

Two Painful Occipital Nodules in a Child Returning from South America: A Quiz

Ilaria SALVI^{1*}, Marco DEL MONTE², Sara NAIM², Angelica PISATI² and Gianmaria VIGLIZZO¹

¹IRCCS Istituto Giannina Gaslini, Genova, Italy, and ²Department of Neuroscience, Rehabilitation, Ophthalmology, Genetics, Maternal and Child Health, University of Genova, Genoa, Italy. Email: ilariasalvi@gaslini.org

An otherwise healthy boy aged six years presented to the emergency department with 2 painful nodular lesions on the occipital scalp that had progressively enlarged over approximately 2 weeks.

The child had recently returned from a trip to Brazil. According to the mother, the lesions initially appeared as small “insect bites” shortly after returning to Italy and gradually evolved into firm nodules. Each lesion displayed a central punctum.

On examination, 2 erythematous, dome-shaped nodules with central openings were noted in the occipital region

of the scalp (Fig. 1). Following gentle squeezing of the lesions, a small amount of seropurulent exudate drained from the central opening. No systemic symptoms were present.

What is your diagnosis?

- 1: Furunculosis.
- 2: Infected epidermal cysts.
- 3: Kerion celsi.
- 4: Furuncular cutaneous myiasis.

See next page for answer.



Fig. 1. Two erythematous nodules with central puncta on the occipital scalp.

ANSWERS TO QUIZ

Two Painful Occipital Nodules in a Child Returning from South America: A Commentary

Acta Derm Venereol 2026; 106: adv-2026-0557.
DOI: 10.2340/actadv.v106.adv-2026-0557

Diagnosis: Furuncular cutaneous myiasis due to *Dermatobia hominis*

After an unsuccessful attempt to induce larval expulsion by occluding the central openings with petroleum jelly in the emergency department, surgical exploration under local anesthesia was undertaken.

Surgical incision of both nodules resulted in the extraction of 2 intact larvae (Fig. 2), subsequently identified as *Dermatobia hominis*, the human botfly. After the extraction, the patient was prescribed oral amoxicillin/clavulanic acid as preemptive treatment of secondary bacterial infection of the wound.

Furuncular cutaneous myiasis is a parasitic infestation caused by fly larvae developing within the skin. *D. hominis* is endemic to Central and South America and represents the most common cause of furuncular myiasis in travelers returning from these regions (1).

Adult botflies deposit their eggs on foliage or directly on hematophagous insects such as mosquitoes, which then transfer the larvae to animal or human hosts during blood feeding. After hatching, the larva penetrates the skin and develops within a subdermal cavity for 5–10 weeks, while maintaining contact with the exterior through a central breathing pore. The most commonly infected areas are the scalp, face, and extremities.

Clinically, lesions resemble single or multiple furuncles or inflamed nodules with a central punctum.



Fig. 2. Two larvae of *Dermatobia hominis* extracted from the lesions.

Patients often report pain, seropurulent discharge, pain, pruritus, or a characteristic sensation of movement due to larval activity (2, 3).

Treatment of myiasis normally involves the extraction of larvae, with or without the administration of antibiotics to reduce the risk of secondary infection. Three main larvae removal methods (manual, mechanical, and surgical extraction) have been described. Manual extraction involves gentle pressing on the foruncle with hands, after the application of occlusive ointments (e.g. petroleum jelly) that may induce larval emergence by causing hypoxia. Mechanical extraction involves specialized devices to facilitate the extraction of larvae. Surgical extraction under local anesthesia is frequently required to avoid rupture of the larva, which can lead to secondary inflammation or infection (4).

In conclusion, while the distinct appearance of facilitates the diagnosis of *D. hominis* infestation in endemic areas, its identification can easily be delayed in temperate regions due to its rarity (5). Cutaneous myiasis should be considered in patients presenting with furuncle-like lesions after travels to endemic areas, particularly when associated with a central pore and subjective crawling sensation.

ACKNOWLEDGMENTS

This work was supported by the Italian Ministry of Health (Ricerca Corrente)

REFERENCES

1. Lachish T, Marhoom E, Mumcuoglu KY, Tandlich M, Schwartz E. Myiasis in travelers. J Travel Med 2015; 22: 232–236. <https://doi.org/10.1111/jtm.12203>
2. Robbins K, Khachemoune A. Cutaneous myiasis: a review of the common types of myiasis. Int J Dermatol 2010; 49: 1092–1098. <https://doi.org/10.1111/j.1365-4632.2010.04577.x>
3. Solomon M, Lachish T, Schwartz E. Cutaneous myiasis. Curr Infect Dis Rep 2016; 18: 28. <https://doi.org/10.1007/s11908-016-0537-6>
4. Jallow BJJ, Gassara G, Bajinka O, Luo Y, Liu M, Cai J, et al. Human myiasis in Sub-Saharan Africa: a systematic review. PLoS Negl Trop Dis 2024; 18: e0012027. <https://doi.org/10.1371/journal.pntd.0012027>
5. Ragi SD, Kapila R, Schwartz RA. The botfly, a tropical menace: a distinctive myiasis caused by *Dermatobia hominis*. Am J Clin Dermatol 2021; 22: 81–88. <https://doi.org/10.1007/s40257-020-00522-2>