Cutaneous Larva Migrans (CLM) is the most common tropically acquired dermatosis, caused by infection with larvae of different kinds of animal hookworms, most common being *Ancylostoma braziliense* (dog hookworm). The most frequently infected sites are feet, hands, and buttock. Involvement of upper abdominal wall in an infant is an extremely uncommon presentation.1-3 Here we describe such a case.

An 11-month female baby was brought by her parents with history of intensely itchy migrating thread like lesion over the upper abdomen since 5 days. Local examination revealed a typical raised, curvilinear and serpiginous lesion with surrounding multiple erythematous papules (Figure 1). No other clinical abnormality, including any lesion on extremities was found on general examination. Her routine blood test reports were within normal limits. Her parents were agriculturists by profession with habit of going to field with the baby and keep the baby on open ground beside them. Based on the typical characteristics of the lesions and epidemiological history, a clinical diagnosis of CLM was made. Parents did not consent for biopsy, therefore, considering the diagnosis, she was treated with oral Albendazole (200 mg daily) for 3 days. A clinical cure was achieved on follow-up visit after one week.

Cutaneous Larva Migrans (CLM) or creeping eruption is widely distributed in all tropical and subtropical countries. Although juvenile larvae can directly penetrate the skin through any site, the most commonly affected area being the feet, hands, and buttock. Anterior abdominal wall has rarely been involved with larva migrans.1-3 Following penetration into the epidermis, the larvae migrate in a serpiginous route at a speed of 3 cm/day. Clinically, the primary lesion is a severely pruritic, erythematous, serpiginous burrow which develop usually 1 - 6 days following skin penetration. Though CLM is by and large a self-limited dermatosis as the larvae usually die within 2 - 8 weeks in humans, but secondary bacterial infection and eczematization can occur as a potential complication due to repeated scratching.4

Diagnosis of CLM is mainly done by the characteristic clinical picture. Biopsy is of no value as the larvae migrate ahead of the serpiginous tract. Epiluminescence microscopy is an effective non-invasive method to detect larvae and confirm the diagnosis. Currently, a single dose of Ivermectin (200 µg/kg, PO) is the treatment of choice. Albendazole (400 mg/day, PO) for 3 days is also an effective alternative for adult.5

REFERENCES

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