Recalcitrant cutaneous larva migrans in an atypical location

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DESCRIPTION
Cutaneous larva migrans (CLM) is an acquired infestation of tropical and subtropical regions, caused by the subcutaneous migration of nematode larvae, such as *Ancylostoma braziliense* and *Ancylostoma caninum*. The diagnosis is clinical since the histopathological detection of the hookworm larvae is rarely possible. The classical clinical lesions are erythematous raised tracks (often located on the feet), with folliculitis being an uncommon presentation.

The authors report the case of a patient in his 80s, referred to a dermatology outpatient clinic for a persistent pruritic zosteriform skin eruption that had started 10 months prior as three isolated papules that slowly coalesced into an erythematous patch. He had since undergone multiple treatments, including four cycles of oral valacyclovir, topical acyclovir, topical corticosteroids and topical antifungals, with no improvement. The patient lived in a rural area and denied any visits to tropical or subtropical regions.

Examination revealed a segmental erythematous patch on his left flank, composed of multiple follicular erythematous papules, a few pustules and slight desquamation (figure 1). Some lesions evoked serpiginous tracks and dermoscopic examination showed translucent brown structureless areas (figure 2). The differential diagnosis of Wolf’s isotopic response, tinea incognita, zosteriform metastasis and CLM were considered. The remaining physical examination, laboratory investigations (including complete blood count and total IgE) and mycological culture and direct exam of the lesions were unremarkable. Histopathology revealed an eosinophile rich intraepidermic vesicopustule, focal spongiosis and an abundant infiltrate of lymphocytes, plasmocytes and eosinophils in the superficial dermis. There was no evidence of atypical cells or fungal infection (including negative PAS staining). Consequently, our main suspicion was of an atypical presentation of CLM, and a therapeutic challenge was tried (figure 3). Two doses of ivermectin 15 mg yielded no response, but two 7-day courses of albendazole 400 mg/day resulted in complete resolution of the dermatosis.

The diagnosis of CLM is usually clinical, but two dermoscopic patterns have been described: translucent brown structureless areas that could be compatible with larval bodies or empty burrows.
While the typical serpiginous skin lesions are easily diagnosed and treated with albendazole or ivermectin, unusual presentations can be misdiagnosed and cause prolonged morbidity. A single dose of ivermectin results in resolution of the dermatosis in >95% of the patients; however, when hookworm folliculitis is present, there is often need for prolonged treatment courses.1 2 6

The present case is atypical, given the location, absence of epidemiological context, prolonged disease course and initial resistance to a first-line treatment. The diagnosis of unusual presentations of CLM may require a high index of suspicion and therapeutical challenges may be performed.

**Learning points**

- The vast majority of larva migrans cases are imported from tropical or subtropical countries but a few autochthonous cases have been reported in Europe.
- Larva migrans is usually self-limited but when follicular involvement is present, prolonged treatment may be required.

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Case reports provide a valuable learning resource for the scientific community and can indicate areas of interest for future research. They should not be used in isolation to guide treatment choices or public health policy.

**REFERENCES**