



## RESEARCH ARTICLE

### CUTANEOUS LARVA MIGRANS: CASE REPORT OF AN UNUSUAL LOCALIZATION

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#### ABSTRACT

*Cutaneous larva migrans* is a zoonotic skin infection caused by the penetration of hookworm larvae, commonly *Ancylostoma braziliense*, into the epidermis. It is endemic in tropical and subtropical regions but increasingly seen worldwide due to international travel. We report the case of a 6-year-old girl who developed CLM after visiting Zanzibar. She presented with intense pruritus and a serpiginous erythematous lesion on her thigh, initially misdiagnosed as eczema. Diagnosis was based on clinical presentation and travel history. A single oral dose of ivermectin (200 µg/kg) led to rapid improvement within two days. This case highlights the importance of considering CLM in returning travelers and supports the efficacy of systemic antiparasitic treatment. Early recognition and appropriate therapy are essential to prevent prolonged discomfort and mismanagement.

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## INTRODUCTION

Cutaneous larva migrans (CLM) is a zoonotic disease. It's a common endemic disease in tropical and subtropical countries. This condition is caused by skin-penetrating larvae of nematodes: *Ancylostoma braziliense* or other nematodes of the family Ancylostomidae. We report a case of a 6 years old child treated for CLM acquired during vacations in Zanzibar.

## CASE REPORT

A 6 years old female patient admitted with intense itching, erythematous and a serpiginous localized lesion on her right posterior thigh for about two weeks that was mistreated as eczema and was treated with topical corticosteroids without any improvement. This child and her family were living in Morocco and travelled to Zanzibar one month ago. Clinical examination revealed a hypochromic, serpiginous track (Figure 1,2) on the posterior thigh, along with an inflammatory, pruritic lesion on the medial thigh (Figure 3). Diagnosis of cutaneous larva migrans was made on history and physical examination. No skin biopsy or stool testing was performed. We prescribed her a single dose of ivermectin 200 µg/kg. After 2 days, the lesion and pruritus had regressed significantly.

## DISCUSSION

CLM is most commonly acquired tropical disease that is originally found in tropical and subtropical countries (1). However, due to increase in foreign travel to many countries around the world, the infection is not limited to these areas. This condition is caused by skin-penetrating larvae of nematodes. Most of the people become infected by walking barefoot, wearing open-toe shoes. Larvae can migrate 2–6 mm in a day. Later on, it leads to a wide pinkish, congested, serpiginous and shapeless lesion (2). The lesions are typically distributed on the lower extremities, including the dorsal of the feet and the interdigital spaces of the toes, anogenital region can also be affected. In some cases, lesions may persist for several months despite the absence of detectable larvae on histological examination. Secondary bacterial infections can occur, particularly frequently in endemic areas (3). Diagnosis of cutaneous larva migrans is assisted by history and the observation of the lesion advancing at a rate of approximately 2- 6mm per day. Laboratory findings are not specific. Transient peripheral eosinophilia may be seen. Biopsy may be done to confirm the diagnosis but usually no parasite is seen. Targeted treatment for this zoonotic disease includes either oral albendazole or oral ivermectin. Additionally, low-dose ivermectin 0.1% cream twice daily for 14 days or topical

thiabendazole 10–15% and albendazole may provide an alternative, although they remain as less potent treatment (4).



Figure 1, 2. Hypochromic, serpiginous track on the posterior thigh.



Figure 3. Typical aspect of a serpiginous lesion

## CONCLUSION

Cutaneous larva migrans should be considered in travellers to tropical countries. Most of the cases are initially under-diagnosed, which results in a delay in starting proper treatment. Oral anti-parasitic agents seem to be more effective than topical treatment.

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