · TINEA CAPITIS · SCABIES

PED. CAPITIS

PED. CORPORIS

DANDRUFF

TINEA CAPITIS

SCABIES

PHARMACOLOGY

PATIENT EDUCATION

13 Sections

NGN Bow-Tie Included

8 NCLEX Pitfall Traps

Differential Diagnosis Focus

NCLEX 2026 Ready

COLOR LEGEND → ● CRITICAL / Emergency ● Pathophysiology ● Expected / Safe Findings ● Complications ● NCLEX Trap / Caution ● Medications

● Patient Education

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PATHOPHYSIOLOGY FLOW – COMPARATIVE

PEDICULOSIS CAPITIS

Pediculus humanus capitis

HEAD LICE · ECTOPARASITE

- **Causative Agent:** Human head louse — feeds on blood q4–6h
- ↓
- **Transmission:** Direct head-to-head contact; fomites (combs, hats, pillows)
- ↓
- **Nit Cement:** Eggs (nits) cemented to hair shaft within 1 cm of scalp — cannot be flicked off
- ↓
- **Immune Rxn:** Saliva → allergic sensitization → intense occipital/postauricular pruritus
- ↓
- **Complication:** Excoriation → secondary bacterial infection (impetigo, lymphadenopathy)

POP: Most common in school-age children 3–11 yrs; all socioeconomic groups

NOT vector-borne

Lymphadenopathy = secondary infection

PEDICULOSIS CORPORIS

Pediculus humanus corporis

BODY LICE · DISEASE VECTOR

- **Causative Agent:** Body louse — lives in clothing SEAMS, not on skin
- ↓
- **Transmission:** Infested clothing/bedding; poor hygiene, crowding, homelessness, disaster conditions
- ↓
- **Feeding:** Moves to skin only to feed → leaves back to clothing seams
- ↓
- **VECTOR:** Transmits *Rickettsia prowazekii* (epidemic typhus), *Bartonella quintana* (trench fever), *Borrelia recurrentis* (relapsing fever)
- ↓
- **S&S:** Intense pruritus, linear scratch marks (trunk, axillae, waistband areas)

VECTOR for 3 systemic diseases

Lives in clothes NOT body

DANDRUFF

Seborrheic Dermatitis (Pityriasis capitis)

NON-INFECTIOUS · CHRONIC INFLAMMATORY

- **Pathogen:** *Malassezia furfur* yeast overgrowth → lipase activity → oleic acid → inflammatory cascade
- ↓
- **Mechanism:** Accelerated keratinocyte turnover → visible scalp flaking; NOT parasitic
- ↓
- **Flakes:** White/yellow, greasy or powdery; easily dislodged with light touch — NO nits cemented to shaft
- ↓
- **Distribution:** Scalp, eyebrows, nasolabial folds, beard area (sebaceous-rich zones)
- ↓
- **Trigger:** Stress, cold weather, neurologic conditions (Parkinson's), immunosuppression (HIV)

NOT contagious

Flakes flick off easily — key NCLEX differentiator

TINEA CAPITIS

Dermatophytosis (Trichophyton tonsurans — most common US)

FUNGAL · SCALP RINGWORM

- **Pathogen:** Dermatophytes — *T. tonsurans* (US), *Microsporum canis* (animal contact)
- ↓
- **Transmission:** Direct contact with infected humans, animals (cats/dogs), fomites (combs, shared headgear)
- ↓
- **Invasion:** Hyphae penetrate hair follicles → keratin destruction → hair breakage at scalp level ("black-dot" pattern)
- ↓
- **Kerion:** Severe inflammatory response → boggy, indurated, pustular mass → scarring alopecia if untreated
- ↓
- **Diagnosis:** KOH prep, fungal culture; Wood's lamp (+) only for *Microsporum* (NOT *T. tonsurans*)

Children 3–7 yrs most affected

Kerion = urgent oral antifungal

SCABIES

Sarcoptes scabiei var. *hominis*

MITE INFESTATION · REPORTABLE

- **Pathogen:** *Sarcoptes scabiei* mite — female burrows into stratum corneum, deposits eggs
- ↓
- **Transmission:** Prolonged skin-to-skin contact; fomites less common (standard); crusted scabies = brief contact sufficient
- ↓
- **Burrows:** Serpiginous/linear grayish-white tracks in epidermis; classic sites — finger webs, wrists, umbilicus, axillae, areolae, genitalia
- ↓
- **Immune Response:** Delayed type IV hypersensitivity → NOCTURNAL PRURITUS (4–6 wks after first exposure; 1–4 days re-exposure)
- ↓
- **Crusted (Norwegian):** 1,000s–millions of mites; hyperkeratotic plaques; immunocompromised patients; highly contagious

Nocturnal itch + burrow = SCABIES

Treat ALL contacts simultaneously

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EXPECTED VS. CRITICAL S&S – DIFFERENTIAL RECOGNITION

✓ EXPECTED / MANAGEABLE FINDINGS

Ped. Capitis:	Scalp pruritus (occipital/postauricular), nits cemented to hair within 1 cm, live lice seen on wet combing
Ped. Corporis:	Generalized pruritus, linear excoriations on trunk, lice/nits found in clothing seams (not on body)
Dandruff:	White/yellow flakes easily dislodged, mild scalp itch, no hair loss, bilateral distribution, chronic/relapsing course
Tinea Capitis:	Circular scaly patches with partial alopecia, "black dot" pattern (broken hair shafts), mild pruritus, scaling
Scabies:	Intense nocturnal pruritus, burrow tracks in finger webs/wrists, papulovesicular rash, involves multiple household members

⚠ CRITICAL / REPORT IMMEDIATELY

Ped. Capitis:	Cervical lymphadenopathy + pustules = secondary bacterial superinfection (S. aureus/Strep); requires antibiotics PLUS pediculicide
Ped. Corporis:	High fever + severe headache + rash in lice-infested pt = epidemic typhus (Rickettsia) — REPORTABLE; immediate medical evaluation
Dandruff:	Severe/sudden onset seborrheic dermatitis in previously healthy adult → screen for HIV (seborrheic dermatitis is HIV-defining dermatosis in severe form)
Tinea Capitis:	Kerion (boggy, tender scalp mass with pustules) = severe fungal inflammation → oral antifungal IMMEDIATELY; risk of permanent scarring alopecia
Scabies:	Crusted/Norwegian scabies in immunocompromised pt (HIV, transplant) = extreme contagion; contact precautions, oral ivermectin + topical permethrin, report to facility infection control

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DIAGNOSTIC COMPARISON TABLE — WITH NCLEX SIGNIFICANCE

CONDITION	CAUSATIVE AGENT	DIAGNOSIS METHOD	KEY FINDING	FIRST-LINE TREATMENT	CONTAGIOUS?	EXCLUDE SCHOOL?	NCLEX SIGNIFICANCE ★
Ped. Capitis Head lice	<i>P. humanus capitis</i>	Visual: nit comb, wet combing; live louse on scalp	Nits cemented <1 cm from scalp, cannot flick off	Permethrin 1% OTC; repeat day 9; wet comb nits	Yes (direct contact)	Varies by policy CDC: NOT required	Nit vs. dandruff differentiation; no-nit policies debated
Ped. Corporis Body lice	<i>P. humanus corporis</i>	Visual: inspect clothing seams for lice/nits	Lice in clothing, NOT on body; linear excoriations trunk	Discard/hot wash clothing ; pediculicide if needed; improved hygiene	Yes (clothing/bedding)	N/A (not school-age focus)	VECTOR for typhus, trench fever, relapsing fever — highest stakes
Dandruff Seborrheic dermatitis	<i>Malassezia furfur</i> (yeast, non-parasitic)	Clinical diagnosis; KOH prep not typically needed	Flakes easily flick off; greasy or powdery; sebaceous distribution	Zinc pyrithione Selenium sulfide Ketoconazole 2%	NOT contagious	No	Reassure caregiver — NOT lice; flakes detach = key differentiator
Tinea Capitis Scalp ringworm	<i>T. tonsurans</i> (US) <i>M. canis</i> (animals)	KOH prep, fungal culture (gold standard); Wood's lamp (+) only for <i>Microsporum</i>	Circular alopecia patches; "black dots" (broken shafts); kerion = inflammatory form	Oral Griseofulvin 6–12 wks (SYSTEMIC required); adjunct selenium sulfide shampoo	Yes (direct + fomites)	Until treated	ORAL antifungal ONLY — topical creams are WRONG answer; Wood's lamp ≠ diagnosis for T. tonsurans
Scabies Mite infestation	<i>Sarcoptes scabiei</i>	Skin scraping + mineral oil prep → microscopy (mites, eggs, feces); clinical diagnosis often sufficient	Burrow tracks (finger webs, wrists); NOCTURNAL pruritus; multiple household members affected	Permethrin 5% neck-to-toe, 8–14 hrs; oral ivermectin (crusted/severe)	Yes — highly (crusted = extreme)	Until 24h post-treatment	Treat ALL contacts SIMULTANEOUSLY; pruritus persists 2–4 wks after successful Rx (NOT treatment failure)

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PHARMACOLOGY — MEDICATIONS & MECHANISMS

PERMETHRIN 1%

(NIX® — OTC)

Ped. Capitis

MOA:

Synthetic pyrethroid → disrupts Na⁺ channel closure → paralysis & death of louse

Application:

Apply to shampooed, towel-dried hair; leave 10 min; rinse; **repeat Day 9** (to kill newly hatched nymphs)

PERMETHRIN 5%

(ELIMITE® — RX)

Scabies

Application:

Apply head-to-toe (NECK to TOES in adults; SCALP & FACE in infants/elderly); leave **8–14 hours**; shower off; single treatment usually sufficient

Key Teaching:

ORAL IVERMECTIN

(STROMECTOL®)

Scabies (severe)
Resistant lice

MOA:

Enhances GABA-gated Cl⁻ channels → paralysis of invertebrates

Dosing:

200 mcg/kg × 2 doses (Days 1 & 14); first-line for crusted

ORAL GRISEOFULVIN

(GRIFULVIN V®)

Tinea Capitis ONLY

MOA:

Disrupts microtubule function → arrests dermatophyte mitosis at metaphase

Duration:

6–12 weeks; take WITH fatty meal to enhance absorption

KETOCONAZOLE 2%

(NIZORAL® SHAMPOO)

Dandruff (1st-line)
Tinea (adjunct)

MOA:

Inhibits ergosterol synthesis → disrupts *Malassezia* cell membrane

Application:

2–3× weekly × 4 weeks (dandruff); ADJUNCT with oral

NCLEX Traps:

Resistance increasing
Safe in pregnancy (Cat B)
Day 9 repeat critical

Itching persists 2–4 wks post-Rx
Apply under fingernails
Treat ALL contacts same day

scabies; used with topical permethrin
NOT for children <15 kg
Pregnancy Cat C

Topical antifungals
INEFFECTIVE alone
Hepatotoxic — monitor LFTs
Photosensitivity

griseofulvin for tinea (reduces shedding/transmission)
Topical = NOT sufficient ALONE for tinea capitis

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NUMBERED PRIORITY NURSING LADDER

1 SAFETY FIRST: Identify & Isolate Crusted Scabies / Body Lice Vector Risk

Crusted scabies → contact precautions immediately. Body lice with systemic symptoms (fever, rash) → report and isolate. These conditions carry highest morbidity/mortality if missed.

2 ASSESS: Correct Differential Diagnosis Before Intervention

Distinguish nits (cemented, can't flick) vs. dandruff (easily removed). Identify burrow tracks for scabies. Assess kerion for tinea. Misidentification → wrong treatment → treatment failure.

3 ASSESS: Secondary Infection Signs

Inspect for lymphadenopathy, pustules, cellulitis (ped. capitis). Assess for kerion (tinea). Secondary bacterial infection requires antibiotics ADDED to primary treatment — priority escalation.

4 INTERVENE: Apply Correct Treatment Protocol

Administer/teach permethrin correctly. Initiate oral griseofulvin for tinea capitis (not topical alone). Treat ALL contacts with scabies simultaneously. Verify Day 9 repeat for ped. capitis.

5 ENVIRONMENT: Decontaminate Linens, Clothing, Contacts

Machine wash/dry (130°F+) all clothing and bedding. Bag items that cannot be washed for 2 weeks (scabies) or 2 days (lice). Vacuum carpets and furniture. DO NOT use insecticide sprays in home.

6 EDUCATE: Patient, Family, and School/Facility Notification

Teach correct product application, duration, and repeat dosing. Notify school nurse/public health per facility policy. Educate on no-sharing of personal items. Reassure on non-contagiousness of dandruff.

7 MONITOR: Treatment Response & Post-Treatment Itch

Scabies: Itch persists 2–4 wks after successful treatment — NOT failure. Tinea: Expect 6–12 wks oral griseofulvin — monitor LFTs monthly. Dandruff: Chronic condition, maintenance therapy needed.

8 FOLLOW-UP: Verify Resolution, Screen for Recurrence & Contacts

Ped. capitis: Check at Day 9–10 for live lice. Tinea: Fungal culture to confirm clearance. Scabies: 1-week follow-up; re-treat if new burrows appear. Identify index case and screen close contacts.

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IF → THEN CLINICAL DECISION RULES

IF → Child has white particles on scalp and parent is unsure if lice or dandruff — try to flick particles off
THEN: If particles flick off easily → **dandruff**. If cemented within 1 cm of shaft → **nits (ped. capitis)**. Refer for treatment accordingly.

IF → Tinea capitis diagnosed and parent asks about using athlete's foot cream on scalp
THEN: Firmly explain topical antifungals (clotrimazole, terbinafine cream) are **INEFFECTIVE** for tinea capitis. Oral griseofulvin is required. Reinforce completion of full 6–12 week course.

IF → Patient with scabies says their spouse doesn't itch, so spouse doesn't need treatment
THEN: Correct misconception. All household contacts must be treated **simultaneously** regardless of symptoms — incubation period is 4–6 weeks. Untreated contacts will re-infect treated patient.

IF → Scabies patient calls 10 days post-treatment reporting still itching intensely
THEN: Reassure — **post-scabietic pruritus persists 2–4 weeks** after successful treatment due to ongoing immune reaction to mite debris. Oral antihistamines and topical corticosteroids may help. Assess for new burrows to distinguish from treatment failure.

IF → Wood's lamp used on child with suspected tinea capitis and result is **NEGATIVE**
THEN: Do NOT rule out tinea capitis. *T. tonsurans* (most common US species) does **NOT fluoresce** under Wood's lamp. Obtain KOH prep and fungal culture to confirm.

IF → Homeless shelter resident presents with severe headache, fever 104°F, and generalized rash with known body lice infestation
THEN: Suspect **epidemic typhus (Rickettsia prowazekii)**. Isolate immediately, notify public health authorities, initiate doxycycline, treat lice infestation concurrently. Medical emergency.

IF → Immunocompromised patient (HIV+ CD4 <200) presents with widespread hyperkeratotic crusty plaques and minimal itch
THEN: Suspect **crusted (Norwegian) scabies**. Initiate contact precautions, treat with oral ivermectin + topical permethrin, notify infection control, treat ALL contacts and exposed healthcare workers.

IF → Parent asks if child with head lice must stay home from school
THEN: Per CDC and AAP: children with head lice should **NOT be excluded from school**; "no-nit policies" are not recommended. Child may attend school; begin treatment that evening.

IF → Child with tinea capitis develops boggy, tender scalp mass (kerion) with purulent drainage
THEN: This is a **kerion** — do NOT drain or administer antibiotics first. Initiate oral griseofulvin immediately. Short-course oral steroids may reduce inflammation. Incision/drainage is contraindicated — risk of scarring.

IF → Previously controlled dandruff suddenly worsens dramatically in a 35-year-old male
THEN: Assess for immunosuppression. Severe/refractory seborrheic dermatitis is an **AIDS-defining condition**. Offer HIV testing per clinical protocol. Treat seborrheic dermatitis while completing workup.

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8-TRAP NCLEX PITFALL GRID — DON'T FALL FOR THESE

⚠️ 1

⚠️ 2

⚠️ 3

⚠️ 4

"Use athlete's foot cream on tinea capitis"

WRONG — topical antifungals do NOT penetrate hair follicle.
CORRECT → Oral griseofulvin is required. Topical is only an adjunct to reduce shedding.

"Scabies itching = treatment failure → re-treat immediately"

WRONG — pruritus normally persists 2–4 weeks post-treatment.
CORRECT → Reassure patient; re-treat only if new burrows appear after 2–4 weeks.

"Negative Wood's lamp = NO tinea capitis"

WRONG — T. tonsurans (most common US) does NOT fluoresce.
CORRECT → KOH prep and fungal culture are needed. Wood's lamp only + for Microsporum.

"Only symptomatic contacts need scabies treatment"

WRONG — incubation period is 4–6 weeks; asymptomatic contacts still harbor mites.
CORRECT → Treat ALL household contacts simultaneously, symptomatic or not.

⚠️ 5

"Body lice are found ON the patient's skin"

WRONG — body lice live in clothing SEAMS; only come to skin to feed.
CORRECT → Inspect clothing seams for lice/nits. Treatment = washing/discarding clothes.

⚠️ 6

"Exclude child with head lice from school immediately"

WRONG — CDC/AAP do NOT recommend school exclusion for lice.
CORRECT → Child may attend; begin treatment that evening. Notify parents per policy.

⚠️ 7

"Permethrin 5% applied neck to toes in all age groups"

WRONG — in infants, elderly, and immunocompromised, apply to face and SCALP too.
CORRECT → Apply neck-to-toe in adults; include scalp/face in infants and elderly.

⚠️ 8

"Drain the kerion (boggy scalp mass) with scalpel"

WRONG — incision/drainage causes scarring alopecia and spread.
CORRECT → Treat with oral griseofulvin; add short-course prednisone for severe inflammation.

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NCLEX PATTERNS GRID — HOW EACH CONDITION IS TESTED

PED. CAPITIS PATTERN

"School nurse assesses a 6-year-old with scalp itching. Mother reports white particles on hair. Which assessment finding distinguishes head lice from dandruff?"

→ **Nits that cannot be removed by flicking the hair** (cemented with chitin). Dandruff flakes dislodge easily. Also: live louse found on wet combing.

Pattern: Differential diagnosis, assessment, parent teaching

PED. CORPORIS PATTERN

"A homeless shelter nurse evaluates a resident with severe pruritus, excoriations, and high fever. Lice are found in the patient's clothing seams. Priority nursing action?"

→ **Notify the healthcare provider immediately** — body lice + systemic fever = potential rickettsia/typhus. Isolate, initiate fever workup, doxycycline anticipated. Treat infestation concurrently.

Pattern: Priority, safety, public health reporting

DANDRUFF PATTERN

"Parent calls clinic concerned that child has 'lice' after noticing white flakes. Nurse advises parent to attempt to remove particles from hair shaft. Which finding indicates dandruff rather than lice?"

→ **Flakes slide off the hair shaft easily** with light touch. Lice nits require mechanical force to remove. Also: particles may be distributed broadly, not occipital-dominant.

Pattern: Teaching, reassurance, differentiation

TINEA CAPITIS PATTERN

"A 5-year-old has circular patches of scalp hair loss with scaling. KOH prep shows fungal hyphae. Mother asks if antifungal shampoo alone will cure the infection. Correct response?"

→ **"No — oral antifungal medication is required."** Topical antifungals cannot reach hair follicle depth. Ketoconazole shampoo is adjunct only. Oral griseofulvin for 6–12 weeks is the treatment.

Pattern: Teaching, pharmacology, route of administration

SCABIES PATTERN

"Patient returns 10 days after permethrin 5% treatment for scabies reporting intense itching. Which response is most appropriate?"

→ **"This is an expected response — itching can persist 2–4 weeks after successful treatment"** due to immune reaction to mite debris. Antihistamines may help. Assess for new burrows only after 4 weeks.

Pattern: Expected outcomes, teaching, reassurance

NGN EXTENDED PATTERN

"Extended multiple response: A nurse assesses a daycare class where 4 children have intense scalp itching. Which actions should the nurse take? Select all that apply."

→ **CORRECT:** Perform wet comb assessment; notify parents; instruct on permethrin 1% use with Day 9 repeat; advise hot-wash bedding/clothing; advise against sharing combs/hats.

INCORRECT: Shave heads; exclude all children; use kerosene (toxic)

Pattern: Select all, priority actions, NGN extended

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NGN BOW-TIE CLINICAL JUDGMENT SUMMARY

NGN BOW-TIE: SARCOPTES SCABIEI INFESTATION WITH RISK FOR SPREAD & SECONDARY INFECTION

Scabies is the highest-acuity integumentary infestation condition tested on NGN NCLEX — it combines infection control, pharmacology, patient education, and public health priorities.

RECOGNIZE CUES

Nocturnal Pruritus

Intense itching worse at night — classic hallmark of Sarcoptes infestation; histamine release from mite saliva

Burrow Tracks

Linear/serpiginous grayish tracks in finger webs, wrists, umbilicus, areolae, genitalia — mite tunnels

Multiple Household Members

Several people in same household reporting itch = epidemiological clue for scabies

Hyperkeratotic Plaques (if present)

ANALYZE CUES

Priority Hypothesis

Primary:

Scabies Infestation → Risk for:

- ▶ Household spread
- ▶ Secondary bacterial infection
- ▶ Crusted scabies (if immunocompromised)

Rule Out:

- ▶ Contact dermatitis
- ▶ Atopic eczema

TAKE ACTION

Tx: Permethrin 5%

Apply neck-to-toe (include scalp/face in infants); leave 8–14 hrs; wash off; repeat in 7–14 days if severe

PHARMACOLOGY

Treat ALL Contacts Simultaneously

All household members treated same day — prevents ping-pong reinfection

INFECTION CONTROL

Decontaminate Environment

Hot-wash/dry all clothing and bedding (130°F+); seal non-washable items in plastic bag × 72 hrs

Crusted/Norwegian variant in immunocompromised — extreme contagion risk

► Ped. corporis
► Folliculitis

Papulovesicular Rash

Erythematous papules & vesicles at burrow sites; secondary excoriation marks

ENVIRONMENT

Crusted Scabies Protocol

Contact precautions; oral ivermectin + permethrin; notify infection control; treat exposed HCWs

PRIORITY ESCALATION

Patient Education

Itch will persist 2–4 wks — expected. Return if new burrows after 4 wks. Antihistamine for comfort.

EDUCATION

EVALUATE OUTCOMES

✓ Treatment Success

No new burrow tracks after 4 weeks post-treatment; old rash fading; pruritus gradually decreasing week by week

⚠ Re-Treat Indicators

New burrow tracks appearing after 4-week post-treatment window; persistent live mites on skin scraping; clear re-exposure to untreated contact

☎ Contact Cleared

All household members completed treatment same day; no new cases in household; school/work clearance after 24 hrs post-treatment

🚑 Escalate If

Signs of secondary bacterial infection (cellulitis, pustules, fever); crusted scabies development; immunocompromised patient with no improvement; systemic spread signs

QUICK NGN DECISION FRAMES — REMAINING CONDITIONS

PED. CAPITIS FRAME

Cues: Occipital itch, nits within 1cm of scalp, cannot flick off, live louse on combing

Action: Permethrin 1% OTC → repeat Day 9; wet comb; hot-wash all items

Evaluate: No live lice at Day 9–10; nits >1cm from scalp = hatched/dead

PED. CORPORIS FRAME

Cues: Lice in clothing seams, pruritus + excoriations trunk/axillae; homeless/crowded conditions

Action: Discard/hot-wash clothing; improve hygiene; assess for systemic symptoms (FEVER = URGENT)

Evaluate: Resolution of infestation; no fever; public health notified if typhus suspected

DANDRUFF FRAME

Cues: Greasy/powdery flakes (flick off easily), chronic/relapsing, sebaceous distribution, no hair loss

Action: Ketoconazole 2% or selenium sulfide shampoo; reassure NOT contagious; assess for HIV if severe

Evaluate: Flaking reduced; no new lesions; understanding that management is chronic (not cure)

TINEA CAPITIS FRAME

Cues: Circular alopecia + scaling in child; KOH prep positive; black-dot pattern; kerion = boggy mass

Action: Oral griseofulvin 6–12 wks (NOT topical alone); adjunct ketoconazole shampoo; monitor LFTs

Evaluate: Hair regrowth; fungal culture negative; no new patches; LFTs within normal limits

12

PATIENT EDUCATION CHECKLIST — TEACH-BACK READY

🐛 HEAD LICE (PED. CAPITIS)

- ✓ Apply permethrin 1% to **clean, dry hair**. Leave on 10 minutes then rinse. Do NOT rewash hair for 1–2 days after.
- ✓ **Repeat treatment on Day 9** to kill newly hatched nymphs — this step is commonly missed and causes treatment failure.
- ✓ Use a fine-tooth nit comb on wet, conditioned hair every 2–3 days to remove nits and lice mechanically.
- ✓ Machine wash (hot cycle) AND dry (high heat) all clothing, bedding, stuffed animals. Seal non-washable items in plastic bag for 2 weeks.
- ✓ Do NOT share combs, brushes, hats, helmets, or pillows. Avoid direct head-to-head contact.
- ⚠ Do NOT use mayonnaise, olive oil, or other home remedies — these are NOT proven effective and may delay treatment.
- ⚠ Your child does NOT need to miss school per CDC guidelines — notify the school nurse and begin treatment at home.

🕷 SCABIES

- ✓ Apply permethrin 5% cream from the **neck to the soles of feet** (include scalp and face in infants and elderly). Apply under fingernails and in all skin folds.
- ✓ Leave cream on for **8–14 hours** (usually applied at bedtime; shower off in the morning).
- ✓ **ALL household members and close contacts must be treated on the SAME DAY** — even if they have no symptoms yet.
- ✓ Machine wash all bedding and clothing in hot water. Dry on high heat. Seal unwashable items in plastic for 72 hours.
- ✓ **Itching is normal for 2–4 weeks after treatment** — this is your immune system reacting to dead mites and debris. It does NOT mean the treatment failed.
- ⚠ Contact your provider if new burrow tracks appear after the 4-week mark — this may indicate treatment failure or re-exposure.
- ⚠ Antihistamines (diphenhydramine) or low-potency topical corticosteroids can relieve ongoing itch — ask your provider.

🍄 TINEA CAPITIS (SCALP RINGWORM)

- ✓ Your child **must take the oral medication (griseofulvin)** for the full 6–12 weeks — even after hair starts growing back. Do NOT stop early.
- ✓ Take griseofulvin **with a fatty meal** (whole milk, peanut butter) to maximize absorption.
- ✓ Use the antifungal shampoo 2–3×/week as directed — this reduces spread to others, but does NOT cure the infection alone.
- ✓ Do NOT share combs, brushes, headgear. Avoid contact with infected pets (cats, dogs) until they are treated by a veterinarian.
- ⚠ If a boggy, painful scalp lump (kerion) develops, seek care immediately — do NOT attempt to drain it at home. Oral steroids may be needed to reduce inflammation.

❄ DANDRUFF (SEBORRHEIC DERMATITIS)

- ✓ Dandruff is **NOT contagious** and **NOT caused by poor hygiene** — it is a chronic inflammatory condition related to a naturally occurring scalp yeast.
- ✓ Use medicated shampoo (ketoconazole, selenium sulfide, or zinc pyrithione) 2–3 times weekly. Leave on scalp 3–5 minutes before rinsing.
- ✓ Condition is chronic — expect flare-ups with stress, cold weather, or illness. Maintenance therapy (1–2×/week) prevents recurrence.

⚠ Sudden severe worsening of dandruff in a previously healthy adult may require HIV testing — this is a clinical indicator, not a judgment.

§ 13 — PDF EXPORT INSTRUCTIONS & STUDY GUIDE

Step 1 — Open in Chrome or Edge

Open this HTML file in Google Chrome or Microsoft Edge browser for best rendering quality and font support.

Step 2 — Print to PDF

Press Ctrl+P (PC) or Cmd+P (Mac) → Select "Save as PDF" → Set scale to 65–70% → Enable "Background graphics" checkbox → Save.

Step 3 — Study Protocol

Cover the treatment column and recall by condition. Use IF→THEN cards for clinical reasoning drills. Complete NGN bow-tie from memory. Test differential diagnosis by the pitfall grid.

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