

A Parent's Guide to Sports-Related Skin Infections

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This guide was designed to inform parents of student-athletes about the most common or serious sports-related skin infections. If an athlete has new skin lesions or infections, they should see their primary care doctor for evaluation and possible treatment. The physician must ultimately “approve return to play” for your student-athlete. This guide is not a substitute for a physician’s examination.

Here are several important points about skin infections:

1. Prevention is the most effective treatment for any infection. Daily bathing after practice or games, very regular cleaning of athletic equipment at home using soaps, and not sharing personal hygiene supplies (soap bars, razors, towels) are the most important things you can emphasize for your child as they begin their season.
2. Contact their doctor if infection is not gone, or has worsened, by the end of their treatment.
3. Images of these skin infections can be found at this excellent website:

<http://www.dermatlas.net/atlas/index.cfm>

Impetigo

Description: “Staph infection”. Red patches of skin with yellow-gold crusting that tend to itch, but are not usually painful. Can be anywhere on body, but most often in exposed areas of skin, such as hands and face.

What causes it: *Staphylococcus* or *Streptococcus* bacteria. These are bacteria that normally live on everyone’s skin.

What about MRSA? This is a type of “staph infection” that is more serious and requires special antibiotics. The school uses cleaning solutions to minimize all bacteria on the athletic equipment and the same recommendation for regular hygiene and clean equipment are effective prevention for MRSA infections.

Why: Infections develop where there is damage to the skin, such as a scrape or an abrasion. Bacteria also grow well in moist areas, such as skin beneath restrictive or heavy, padded athletic equipment.

Treatment and resolution: Antibiotics, which can be taken as a pill or a cream. Infection improves over 5-7 days.

Return to play: Antibiotic treatment for 3 days and no new skin infections for 2 days with clearance from physician.

Prevention: Daily bathing using anti-bacterial soap (available at Murray’s Drug Store), including cleaning of the face. Regular washing of athletic equipment.

***Special note:** If there are a series of impetigo infections on a team, antibiotics are only helpful to those athletes with active infections and are not used to prevent infection in unaffected athletes.

Folliculitis and Pseudo-folliculitis

Description: Cluster of raised, red spots at the base of skin hairs. Typically itch and occasionally painful. Pseudo-folliculitis is associated with shaven areas of hair and skin - often curly hair.

What causes it: *Staphylococcus* and *Pseudomonas* bacteria. May also be simply an irritation of hair follicle.

Why: Occlusion of skin with athletic equipment or shaving. Shared athletic hot tubs. Some folliculitis is acquired by sharing soap bars in locker room showers.

Treatment and resolution: Bacterial infections treated with antibiotics and improve within 5-7 days. Pseudo-folliculitis may resolve on it’s own or can be treated with a steroid cream for 3-5 days.

Return to play: Antibiotic treatment for 3 days and no new skin infections for 2 days. Pseudo-folliculitis has no return to play restrictions.

Prevention: Avoid sharing of towels or soap bars. For pseudo-folliculitis, avoid shaving irritated areas of skin.

Tinea pedis

Description: “Athlete’s foot”. Redness with peeling and cracking of skin between toes. Moist or dry skin. Typically itches, occasionally painful.

What causes it: Fungal species, *T. rubrum*. Extremely common skin infection (70% of world population).

Why: Tight athletic shoes and sweating provide moist environment for growth.

Treatment and resolution: Over the counter anti-fungal, “athlete’s foot”, medications. Apply until infection resolves, up to 2-4 weeks. This infection will typically re-appear many times.

Return to play: No restrictions.

Prevention: Shower sandals in locker room and wash with benzoyl peroxide bar after shower. Re-occurring infections may benefit from aluminum chloride hexahydrate 20% decrease moisture.

Tinea corporis

Description: “Ring worm”. Red, raised, scaly, *ring-shaped* rash on arms, legs, trunk, face. Size is variable; may itch.

What causes it: Fungal species *T. rubrum*, *T. tonsurans*, and *M. canis*. Very contagious infection. May be contracted from athlete’s own feet, another person, animal contact, or contact with surfaces of locker room.

Why: Tight athletic equipment and sweating provide moist environment for growth. Very common in wrestlers, due to close, frequent contact between different athletes (for example, in tournaments), abrasions in skin.

Treatment and resolution: Over the counter anti-fungal, “athlete’s foot”, medications. Apply until infection resolves, 2-4 weeks.

Return to play: Treatment for 3 days with anti-fungal cream. Athletic coach may cover a treated infection with dressing or bandage during practice and competition.

Prevention: Recognize affected athletes and begin treatment promptly to avoid spread to other team members.

Herpes Simplex

Description: “Cold sore”. Small, shiny blisters surrounded by redness on face, body, arms, hands, legs. May have associated fever, swollen lymph nodes, tingling or burning of skin when blisters first appear.

What causes it: Herpes virus type 1. Common infection in general population (40-60% contract it over lifetime) and among athletes (up to 40% of wrestlers).

Why: Since it is a common infection in general, it is common in athletes. It is spread via close athletic contact especially if cuts or abrasions are present on skin, in particular in wrestling and football.

Treatment and resolution: Most infections will resolve without treatment. Medical treatment does shorten the length of time of the infection and medicines are most effective at the early stages of the infection. There is no cure for herpes simplex and it will likely re-appear later in life.

Return to play: No new blisters for 3 days with treatment for 3-5 days.

Prevention: Recognize affected athletes and follow “return to play” guidelines to avoid spread to other team members. Avoid skin-to-skin contact with active infections.

*Special note: Blisters on or near the eye may cause serious damage to the eye, and should be evaluated by a physician.