

Our School Nurses have provided some clarifying information regarding head lice and the school setting. The information below is an excerpt from the Journal of the American Academy of Pediatrics.

<https://pediatrics.aappublications.org/content/135/5/e1355>

The recommendation is a notification only if high incidents of infestation in a school, which would fall in line with our school needing to do a thorough cleaning of the classroom or rooms as well at that point.

Management on the Day of Diagnosis

Because a child with an active head lice infestation likely has had the infestation for 1 month or more by the time it is discovered and poses little risk to others from the infestation, he or she should remain in class, but be discouraged from close direct head contact with others. If head lice is diagnosed in a child, confidentiality is important. The child's parent or guardian may be notified that day by telephone or by having a note sent home with the child at the end of the school day stating that prompt, proper treatment of this condition is in the best interest of the child and his or her classmates. Common sense and calm should prevail within a school when deciding how "contagious" an individual child may be (a child with hundreds versus a child with 2 live lice). It may be prudent to check other children who are symptomatic or who were most likely to have had direct head-to-head contact with the infested child. Some experts argue that because of the relatively high prevalence of head lice in young school-aged children, it may make more sense to alert parents only if a high percentage of children in a classroom are infested. Other experts feel strongly that these "alert letters" violate privacy laws, cause unnecessary public alarm, and reinforce the notion that a head lice infestation indicates a failure on the school's part rather than a community problem. However, studies examining the efficacy of alert letters are not available; consequently, some schools choose to design guidelines that they believe best meet the needs of their student population, understanding that although a head lice infestation may not pose a public health risk, it may create a public relations dilemma for a school.

Criteria for Return to School

A child should not be restricted from school attendance because of lice, because head lice have low contagion within classrooms. "No-nit" policies that exclude children until all nits are removed may violate a child's civil liberties and are best addressed with legal counsel for schools. However, most health care professionals who care for children agree that no-nit policies should be abandoned. International guidelines established in 2007 for the effective control of head lice infestations stated that no-nit policies are unjust and should be discontinued, because they are based on misinformation rather than objective science. The American Academy of Pediatrics and the National Association of School Nurses discourage no-nit policies that exclude children from school. However, nit removal may decrease diagnostic confusion, decrease the possibility

of unnecessary retreatment, and help to decrease the small risk of self-reinfestation and social stigmatization.

A school nurse familiar with lice infestations, if present, can perform a valuable service by rechecking a child's head if requested to do so by a parent. In addition, the school nurse can offer extra help to families of children who are repeatedly or chronically infested. In rare instances, it may be helpful to make home visits or involve public health nurses if there is concern about whether treatment is being conducted effectively. Parent education by school health professionals can reinforce similar goals for the medical home.

Summary of Key Points

1. No healthy child should be excluded from school or allowed to miss school time because of head lice or nits. Pediatricians may educate school communities that no-nit policies for return to school should be abandoned.
2. It is useful for pediatricians to be knowledgeable about head lice infestations and treatments (pediculicide and alternative therapies); they may take an active role as information resources for families, schools, and other community agencies.
3. Unless resistance to these products has been proven in the community, 1% permethrin or pyrethrins are a reasonable first choice for primary treatment of active infestations if pediculicide therapy is required.
4. Carefully communicated instructions on the proper use of products are important. Because current products are not completely ovicidal, applying the product at least twice, at proper intervals, is indicated if permethrin or pyrethrin products are used or if live lice are seen after prescription therapy per manufacturer's guidelines. Manual removal of nits immediately after treatment with a pediculicide is not necessary to prevent spread. In the school setting, nit removal may be considered to decrease diagnostic confusion and social stigmatization.
5. If resistance to available OTC products has been proven in the community, if the patient is too young, or if parents do not wish to use a pediculicide, consider the manual removal of lice/nits by methods such as "wet-combing" or an occlusive method (such as petroleum jelly or Cetaphil cleanser), with emphasis on careful technique, close surveillance, and repeating for at least 3 weekly cycles.
6. Benzyl alcohol 5% can be used for children older than 6 months, or malathion 0.5% can be used for children 2 years or older in areas where resistance to permethrin or pyrethrins has been demonstrated or for a patient with a documented infestation that has failed to respond to appropriately administered therapy with permethrin or pyrethrins. Spinosad and topical ivermectin are newer preparations that might prove helpful in difficult cases, but the cost of these preparations should be taken into account by the prescriber.
7. New products should be evaluated for safety and effectiveness.
8. School personnel involved in detection of head lice infestation should be appropriately trained. The importance and difficulty of correctly diagnosing an active head lice infestation should be emphasized.

9. Head lice screening programs have not been proven to have a significant effect over time on the incidence of head lice in the school setting and are not cost-effective. Parent education programs may be helpful in the management of head lice in the school setting.