



Impetigo^{*}

Impetigo

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On the March/April 2012 edition Empinotti et al¹ quoted the streptococcus as the main agent of non-bullous impetigo. In terms of treatment they reported the possibility of using common penicillin to treat disseminated lesions. According to the world literature, conflicting data is found.

S. aureus was the predominant organism in crusty (non-bullous) impetigo during the decades of 1940 and 1950 and, subsequently, the prevalence of streptococcus increased. However, in studies conducted during the last three decades, there was a resurgence of *S. aureus* as the main agent in crusty impetigo. *S. aureus*, isolated or in combination with streptococcus, is responsible for 80% of the cases, and *S. aureus* is the most recovered agent in an isolated form.^{2,3} Despite the fact that Brazilian articles related to the epidemiology of impetigo were not found, these data are repeated in different countries: United

States, Israel, Thailand, Japan, French Guiana, India, Chile, Norway.

In terms of treatment, the antibiotic spectrum to be chosen should cover staphylococcus and streptococcus for both bullous and non-bullous impetigo.⁴ As such, benzathine penicillin and others sensitive to penicillinases are not indicated in the treatment of impetigo. In a systematic review conducted by *The Cochrane Library* it was considered that V penicillin had a worse response than erythromycin and cloxacillin.⁵ Another interesting aspect reported was the absence of glomerulonephritis as a complication of impetigo, a fact that could reflect the reduced importance of streptococcus in impetigo.

I consider it important to report these data from the literature, as they lead to a considerable change in the conduct of a patient with impetigo. □

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