Reminder of important clinical lesson

Cutaneous lava migrans in the paediatric foot

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Summary

Dermatological referrals to paediatrics are a common occurrence often with a vast range of diagnoses made prior to referral to secondary care services. The authors report a case of cutaneous lava migrans infection in an 11-year-old girl in Northern England following her return from a family holiday in Jamaica. The authors report this case to raise awareness of this diagnosis. This girl initially received treatment for alternate diagnoses, and our aim is to encourage people to think of tropical dermatoses as a diagnosis in the returning traveller of all age groups.

BACKGROUND

Cutaneous larva migrans is a hookworm infection usually seen in tropical climates, although with the ease of travel to the tropics its incidence could well be increasing on return to the UK.¹ It is the most commonly acquired tropical dermatoses, but its presentation still remains uncommon in the UK in children. It is for this reason that we present this case as initially this girl was managed for a verruca and obviously had continuing spread of the lesion. It is therefore important that tropical dermatoses are considered in the differential diagnosis of a skin lesion in the returning traveller. We report this case to raise awareness of this diagnosis and its management options.

CASE PRESENTATION

An 11-year-old girl was referred by her general practitioner with a skin lesion on her left foot following return from Jamaica 2 weeks previously. This initially started off as a

small pinpoint lesion on the sole of the foot, which had been treated as a verruca with over the counter treatment. Over time an itchy red line started to migrate from the sole of the foot to the dorsum of the foot. She could recall no trauma or insect bites but reports walking barefoot on the sandy beach and resort while on holiday. The diagnosis was uncertain in general practice and so was referred for further assessment.

On examination, the girl was systemically well, with only a discrete serpiginous erythematous line on the sole of her left foot, travelling to the dorsum and ending on the big toe (figure 1).

The remainder of the skin, hair and nail examinations were unremarkable.

TREATMENT

The girl was treated with a single oral dose of 3 mg of ivermectin. Other treatment options were considered and reviewed in the discussion below.

Figure 1 Skin lesion on lateral border of foot.

OUTCOME AND FOLLOW-UP

She was reviewed a month later and the lesion had resolved and itching had ceased. No further follow-up was arranged.

DISCUSSION

Cutaneous larva migrans is a hookworm infection usually seen in tropical climates, although with the ease of travel to the tropics its incidence could well be increasing on return to the UK.¹ It is the most commonly acquired tropical dermatosis, but its presentation still remains uncommon in the UK in children. The most common hookworm organism is *Ancylostoma braziliense*. The natural hosts are cats and dogs. Their eggs are excreted in the animal faeces, and humans are usually infected with the larvae when walking barefoot. Therefore, the tracks seen by the hookworm are usually found on the feet, legs and buttocks. In rare cases the hookworms can mature and reside in the intestines, which cause diarrhoea and malabsorption.² The treatment options include topical thiabendazole 15% three times for 5 days, albendazole 400 mg orally once a day for 7 days or ivermectin (200 mg/kg) as a once only dose, which has advantages in paediatric practice.²⁻³ In this case we used ivermectin to good effect and with no adverse effects to the child.

Learning points

- Consider tropical infections in all children and adults returning to the UK with clinical problems such as skin lesions.
- Cutaneous larva migrans is the commonest tropical dermatosis and develops as a track on the foot.
- In paediatric practice, you need to consider all the treatment options for tropical dermatoses and it is important to seek help from paediatric infectious disease teams and paediatric pharmacists.

Competing interests None.

Patient consent Obtained.

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