

INTRODUCTION

Myiasis is a rare parasitic infestation of body tissues and natural body cavities of live human with dipterous (two-winged) larvae (maggots). Migratory myiasis occurs when maggots start to burrow aimlessly underneath the skin.

Classification of myiasis are based on entomological or clinical grounds. Entomologically, there are 3 groups namely facultative, obligatory and accidental/pseudomyiasis whereas clinically, it follows the anatomical location on the host³. There are 4 main groups following anatomical classification viz. cutaneous (furuncular and migratory), sanguivorous (bloodsucking), wound/traumatic and rarely cavitary myiasis³.

Here we present a 42-year-old lady with migratory scalp myiasis from the deep jungle of Borneo with no road connection to our hospital.

CASE PRESENTATION

A healthy 42-year-old lady who lived with another gravid female in a riverine longhouse had not washed her hair for the past 1 year owing to local taboo of no haircut, hair wash and trimming of fingernails after her mother's passing.

She presented with a 2-week history of 3 round scalp wounds infested with maggots and serosanguinous discharge. On examination, she was well and alert. There were 3 round scalp defects, measuring on average 4x4cm with myriads of maggots and serosanguinous discharge.

Her routine laboratory tests were all within the normal range. Contrast-enhanced computed tomography (CECT) of the brain showed no osteomyelitic changes or intracranial extension.

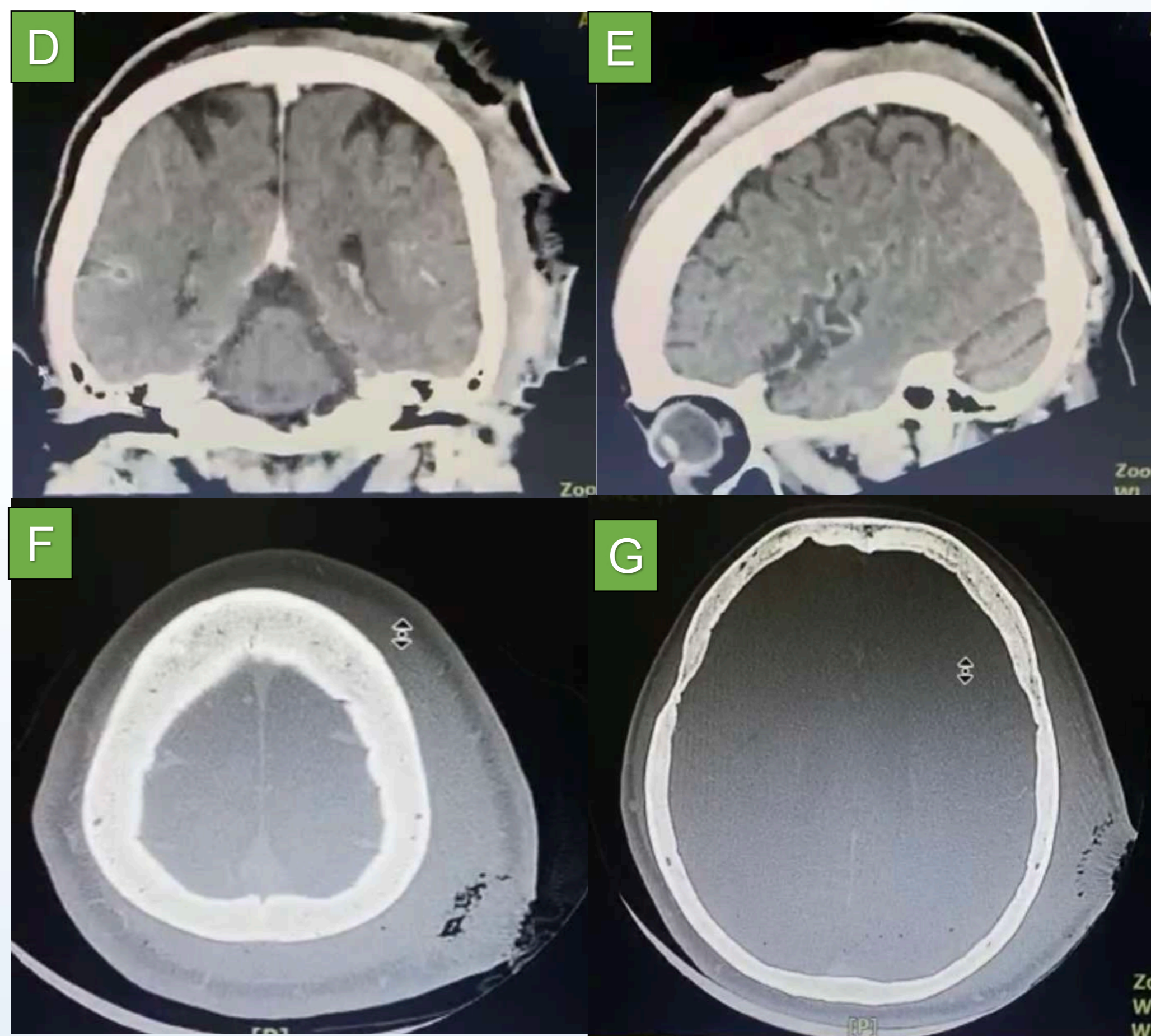
The patient underwent wound debridement and washout at bedside and under general anaesthesia. Intraoperatively, uncountable maggots were arranged in bundles within the 3 scalp wounds and distinct migratory tunnels filled with maggots were noted connecting all 3 scalp wounds. All maggots were removed followed by wound curettage.

She was then covered with broad spectrum antibiotics. Daily normal saline dressings were applied until the wounds were well healed.



Figure A shows the 3 round scalp defects over left frontal, posterior parietal and temporal regions. All scalp wounds were infested with maggots.

Figures B and C are close-up pictures of the scalp wound at left temporal and left frontal regions respectively.



Figures D and E showed no intracranial extension. **Figures F and G** showed no osteomyelitic change.

DISCUSSION

Although the common agents of migratory myiasis are *Gasterophilus spp.* and *Hypoderma spp.*, the culprit of most of the reported myiasis cases in Malaysia was *Chrysomya bezziana*¹.

Poor hygiene, superstition, health illiteracy and odour emanating from gravid female were the main factors of this uncommon presentation.

The mainstay of treatment was removal of all maggots followed by wound debridement². Removal of all visible maggots should be done meticulously to prevent leaving fragments of larvae behind, increasing the risk of secondary infection³. This was particularly challenging in this case as there were hordes of maggots with multiple migratory tracts hidden underneath the skin. These maggots were removed with forceps and curette. She was then covered with cloxacillin to prevent secondary infections.

Broad spectrum antiparasitic agent such as Ivermectin was effective in severe myiasis⁴. There was no reported cases of meningitis nor encephalitis secondary to myiasis².

CONCLUSION

Migratory scalp myiasis is a rare but benign parasitic infestation. Intracerebral myiasis may occur but exceedingly scarce. Removal of all visible maggots should be done thoroughly to prevent secondary infection. Culturally competent care, health literacy and good sanitation are keys to prevention.

REFERENCES

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