

Cutaneous Larva Migrans in an Infant

**Yash Paul
Jagdish Singh**

Cutaneous larva migrans (creeping eruption) is an infection of the human skin caused by larvae of the dog and cat hookworm, *A. braziliense*. Other animal hookworms (*A. caninum*, *Uncinaria stenocephala*, and *Bunostomum phlebotosum*) and human parasites (*Necator americanus*, *A. duodenale* and *Strongyloides stercoralis*) may also produce the disease(1). Parasite eggs deposited in feces of animals hatch to form infective larvae. Contact of human skin with infective larvae is necessary for infection to occur. Hence, it usually is seen beyond infancy, the sharpest increase occurs between 2-5 years and the peak at 5-14 years(2). Here we report a case of creeping eruption in a 10 month infant. This is, to the best of our knowledge, the youngest age at which this condition is being reported.

From Yashpaul Children Clinic and Sir Padatnpat Mother and Child Health Institute, S.M.S. Medical College, Jaipur.

Reprint requests: Dr. Yash Paul, A-C-4, Gayatri Sudan, Jai Singh Highway, Banipark, Jaipur 302 016.

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Case Report

A 10-month-old male child, 3rd in the birth order, weighing 7.45 kg presented with a bleb in the right gluteal region (*Fig. 1*, position B). The bleb was first noticed by the mother 15 days earlier, in the perianal region (*Fig. 1*, position A). Next day she noticed that the bleb had shifted and there was red line from previous clay's position to the new position. This shifting of the bleb continued and the child was brought to us on the 15th day. The raised, erythematous serpigenous track (35 cm in length and 1 mm in width) with a papule was characteristic. The mother had no other complaint regarding the child. The physical examination was otherwise unremarkable.

Blood examination showed the following values: hemoglobin 9.5 g/dl; leucocytes 14,000/mm³ with 26% neutrophils, 71% lymphocytes, and 2% eosinophils. The total eosinophil count was 150/mm³. Stool examination was negative for ova and cysts.

The child was given 25 mg levamisole orally, which was repeated after 2 days. Mebendazole suspension was applied locally twice daily. Progress of lesion stopped on the 2nd day and it gradually started fading and disappeared by the 10th day.

Discussion

Creeping eruption occurs in children who become exposed to the 3rd stage infective larvae in the soil, sand or sand boxes where infected dogs and cats have defecated. An erythematous, intensely pruritic papule forms at the point of penetration. In a few days it vesiculates and the larvae become trapped in the epidermis. This occurs because the larvae of these species are not

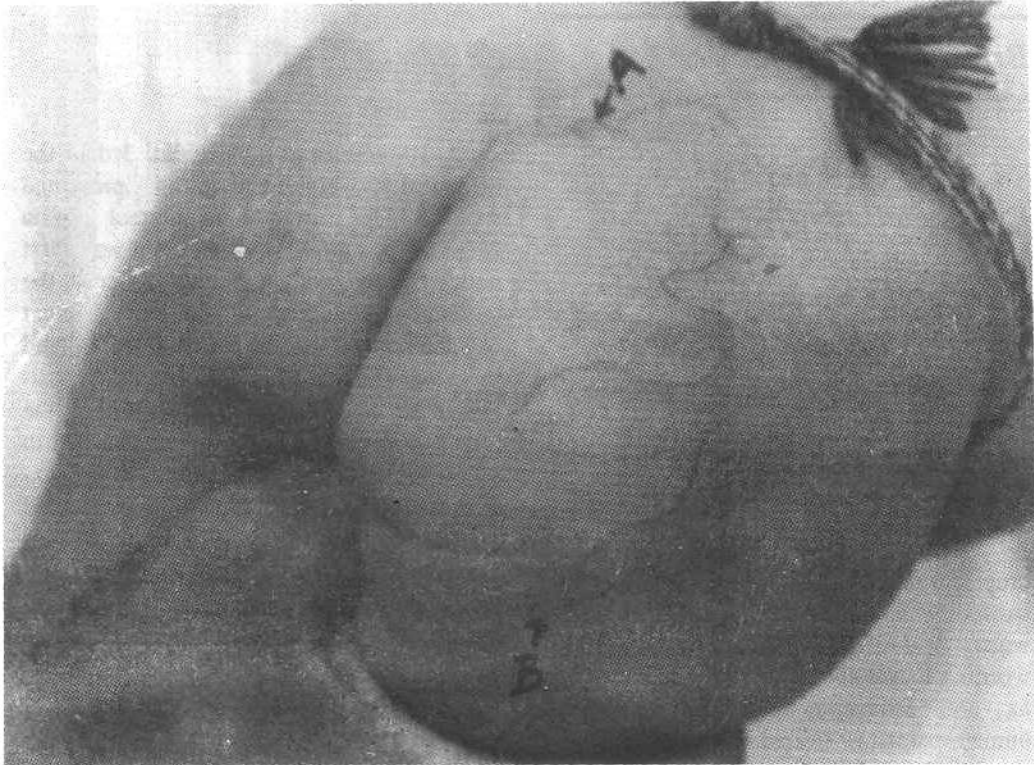


Fig. 1. Creeping eruption of cutaneous larva migrans. Position A: Site of bleb when first noticed. Position B: Site of bleb on 15th day.

adapted to man and cannot negotiate the epidermis below the stratum germinativum(3,4). It begins to migrate aimlessly, leaving serpigenous erythematous vesicular tunnels behind. Larvae may migrate for weeks or months before finally dying. Lesions can occur at any site but are seen most often on the soles and dorsum of the feet, buttocks, face and back. The only complication that occurs, results from intense itching and scratching with secondary infection by pyogenic bacteria(4). Systemic reactions include profound eosinophilia(5). Surprisingly none of these were seen in our case.

Generally the infection is mild and self

limited and requires no treatment. In case of persistent or severe infection, or anxiety on part of the parents, topical therapy by freezing with ethyl chloride is effective. Thiabendazole ointment or suspension applied locally and/or oral thiabendazole given in dose 25 mg/kg twice daily for 2 days is the treatment of choice(4). As this was not available, the above mentioned treatment given to the child also proved effective. Albendazole given in a dose of 400 mg/day for 3 consecutive days has given excellent results(6,7). Further trials suggest that a single oral dose of 400 mg may be effective as well(6). Single dose Ivermectin has also been found to be effective(8).

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An Outbreak of Poliomyelitis in the Marathwada Region of Maharashtra State: 1990

V.B.Mandke
R.M. Pawar
D.D. Naik
S.D. Salgaonkar

Paralytic poliomyelitis continues to be a

From the Enterovirus Research Centre, Indian Council of Medical Research, Bombay.

Reprint requests: Dr. V.B. Mandke, Assistant Director, Enterovirus Research Centre (ICMR), Haffkine Compound, Parel, Bombay 400 012.

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public health problem in India. Lack of high and sustained immunization coverage in the susceptible population leads to increased endemicity or periodic outbreaks.

One such outbreak in the Marathwada region (comprising 7 districts) of Maharashtra state in June 1990 was investigated by the Enterovirus Research Centre, Bombay. This was the second outbreak in this region since 1986(1). Epidemiological observations from the investigation are presented here.

Material and Methods

During the field investigations, detailed district-wise data of the outbreak, and data from the preceding 4 years as reported by the District Health Officers to the Deputy Director of Health Services, Aurangabad were obtained.

Stool samples were obtained from 52,