Sir,

The cutaneous larva migrans (CLM), also known as creeping eruption, is a common infectious disease, especially found in tourists travelling to tropical and subtropical countries. In this reported case of an extensive CLM infection we could find a larva by epiluminescent microscopy to confirm the diagnosis.

CASE REPORT

A 34-year-old man presented the following clinical picture after a 3-week holiday on the island Isla de Mujeres, Mexico: large areas of elevated, serpiginous and erythematous trails, which were translucent and filled with a serous liquid towards the end. These eruptions were accompanied by a wide-spread inflammatory skin reaction (Fig. 1). Laboratory investigations revealed an eosinophilia of 14.8%. All other parameters were normal. The cutaneous manifestations had been presented for 10 days, beginning with great sensations of itching at the abdomen, the lateral sites of the thighs and the buttocks. In an affected skin lesion it was possible to detect a larva by epiluminescent microscopy (Fig. 2). Because of this extensive infection a treatment with a topical application of 15% thiabendazole for seven days under occlusive conditions in combination with an oral single dose of 12 mg ivermectin was provided. The pruritus and the progression of cutaneous tracks ended within three days. No recurrences of skin lesions were observed. Our patient experienced a complete resolution of lesions within 3 weeks and the treatment was well tolerated.

DISCUSSION

The diagnosis of CLM is based on the characteristic clinical history and symptoms. Histological evidence of the larva is

Fig. 1. A serpiginous tunnel-like lesion.

Fig. 2. A larva detected by epiluminescent microscopy (x 40).
limited in the most cases, because the cutaneous manifestations normally appear several hours after larva’s migration. The epiluminescent microscopy, however, is an effective and rapid non-invasive method for detecting a larva to confirm the diagnosis of CLM.

Accepted April 14, 1997.

Lichen Planus and Crohn’s Disease

Sir,

Lichen planus (LP) may occur with ulcerative colitis and hepatitis (2, 3). However, it has not previously been reported in association with the other major inflammatory bowel disease, Crohn’s disease. We describe such a patient.

CASE REPORT

A 32-year-old man presented with a 3-year history of intermittent non-bloody diarrhea. A barium enema was performed, which demonstrated the presence of colonic mucosal ulceration and loss of normal haustral pattern from the transverse colon to the rectum. Histology of multiple colonic mucosal biopsies was diagnostic of Crohn’s disease. Haematology and biochemical investigations were normal. Coliflox rapidly produced symptomatic relief.

The patient presented to the dermatology department 1 month later with a 3-month history of a rash affecting his right wrist and both palms. The lesions on the wrist were hypopigmented hyperkeratotic plaques with Wickham’s striae. There was involvement of the oral cavity, with a linear row of fine white streaks over the buccal mucosa and erosive lesions on the tongue. The clinical diagnosis was one of LP. The rest of the history and examination was unremarkable. Hepatitis serology was negative. The hypertrophic plaques were treated with 0.05% dexamethasone propionate and cleared within 1 month.

DISCUSSION

The cutaneous manifestations of disorders associated with Crohn’s disease are erythema nodosum, pyoderma gangrenosum, recurrent aphtous stomatitis and glossitis, perineal fistulae and abscesses, Sweet’s syndrome, subcorneal pustulatum dermatitis, granuloma, epidermolysis acquisita and cutaneous vasculitis.

Ulcerative colitis has also been associated with LP pemphigoids (5). Our patient did not display the widespread rash followed by bullae formation which is seen in that condition. Sulfasalazine and mesalazine, commonly used agents in the treatment of Crohn’s disease and ulcerative colitis, have also been linked with the development of LP. The aminosalicylic moiety is thought to be responsible (4). These drugs were not used in our case.

The temporal link between the diagnosis of the predisposing condition and the onset of the skin eruption in our patient is also convincing. Examination of the oral cavity and the skin may therefore give physicians useful diagnostic clues to the aetiology of gastrointestinal symptoms.

REFERENCES


Accepted April 30, 1997.

S.G. Kornbau1, P.C. Hayes2 and J.A.A. Hunter1
1Section of Dermatology, University of Sheffield, Royal Hallamshire Hospital, Sheffield, S10 2JF, UK. 2Centre for Liver and Digestive Disorders and 3Department of Dermatology, Royal Infirmary of Edinburgh NHS Trust, Edinburgh, UK.