

CUTANEOUS LARVA MIGRANS: REPORT OF THREE CASES WITH EXCELLENT RESPONSE TO ALBENDAZOLE

CUTANEOUS LARVA MIGRANS: RAPORT TRZECH PRZYPADKÓW Z DOSKONAŁĄ ODPOWIEDZIĄ NA ALBENDAZOL

Anca Chiriac¹, Cristina Birsan¹, Anca E. Chiriac², Alina Murgu³, Caius Solovan⁴

¹*CMI Dermatology, Iasi-Romania*

²*University of Medicine Gr T Popa Iasi-Romania*

³*University Hospital of Pediatrics Sf Maria, Iasi, Romania*

⁴*University of Medicine V Babes, Dept of Dermatology, Timișoara-Romania*

Corresponding author: Anca Chiriac, MD PhD

ancachiriac@yahoo.com

Our Dermatol Online. 2012; 3(2): 126-127

Date of submission: 02.01.2011 / acceptance: 03.02.2012

Conflicts of interest: None

Abstract

Cutaneous larva migrans is a common tropically-acquired cutaneous eruption, but it can be rarely observed in other areas, in Eastern Europe, like Romania. It presents as an erythematous, serpiginous, pruritic, cutaneous eruption associated with percutaneous penetration and subsequent migration of larvae of various nematode parasites. We report three cases with excellent response to treatment.

Streszczenie

Skórna postać larwy wędrującej jest częstą tropikalną-nabytą zmianą, ale może być rzadko obserwowana w innych obszarach, we wschodniej Europie, na przykład w Rumunii. Prezentuje się jako rumieniowa, pełzająca, swędząca, erupcja skórna związana z penetracją przezskórną, a następnie migracją larw nicienia różnych pasożytów. Przedstawiamy trzy przypadki z doskonałą odpowiedzią na leczenie.

Key words: cutaneous larva migrans; albendazole; skin disease

Słowa kluczowe: skórna postać larwy wędrującej; albendazol; choroby skóry

Introduction

Cutaneous larva migrans is a common tropically-acquired cutaneous eruption, but it can be rarely observed in other areas, in Eastern Europe, like Romania. It presents as an erythematous, serpiginous, pruritic, cutaneous eruption associated with percutaneous penetration and subsequent migration of larvae of various nematode parasites.

We report three cases with excellent response to treatment.

Case study I

A 45-year-old woman presented with complaints of an itchy eruption on the lateral side of her right arm, of several weeks duration. She was an inside worker, with cats and dogs at her house, with no previous trips in tropical areas, the lesion appeared during winter time. She gave no history of fever, cough, dyspnea, or bowel and bladder problem. She was treated with antibiotics and antihistamines with no relief and with the enlargement of the lesion (Fig. 1).

The laboratory parameters were within normal limits. Biopsy

was not accepted by the patient and taking into account of its little value for this condition (the larvae advance ahead of the clinical tract) it was not done.

Based on clinical findings, a diagnosis of cutaneous larva migrans was made.

Treatment with Albendazole 400 mg per day was administered; there was complete remission after 10 days.

Case study II

A 52-year-old female patient presented in our department, seeking advice for a lesion appeared many months ago on the dorsal aspect of the trunk, during summer time while she was working in a farm, with no symptoms, no laboratory modifications. She was diagnosed with cutaneous larva migrans and the lesion completely disappeared after 10 days of oral Albendazole 400mg per day (Fig. 2).



Figure 1. The clinical aspect of the lesion of case 1



Figure 2. Clinical picture of case 2

Case study III

A 47-year-old man came to us very frightened by the appearance of an intense pruritic, serpiginous lesion, seen on the thorax, 72 hours before the admission to the hospital. The patient was diabetic non insulin-dependent; he was diagnosed by the general practitioner with herpes zoster and he was put on medication: Aciclovir orally, with no improvement. The diagnosis was cutaneous larva migrans and the lesion disappeared, with no scar, after two weeks of Albendazole systemic therapy (Fig. 3).

Discussion

Cutaneous larva migrans is also known as sand worms, creeping verminous dermatitis, creeping eruption, plumber's itch, and duck hunter's itch. Numerous organisms are associated with larva migrans: *Ankylostoma caninum* (from dog, the most frequent), *Ankylostoma ceylonicum*, and *Ankylostoma braziliense*, *Uncinaria stenocephala*, *Bubostomum phlebotomum*, *Gnathostoma spp.*, *Diriofilaria conjunctivae*, *Capillaria spp.*, *Anatrichostoma cutaneum*, *Strongyloides stercoralis*, *Diriofilaria repens*, *Spirometra spp.*, *Gastrophilus spp.*, *Hypoderma spp.*



Figure 3. Clinical picture of case 3

These penetrate intact skin and then migrate through the epidermis. The most common locations are: the foot, buttocks, back, and thighs although there were reports on the penis, abdominal wall, even oral mucosa.

The larvae usually die in 2-8 weeks, with an incubation of 1-7 days, with a self-limited evolution.

Complications were reported: survival of the larvae up to 2 years, secondary bacterial infection and eczematization, extensive lesions with wheezing, dry cough, and urticaria, eosinophilic enteritis (after the migration of the *Ankylostoma caninum* larvae to the small intestine) and transient eosinophilia.

Different methods of treatment are available:

- freezing the lesion, but knowing that the larva is up to 2 cm ahead from the visible burrow;
- Ivermectin (a single dose of 200 µg/kg body weight);
- Albendazole (400 mg a day by mouth for 3 days);
- 10 percent topical thiabendazole suspension 4 times a day for at least 2 days after the last sign of burrow activity;
- oral Thiabendazole.

The particularities of our cases:

- young, healthy persons, from non-tropical areas;
- sudden appearance of typical lesions of larva migrans, possible after contact with dogs;
- complete resolution after oral Albendazole with prolonged administration (10 days), with no recurrence and no complications.

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