blood count showed eosinophilia and stool examination for parasitic ova and cysts were negative. He was treated with albendazole 400 mg twice daily for three days. Progression of the lesions was halted in three days and complete resolution was seen in a week.

Numerous organisms can cause cutaneous larva migrans (CLM): *Ancylostoma brasiliensis*, *A. caninum*, *Uncinaria stenocephala* and *Bubostomum phlebotomum*. [1] *A. brasiliensis* and *A. caninum* (the dog and cat hookworms) are the most common causes. Most of the larvae are unable to undergo further development in humans (accidental host) and die within 2-8 weeks time. [2] Though the condition is worldwide in distribution, it is substantially more common in tropical and subtropical countries. Activities that increase the risk of infestation include walking barefoot on a beach, working in the garden and playing in sandpits. The incubation period varies between 1-6 days. The clinical features of CLM vary from nonspecific dermatitis at the site of penetration of the larva to a typical creeping eruption.

After penetration, the larva can lie quiescent for weeks or immediately begin their creeping activity. The characteristic lesion of CLM consists of slightly raised, erythematous thread-like linear or serpentine tracks. The condition is extremely itchy. Large number of larvae may be active at the same time with the formation of a disorganized series of loops and tracks. The larva usually lies somewhat in front of the head of the track. Vesiculobullous lesions along the tracks and folliculitis are other uncommon manifestations. [3,4] Excoriation and impetiginization of the lesion are common.

CLM confined to the penis is very rare with the mode of larval entry being unclear in such cases. Our patient hails from the coastal area and used to spend his leisure time on the beach. Karthikeyan et al have speculated that the habit of not wearing any underwear while playing on the beach is a possible cause of such penetration. [5] This could be applicable to our patient too.

Skin biopsy is of little help and the diagnosis is mainly clinical. Epiluminescence microscopy is a noninvasive method to detect larva and confirm diagnosis. [6] Differential diagnosis of CLM includes cercarial dermatitis, migratory myiasis and contact dermatitis. Surgery and cryotherapy are ineffective as the larva is easily missed, being ahead of the visible track. A single dose of Ivermectin (150-200 µg/kg) is the best treatment. Albendazole (400-800 mg/day) for three days and topical thiabendazole (10%) are also useful.

### References


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Histological examination of these nodules were diagnostic of neurofibroma with dilated follicular ostia filled with keratinous plugs and pilar differentiation.

Pilar dysplasia and folliculosebaceous differentiation have been described in neurofibromatosis by del Rio et al. in two patients. They considered it to be a stimulation phenomenon reflecting the essential role of the stroma in many cutaneous epithelial hyperplasias, hamartomas and possibly in some neoplasms. Various growth factors and their receptors are present in cutaneous neurofibromas. Mast cells, nonspecific cholinesterase, S-100 protein, myelin basic protein and factor XIIIa have been demonstrated in neurofibromas. Epidermal follicular differentiation may follow induction by several dermal mesenchymal proliferations including dermatofibroma, focal mucinosis, scar, nevus sebaceous, dermatofibrosarcoma protuberans and hemangioma. Follicular induction may yield a spectrum of follicular differentiation from germinative basaloid hyperplasia to advanced follicle formation. The production of the comedones in the overlying skin of neurofibromas could be due to the defective formation of follicle ostia.

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