

Cutaneous Larva Migrans Masquerading as Tinea Corporis: A Case Report

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ABSTRACT

A 25-year-old male was seen with complaints of itchy skin lesions over left thigh. On examination multiple annular scaly plaques with wavy borders, peripheral papules and central clearing was seen. Closer examination revealed multiple forked tracts with excoriated papules. A diagnosis of cutaneous larva migrans was made and the patient treated using T.Albendazole 400 mg twice daily for 7 days which resulted in complete clinical cure.

Key words: Cutaneous larva migrans, Sandworm eruption, Creeping eruption

CASE REPORT

A 25-year-old male, fisherman by occupation, came with complaints of itchy skin lesion over left thigh for the past one month. He gave history of spending long hours on the beach. There was no history of trauma or fever. He had no pet animals. None of his family members had history of similar illness. He was treated elsewhere using topical and systemic antifungals and antihistamines with no response. On gross clinical examination, multiple annular plaques with wavy borders, peripheral excoriated papules with scaling and central clear space was noted over the lateral, anterior and medial aspects of left upper thigh. A closer examination revealed multiple excoriated papules and plaques with wavy serpentine forked tracts closely mimicking dermatophyte infection. A skin smear for fungus was found to be negative. A diagnosis of cutaneous larva migrans was made out from the history and clinical presentation. The patient was treated using oral Albendazole 400mg twice daily for one week. This led to complete resolution of the lesions on the thigh.

DISCUSSION

Cutaneous larva migrans, also known as creeping eruption or sandworm eruption is caused by the filariform (third stage) larvae of the nematodes mostly affecting the dogs and cats [1]. The most common organism is *Ankylostoma brasiliensis* followed by *Ankylostoma caninum*, *Ankylostoma ceylonicum*, *Bubostomum phlebotomus*, *Strongyloides stercoralis*, *Diriofilaria spp*, *Spirometra spp*, *Gnathostoma spp*, and *Loa loa* [2]. Humans become accidental hosts as the larva burrows through the intact skin when they come in contact with contaminated soil. These larvae get trapped in the epidermis, where they wander freely resulting in the classical clinical picture [3]. The incubation period may vary from a few minutes to days or sometimes even weeks [4]. Clinically, it is characterized by an intensely itchy erythematous, linear or serpiginous eruption seen mostly over feet, back, buttocks, thigh and abdomen. The lesions advance haphazardly at a rate varying from a few millimeters upto 3cm every day [1].

Cutaneous larva migrans has to be differentiated from scabies, Erythema chronicum migrans, larva currens and phytophotodermatitis. In our case, the eruption has closely resembled dermatophyte infection. The diagnosis is made purely on clinical grounds. Biopsy usually does not reveal the larva and is non-contributory, since the larva is usually situated 1-2 cm ahead of the visible tract.

Early treatment of cutaneous larva migrans is important as it can be complicated by secondary bacterial infection and rarely by Loeffler's syndrome [3]. Topical Thiabendazole 15% cream has been found to be effective [5]. Though, oral Thiabendazole is found to be effective, it has a high incidence of adverse effects [5]. Oral Albendazole 400 mg twice daily for 3-7 days has proven to be effective. Recently, oral ivermectin at a single dosage of 12mg has also been found to be effective.

CONCLUSION

In a tropical country like India, cutaneous larva migrans is so ubiquitous that eradication may be deemed impossible. Physicians also need to be sensitized to identify varied clinical presentations of this common disease. This case has been reported for its varied presentation.

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