

Article Information

Received date: Mar 16, 2017
Accepted date: Mar 25, 2017
Published date: Mar 27, 2017

*Corresponding author

Kevin Tavangarian, Department of
Emergency Medicine, Staten Island
University Hospital, Staten Island, NY,
USA, Tel: 718-226-5686; Email: Kevin.
tavangarianmd@gmail.com

Distributed under Creative Commons
CC-BY 4.0

Keywords Larva migrans; Serpentine
rash

Clinical Image

Cutaneous Larva Migrans

Kevin Tavangarian^{1*} and Ryan Don Aycock²

¹Department of Emergency Medicine, Staten Island University Hospital, USA

²Department of Emergency Medicine, Eglin Air Force Base Hospital, USA

The Case

A 61-year-old previously healthy male presented to an emergency department with a pruritic rash on his left first toe after returning from a vacation that included a visit to Miami, Florida. He recalled walking barefoot during his time there. The physician initially diagnosed non-specific blistering and recommended diphenhydramine and watchful waiting. On a repeat visit the rash was noted by the patient to have spread (Figure 1). The definitive diagnosis was made and treatment started.



Figure 1: Close-up pictures of linear eruption on the left first toe.

Diagnosis

Cutaneous Larva Migrans (CLM) is a reaction to the larvae of various *Ancylostoma* (nematode) species found most commonly in the tropical and subtropical areas of the United States. The nematode has a predilection for warm, moist, sandy soil and is most commonly contracted from walking barefoot on a beach [1]. In the natural host (usually the cat or the dog) the larva migrates to the lungs. In accidental human infections it is not able to penetrate the basal membrane of human skin and is thus confined to the epidermis in a benign, self-limited reaction.

Clinically CLM is characterized by lower extremity creeping serpiginous and erythematous tunnels of 2-3 mm width that track 3-4 cm from the site of penetrations and advance daily by 1-2 cm. The inoculation period is usually 1-5 days but can last as long as 1 month. Clinical history is paramount in providing diagnosis. Once the diagnosis is made, albendazole treatment typically leads to reductions in pruritus within 48 hours and resolution within a week [2]. The best treatment option is prevention in the natural hosts: dogs and cats [3].

References

1. Feldmeier H, Schuster A. Mini review: hookworm-related cutaneous larva migrans. Eur J Clin Microbiol Infect Dis. 2012; 31: 915-918.
2. Rizzitelli G, Scarabelli G, Veraldi S. Albendazole: a new therapeutic regimen in cutaneous larva migrans. Int J Dermatol. 1997; 36: 700-703.
3. Heukelbach J, Feldmeier H. Epidemiological and clinical characteristics of hookworm-related cutaneous larva migrans. Lancet Infect Dis. 2008; 8: 302-309.