Dermatology Practical & Conceptual

Benzyl Benzoate 25% Versus Permethrin 5% for Scabies. Are Topical Drugs Still Required in the Oral Ivermectin Era?

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To the Editor,

Scabies is a diffuse skin infestation that currently represents a significant social and health problem. Itching, the primary symptom, significantly compromises the quality of life [1], Therapy is still a challenge, and in recent years, several issues have emerged. First, numerous literature case reports have described resistance to topical permethrin 5%, which has been the main approach for many years [2]. On the other hand, the availability of oral ivermectin (OI) has modified the treatment landscape. But is this truly the case?

In our unit, we treated 87 patients over the last 2 years, all of whom were over 18 years old. In all cases the diagnosis was confirmed by mite detection with the dermatoscope. Sixty-three patients received OI at the standard dosage (200 µg/kg), administered once and repeated after 1 week; 24 patients refused oral therapies and wanted topical ones only. We employed different topical approaches in the patients who accepted OI: 29 patients applied permethrin 5% 3 times over 2 days and then repeated after 1 week, and the other 34 patients used galenic benzyl benzoate (BB) 25% in vaseline oil, applying it twice daily for 5 days and then repeating after 1 week. We chose topical BB 25% in vaseline oil for the 24 patients who refused OI because of its longer application cycle. The selection of the topical treatment for patients doing OI was random; moreover, patients who had already undergone one of these topical treatments, were assigned to the other group (Table 1). After 1 month, the OI and permethrin group showed remission in only 11 cases, which decreased to 6 after 3 months of follow up. In contrast, the OI and BB group exhibited markedly different results. After 1 month, only 5 patients showed signs of the disease. A meticulous examination revealed that 4 of these 5 cases were linked to low compliance with the therapy. After 3 months, all patients in this group were completely healed both clinically

Table 1. General Features of the Groups.

Kind of Treatment	Benzyl Benzoate 25% With OI Group 34 Patients	Permethrin 5% With OI Group 29 Patients	Benzyl Benzoate 25% Alone Group 24 Patients
Age, mean, years	39.3	43.7	44.1
Sex, F:M, N	13:21	18:11	9:15
Weight, mean, Kg	81.2	76.7	82.4
Comorbidities, % Hypertension Obesity Diabetes	 2.0 3.2 0.8	 2.1 2.9 0.6	 3.1 4.1 0.9
Previous treatment, % (N)	permethrin 5% (4 pt), oral ivermectin alone (3 pt), 10% sulfur ointment (1 pt)	Benzyl benzoate 10% (3 pt), oral ivermectin alone (2 pt), 10% sulfur ointment (1 pt)	permethrin 5% (3 pt), oral ivermectin alone (1 pt), 10% sulfur ointment (0 pt)

Abbreviations: OI: oral ivermectin; pt: patients.

and dermoscopically, and 9 patients presented mild signs of irritant dermatitis due to BB topical toxicity, which we successfully treated with a short course of topical steroids. Finally, the group doing only BB topical therapy had stunning results. In fact, these patients had healing data comparable to the patients treated with OI and BB therapy in terms of efficacy and topical toxicity. After 1 month, only 3 of them showed signs of disease which were actually related to a low compliance. Long- term healing was confirmed after the 3-month follow-up.

We deduced 2 main observations: first, BB is currently much more effective than 5% permethrin, and second, the role of OI may need to be reconsidered. In fact, we observed that patients treated with only BB topical therapy had similar efficacy to the ones treated with OI and BB therapy. These patients also showed superior results to the group treated with topical 5% permethrin and OI. Therefore, OI may be better reserved for more severe cases, given the efficacy of topical BB therapy alone.

Based on our clinical experience, the previous approach of using topical 5% permethrin alone should be entirely abandoned. It is evident that topical treatment remains essential. The limitations of this study include the absence of a randomized blind control, challenges in assessing topical application compliance and home disinfection efficacy, as well as difficulties in achieving group homogeneity. More studies should be conducted to assess the best and well tolerated treatment for scabies, and to find out whether treatment with OI is still necessary given the efficient outcomes of topical treatment with BB alone, as also demonstrated by other studies (3).

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