

Unusual presentation of cutaneous myiasis

Sir,

A 38-year-old married female presented with pain, swelling and redness of the clitoral area of 5 days duration. Pain was sudden in onset, throbbing in nature and associated with crawling sensation. For the above complaints, she consulted a doctor in her village and was treated with analgesics and antibiotics. The pain increased in spite of 3 days of medication. She consulted the Department of OBG in our hospital, where no gynecological cause for pain was found. She was referred to dermatology to rule out any sexually transmitted infections. There was no past history of significant medical or surgical illness. On examination, the clitoris and surrounding area was erythematous, swollen and extremely tender to touch. No ulcer or vesicle was seen in the genitalia. On pulling the prepuce skin over the clitoris, two maggots were seen in the space between the clitoris and the prepuce [Figure 1]. Both maggots were removed manually using forceps [Figure 2]. The patient was relieved of symptoms immediately after removal of the maggots.



Figure 1: Maggots seen in the space between the clitoris and the prepuce



Figure 2: Maggots removed by forceps

Later, detailed history was taken to determine the etiology of myiasis. The patient used to go to the fields and forest area to collect wood for household purpose. At noon, she used to rest under the trees. She did not use undergarments. It is possible that flies must have laid their eggs on her genitalia and, after hatching, larvae must have lodged themselves in the space between the clitoris and the prepuce.

Myiasis (from the Greek “muia,” meaning fly) is infestation of tissues of living vertebrates by the larvae of dipterous flies. Clinically, myiasis can be primary or secondary. Primary myiasis is caused by biophagus larvae (feed on living tissues) while secondary myiasis, more common type, is due to necrobiophagus flies (feed on dead tissues). Depending on the body parts involved, myiasis can be ophthalmic myiasis, nasopharyngeal myiasis, intestinal myiasis and cutaneous myiasis. Cutaneous myiasis is of three forms: creeping myiasis,^[1] furuncular myiasis^[2,3] and

traumatic or wound myiasis.^[4] Myiasis of urogenital passages^[5,6] is rarely described, and species involved are chrysomyia (family Calliphoridae), sarcophagi (family Sarcophagidae), Cochliomyia, Wohlfartia, Piophilina, Scenopinus, Scatopsidae and Anisopus.^[7]

The aim of the treatment is to remove the larvae and treat any secondary infection with antibiotics. Symptoms improve immediately after removal of larvae. In wound myiasis, the larvae may be removed mechanically with forceps and, preferably, destroyed to prevent them from pupating. Occlusion of spiracles of larva using petrolatum, animal fat, beeswax, paraffin, butter and mineral oil can either kill them or induce them to move toward the skin surface. Maggots may be forced out by the lateral application of pressure or by injection of lidocaine beneath the lesion. When larvae are burrowed on to deeper tissues, they can be made to come out by application of gauze soaked in turpentine. In furuncular myiasis, under local anesthesia, the lesion should be incised and the larvae should be picked out without cutting them. In a creeping eruption, the larvae can be extracted with a needle. Systemic antihelmintics like albendazole, thiabendazole, diethylcarbamazine^[1] or Ivermectin can be used.

It is very important to examine the patient unbiased. High index of suspicion is necessary when history and clinical findings are not coinciding. In our case, pain, swelling and redness of genitalia can be easily mistaken for sexually transmitted infection.

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