Title: Perils of Peru: Fever and periorbital edema in a returning traveler

Authors: Megan Edwards, MD, Infectious Disease Fellow Maine Medical Center, Portland, ME; Robert P Smith, MD, Infectious Disease Department Maine Medical Center, Portland, ME

Abstract:

Introduction: Fever and skin nodules in a returning traveler often present a diagnostic challenge. Here we present an etiology to consider when evaluating patients with recent tropical travel.

Case Description: A 55 year old woman with minimal past medical history returned from Peru with facial nodule later complicated by left eye swelling.

The patient presented to care one week after returning from a vacation to Peru. She traveled to Machu Pichu, Cuzco, Lima, Iquidos, and spent time in a remote village on the Amazon River. She denied noticing any mosquito bites and did not take malaria prophylaxis.

Three days prior to presentation, she developed a small papule with surrounding erythema above left eyebrow. She also noticed generalized malaise, nausea, and subjective fevers. She experienced intermittent sharp pain over her eyebrow followed by drainage of clear to red fluid from the center of the nodule. She took Doxycycline without improvement. She denied any other rashes, difficulty breathing, chest discomfort, diarrhea, joint pain, or urinary symptoms. Symptoms progressed to include periorbital swelling and she was unable to open her left eye.

On initial physical exam she was well appearing and afebrile. Left periorbital edema and erythema with 0.5 cm palpebral opening was observed. A 1x 1.5 cm circular, erythematous nodule with central pore covered in yellowish crust was noted approximately 1 cm above left eyebrow. Extraocular movements were intact without pain and sclera was clear. She also had shotty, nontender, left-sided preauricular and anterior cervical lymphadenopathy

She was diagnosed with periorbital cellulitis and was prescribed trimethoprim-sulfamethoxazole and levofloxacin. After one week, periorbital edema had resolved, but she continued to have intermittent dark red drainage and a “digging” pain from the now enlarged nodule. She was instructed to put petroleum jelly over the lesion and was referred to plastic surgery.

A dead bot fly larva, *Dermatobia hominis*, was extracted from her forehead three days later. Antibiotics were discontinued. Surgeon reported: “She is very relieved and happy to be rid of the parasite.” Several months later the patient denied any residual pain, swelling, or psychological distress.

Discussion: Furuncular myiasis, or larvae infestation is common in the tropics, but infrequently seen in more temperate climates. Humans and other mammals are often part of the life cycle of these insects. Many come to medical attention with secondary bacterial infections. This case illustrates the potential for parasitic infection, especially *Dermatobia hominis*, in a returning traveler with cutaneous nodules.