

The Past, Present, and Future of Cutaneous Larva Migrans in Türkiye: From Selim Kurtoğlu's 1981 Case to Current Clinical and Epidemiological Reality

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ABSTRACT

Objective: To place Selim Kurtoğlu's 1981 Turkish report of cutaneous larva migrans (CLM) within the context of pre-digital medical history and the updated Türkiye-related literature.

Materials and Methods: We conducted a historical documentary review of the 1981 article and a scoping search of PubMed/MEDLINE, Google Scholar, TR Dizin, DergiPark, journal websites, bibliographic catalogs, and accessible archives. The search was updated on July 27, 2026.

Results: Robert James Lee's 1874 report served as the international historical anchor. Kurtoğlu's 1981 article described a 2.5-month-old boy from Nevşehir with widespread pruritic, tunnel-like lesions and cited a 1947 Turkish parasitology item by Şekban under the term "köstebek hastalığı"; however, neither the cited item nor Şekban's biographical details could be independently verified. The updated search identified 11 subsequent digitally accessible Türkiye-related CLM publications and one 2026 Turkish report of a CLM mimic. The CLM literature included travel-associated disease, probable local acquisition, pediatric and atypical presentations, a 22-patient regional series, and discussions related to climate.

Conclusion: Kurtoğlu's 1981 report demonstrates that the history of CLM in Türkiye is older and more complex than digital databases alone suggest. The 1947 Şekban citation remains a historical trace awaiting archival confirmation, and older Turkish medical periodicals and local archives are essential for reconstructing the national chronology.

Keywords: Archives, epidemiology, history of medicine, larva migrans, parasitic, skin diseases, Türkiye.



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INTRODUCTION

The classical global starting point for the medical description of creeping eruption is the 1874 report by Robert James Lee, MD, FRCP, an English physician whose appointments included assistant physician and later physician at the Hospital for Sick Children, Great Ormond Street,



London.^{1,2} The report appeared in Transactions of the Clinical Society of London. It provided a recognizable description of a migrating cutaneous eruption but predated contemporary parasitological classification.

In Türkiye, Prof. Dr. Selim Kurtoğlu published “Kutanöz Larva Migrans: Bir Olayın Raporu” in *Sağlık Dergisi* (Health Journal) in 1981. The report described a 2.5-month-old infant from the Nevşehir region and cited an earlier Turkish parasitology item attributed to Şekban in 1947 under the folk term “köstebek hastalığı.”³ Because the original 1947 source has not been retrieved, it is treated here as an archival lead rather than as a verified Turkish CLM case.

Historical and Contemporary Terminology

Historical texts sometimes used CLM, creeping eruption, larva currens, epidermitis linearis migrans, and other terms for migratory dermatoses with overlapping meanings. Contemporary usage should distinguish the clinical sign “creeping eruption” from hookworm-related CLM and differentiate both from Strongyloides-related larva currens, which typically advances more rapidly and may indicate persistent systemic infection.^{4–6} This terminology is consolidated here and applied consistently throughout the manuscript.

Hookworm-related CLM is usually characterized by a pruritic, slowly migrating, serpiginous eruption following contact with soil or sand contaminated by animal hookworm larvae.⁴ Türkiye-related evidence is dispersed across pre-digital local journals, travel-associated reports, probable locally acquired cases, and small regional series. The present study therefore analyzes Kurtoğlu’s 1981 report as a historical source and compares it with the updated literature, focusing on chronology, clinical and epidemiological patterns, diagnostic terminology, treatment, archive accessibility, and future surveillance.

METHODS

Study Design

This was a historical documentary study combined with a scoping literature analysis. It was not designed as a systematic review or meta-analysis, and no quantitative synthesis was planned. The principal question was whether the currently accessible digital literature adequately represents the chronology and clinical significance of CLM in Türkiye.

Archival and Historical Sources

The principal archival source was Kurtoğlu’s 1981 article in *Sağlık Dergisi*, volume 55, issue 1–3, pages 33–37.³ A scanned/facsimile copy was reviewed for bibliographic information, patient age and region, clinical description, terminology,

treatment, and public health comments. The cited 1947 item was searched by author surname, title phrase, year, folk terminology, and spelling variants. The expanded search did not establish Şekban’s full name, specialty, institutional affiliation, journal title, volume, issue, or page numbers; therefore, no conjectural citation was added to the reference list.

Literature Search, Eligibility, and Data Extraction

The search was last updated on July 27, 2026. PubMed/MEDLINE, Google Scholar, TR Dizin, DergiPark, journal websites, bibliographic catalogs, and accessible full-text archives were searched using combinations of “cutaneous larva migrans,” “creeping eruption,” “hookworm-related cutaneous larva migrans,” “larva migrans Turkey,” “kutanöz larva migrans,” “kutanöz larva migrans,” “köstebek hastalığı,” “larva currens,” and “Türkiye.” The reference lists of eligible articles were also screened.

Eligible publications reported CLM in Türkiye, imported cases diagnosed in Türkiye, or Turkish data relevant to local epidemiology, climate, travel, or public health. A 2026 Turkish report of cutaneous pili migrans was included separately because it directly addressed a clinically important CLM mimic; it was not counted as a CLM case. For each publication, we extracted the study type, number and age of patients, geographic and acquisition context, travel history, lesion site, treatment, outcome, and specific contribution.

Source Access, Permissions, and Ethics

No rights-cleared institutional copy of Kurtoğlu’s 1981 article with a stable public URL was identified. Copyright status and republication permission for a page facsimile or patient photograph could not be confirmed; consequently, neither is reproduced. Deposit in an institutional repository or publication as supplementary material would be appropriate after written permission is obtained from the rights holder and the journal. Ethics committee approval was not required because the study used published and publicly accessible sources and involved no new patient contact or unpublished patient-level data.

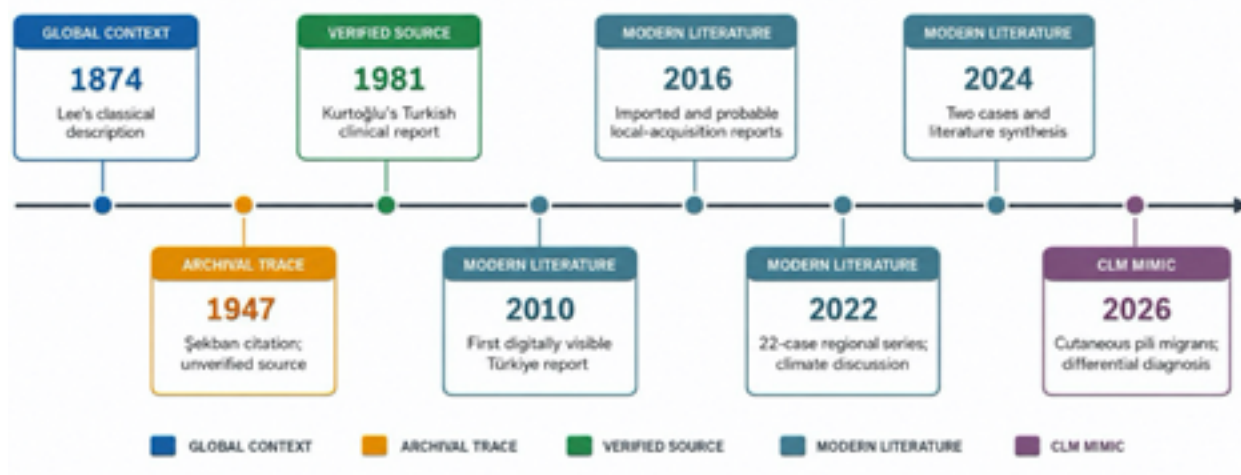
RESULTS

Historical Anchor Points

Lee’s 1874 report provides the classical international historical anchor.¹ In the chronology of CLM in Türkiye, Kurtoğlu’s 1981 article is the earliest retrievable clinical report identified in this study.³ Kurtoğlu’s citation of Şekban’s 1947 “köstebek hastalığı” item is historically important, but the source remains unverified and therefore cannot establish the first national clinical case. Figure 1 distinguishes the 1947 archival trace from verified reports.

Historical visibility of cutaneous larva migrans in Türkiye

Verified evidence, archival traces, and changes in clinical interpretation



The 1947 item remains a citation within Kurtoğlu's paper, not an independently verified clinical report.

Figure 1. Chronological anchors in the visibility and interpretation of cutaneous larva migrans in Türkiye. The 1947 Şekban item is presented as a citation within Kurtoğlu's paper and as an unverified historical trace, rather than as a confirmed clinical case. The 2026 cutaneous pili migrans report is presented as a CLM mimic relevant to the differential diagnosis, rather than as an additional CLM case.

Kurtoğlu's 1981 Report

The report originated from the Department of Pediatrics, Gevher Nesibe Faculty of Medicine, Kayseri University, and concerned a 2.5-month-old male infant from Yuva village in Nevşehir.³ The infant had systemic symptoms and an approximately 1-month history of raised, intensely pruritic, tunnel-like tracks involving the chest, abdomen, anterior and posterior trunk, arms, and ears. The distribution was unusually widespread compared with the more common distal-extremity pattern. Because the original clinical records, microscopy findings, and pathology material are unavailable, the present study interprets the publication from a historical perspective and does not attempt to re-diagnose the patient. The extracted features are summarized in Table 1.

Kurtoğlu's discussion extended beyond the individual case to animal reservoirs, contaminated soil, the Niğde–Nevşehir region, hygiene, parasitological investigation, and public education.³ These observations gave the report epidemiological as well as clinical value. Kurtoğlu's discussion anticipated concerns now framed within the human–animal–environment interface and the One Health concept.

Later Türkiye-Related Literature

The updated search identified 11 digitally accessible Türkiye-related CLM publications published after 1981 and one Turkish report of a CLM mimic. The 2010 and early 2016

publications included a travel-associated case diagnosed in Türkiye, a three-patient cluster of probable local acquisition, and another imported case.^{7–9} Further reports published from 2016 to 2018 described zosteriform disease associated with local exposure, an imported presentation, and a prolonged bullous case following domestic environmental exposure.^{10–12} Publications from 2020 to 2021 emphasized pediatric disease, atypical localization, diagnostic delay, and probable local acquisition.^{13–15} A 22-patient Eastern Black Sea series and a two-case travel-associated report broadened the regional and epidemiological evidence base.^{16,17} The 2026 publication addressed cutaneous pili migrans as a CLM mimic rather than as an additional CLM case.¹⁸ Detailed clinical and epidemiological characteristics are provided in Table 2 rather than repeated in the text.

The 2020 pediatric report described a 2-year-and-7-month-old boy from rural Samsun with no history of international travel, exposure to sand or soil contaminated by dogs and cats, atypical truncal lesions, an incomplete response to 5 days of albendazole, and regression after oral ivermectin.¹³ The 2026 report described cutaneous pili migrans in a 17-month-old girl: a black linear hair shaft on the sole was identified dermoscopically and removed, with no recurrence at 3 months.¹⁸ This latter publication expands the differential diagnosis but does not add a CLM patient to the national case count.

Table 1. Key clinical, historical, and archival elements extracted from Kurtoğlu's 1981 report in *Sağlık Dergisi*

Domain	Information extracted from the 1981 report	Contemporary interpretation
Bibliographic source	Kurtoğlu S. "Kutanöz Larva Migrans: Bir Olayın Raporu." <i>Sağlık Dergisi</i> . 1981;55(1–3):33–37.	Verified Turkish-language published source that is difficult to retrieve through routine digital searches.
Patient and place	2.5-month-old boy from Yuva village, Nevşehir.	Very early pediatric report from central Türkiye.
Clinical pattern	Raised, intensely pruritic, tunnel-like tracks on the chest, abdomen, anterior and posterior trunk, arms, and ears.	Widespread and atypical distribution; the historical source is analyzed without retrospective re-diagnosis.
Terminology	CLM, larva currens, creeping eruption, epidermitis linearis migrans, and migratory parasitic dermatoses discussed in proximity.	Reflects the terminology of the period; current usage distinguishes hookworm-related CLM from Strongyloides-related larva currens.
Diagnosis and treatment	Needle extraction/biopsy and treatment options available at the time, including local measures and oral mebendazole, were discussed.	Typical CLM is now usually diagnosed clinically; albendazole and ivermectin are standard systemic treatment options.
Public health observations	Animal reservoirs, soil contamination, the Niğde–Nevşehir region, hygiene, parasitological investigation, and public education were discussed.	Anticipated concerns now framed within the human–animal–environment interface and the One Health concept.
Archival status	The article was reviewed from a scan/facsimile; the cited 1947 Şekban item was not retrieved.	A rights-cleared institutional deposit and a stable URL are desirable; the 1947 citation remains an archival lead.

Diagnosis, Treatment, and Evidence Gaps

Across time periods, diagnosis depended primarily on a compatible exposure history and the presence of a pruritic migrating track. Kurtoğlu discussed extraction and biopsy alongside the treatment options available at the time, including mebendazole.³ Contemporary guidance generally supports a clinical diagnosis in typical cases and places albendazole or ivermectin at the center of therapy.^{19,20} Modern reports also demonstrate why morphology matters: a black, relatively straight filament and a dermoscopic hair-shaft appearance support cutaneous pili migrans, whereas hookworm-related CLM is usually erythematous, pruritic, and tortuous.¹⁸

The principal evidence gaps include incomplete digitization of older Turkish journals, reliance on case reports and small series, inconsistent documentation of travel and local exposure, and the absence of linked human, animal, and environmental data. These limitations preclude estimation of the national incidence or confident attribution of temporal trends to climate. Proposed priorities are summarized in Table 3.

DISCUSSION

The central contribution of this study is historical: Kurtoğlu's 1981 pediatric report restores a pre-digital Turkish source to the CLM chronology while maintaining a clear evidentiary boundary around the unverified 1947 Şekban citation. The updated search also demonstrates that the modern

literature cannot be reduced to a narrative of imported disease; it includes travel-associated cases, probable domestic acquisition, pediatric and atypical presentations, and a regional case series.

Digital Visibility Does Not Equal National Disease Onset

If only indexed databases are searched, Türkiye-related CLM appears to begin in 2010. Kurtoğlu's report demonstrates the distortion created by this approach. Conversely, the 1947 citation should not be elevated from an archival clue to a confirmed case without the underlying document and adequate bibliographic identification. This two-level chronology—verified source versus archival trace—is more defensible than either ignoring pre-digital literature or overinterpreting an inaccessible citation.

The clinical literature supports a similarly balanced interpretation. Cases linked to hazelnut-grove work, barefoot stream exposure, contaminated rural soil, gardening, and animal waste make exclusive importation unlikely.^{8,10,12,13,15} However, the evidence is too sparse and selectively reported to establish endemicity, frequency, or a climate-driven increase at the national level. The 22-patient Eastern Black Sea series, which included tea harvesting and soil contact, is important for hypothesis generation, but exposure surveillance and denominator data are needed before causal claims can be made.¹⁶

Table 2. Clinical and epidemiological features of digitally accessible Türkiye-related publications (2010–2026)

Citation/ year	Patients	Region and acquisition context	Travel/ local status	Lesion site/ pattern	Treatment and outcome	Specific contribution
Yavuzer et al., 2010 ⁷	1; 27-year-old Australian woman	Evaluated in Nevşehir after travel to the Brazilian Amazon; wore sandals	Imported; diagnosed in Türkiye	Dorsum of the right foot; serpiginous track	Albendazole 400 mg/day; marked regression	First modern, digitally accessible Türkiye-diagnosed report; not evidence of local acquisition
Çalışkan et al., 2016 ⁸	3 men; 23–54 years	Düzce, Western Black Sea region; hazelnut-grove mowing with a motorized trimmer; no foreign travel	Probable local acquisition	Abdomen, trunk, and neck; one case with secondary bacterial infection	Albendazole 400 mg/day for 3 days; all lesions regressed; one patient also received antibacterial therapy	Three-case occupational/environmental cluster supporting domestic acquisition and atypical lesion sites
Oral et al., 2016 ⁹	1; 54-year-old Turkish man	Evaluated in Istanbul after travel to the Brazilian Amazon	Imported	Right arm; 4–5-cm pruritic serpiginous lesion	Albendazole 400 mg/day; improvement within days	Additional travel-associated report involving a Turkish patient identified in the updated search
Aktaş et al., 2016 ¹⁰	1; 43-year-old woman	Karabük; recent contact with sheep and cow feces during cultivation	Probable local acquisition	Left submammary area; unilateral zosteriform pattern	Albendazole 400 mg/day for 3 days plus topical metronidazole; treatment course repeated; complete clearance	Unusual morphology and site associated with domestic animal-waste exposure
Sönmezer et al., 2017 ¹¹	1; 36-year-old man	Diagnosed in Ankara after travel to the Brazilian Amazon and barefoot exposure	Imported	Bilateral feet; secondary infection	Albendazole plus antibacterial treatment; rapid improvement	Imported CLM with a typical history of travel and barefoot exposure
Rastgar et al., 2018 ¹²	1; 44-year-old man	Sakarya; walked barefoot in a stream; no tropical travel	Probable local acquisition	Medial malleolar/ankle region; serpiginous and bullous lesions; 6-month course	Albendazole 400 mg/day for 3 days plus topical metronidazole; regression without recurrence	Prolonged, bullous, locally acquired case following moist-soil exposure
Kökçü Karadağ et al., 2020 ¹³	1; 2-year-7-month-old boy	Rural Samsun; played in sand/soil contaminated with dog and cat feces; no travel	Probable local acquisition	Back and trunk; atypical pediatric distribution	Albendazole for 5 days produced an incomplete response; oral ivermectin resulted in regression	Pediatric probable local-acquisition report highlighting atypical truncal distribution and successful ivermectin treatment after an incomplete response to albendazole

Table 2 (cont). Clinical and epidemiological features of digitally accessible Türkiye-related publications (2010–2026)

Citation/ year	Patients	Region and acquisition context	Travel/ local status	Lesion site/ pattern	Treatment and outcome	Specific contribution
Subaşı Gökşin et al., 2020 ¹⁴	1; 26-year-old man	Denizli; travel to Thailand and hostel stay 2 months earlier	Imported	Right periumbilical abdomen; buttock papules; initially treated as scabies	Cryotherapy plus albendazole 400 mg/ day for 5 days; healed with post-inflammatory pigmentation	Atypical lesion site and diagnostic delay following travel
Önder et al., 2021 ¹⁵	1; 45-year-old man	Ordu; weekend gardening; no recent foreign travel	Probable local acquisition	Thigh to hip, trunk, and back; approximately 10 cm	Albendazole 800 mg/day for 3 days; complete resolution	Local garden exposure with eosinophilia and histopathological evaluation
Can and Yürekli, 2022 ¹⁶	22 patients; retrospective series	Eastern Black Sea region; tea harvesting/soil contact	Local regional series	Feet, arms, and trunk reported	Not specified in the accessible report summary	Largest Türkiye series; generated a hypothesis linking increased case numbers with temperature and environmental change
Aydın et al., 2024 ¹⁷	2 men; 43 and 47 years	Diagnosed in Türkiye after frequent travel to Somalia and barefoot sand sports	Imported	Plantar, medial, and dorsal foot lesions	Albendazole 400 mg/ day for 3 days; one patient required a repeated course; both improved	Two cases plus an updated synthesis of Türkiye-related literature
Güven et al., 2026 ¹⁸	1; 17-month- old girl	Aydın; embedded hair shaft rather than infectious acquisition	CLM mimic: cutaneous pili migrans	Left sole; black, thin, relatively linear/curvilinear filament	Curettage and forceps extraction; no recurrence at 3 months	Dermoscopy- based differential diagnosis that may prevent unnecessary antiparasitic treatment; not counted as CLM

Modern diagnostic practice also benefits from a broader differential diagnosis. Typical hookworm-related CLM is usually diagnosed clinically, whereas biopsy rarely demonstrates the larva.¹⁹ Larva currens should prompt consideration of strongyloidiasis, whereas cutaneous pili migrans can be recognized by a visible black filament, a relatively linear trajectory, a dermoscopic hair-shaft structure, and resolution after extraction.^{6,18} Distinguishing these entities helps avoid unnecessary anthelmintic therapy and prevents potentially important Strongyloides infection from being mislabeled as ordinary CLM.

Treatment terminology has evolved from local methods and older anthelmintics to systemic albendazole and ivermectin. Contemporary guidance and reviews support these systemic options.^{19,20} Comparative and prospective

clinical evidence also supports both agents.^{21–23} Türkiye-related reports nevertheless show variation in dose, duration, adjunctive therapy, and response. A standardized case registry should therefore capture exposure, lesion progression, anatomic site, laboratory findings when obtained, treatment regimen, adherence, response time, relapse, and adverse events.

Prevention requires attention to animal reservoirs and contaminated environments. Dog and cat hookworms, occupational or recreational soil contact, and suitable microclimatic conditions create a human–animal–environment problem.^{24–26} Priorities for Türkiye include digitizing older medical periodicals, verifying the Şekban lead, improving clinician recognition of both local and imported disease, mapping human reports alongside

Table 3. Proposed historical, research, and public health priorities for cutaneous larva migrans in Türkiye

Priority	Rationale	Minimum data or action	Expected output
Digitize older medical periodicals	Pre-digital Turkish reports may be missed in routine searches.	Rights-cleared scans, bibliographic metadata, optical character recognition, and stable institutional URLs.	A searchable national archive and durable access to sources such as the 1981 report.
Verify the 1947 Şekban citation	The citation may alter the national chronology but cannot be accepted without the original source.	Search bound journal volumes, library catalogs, institutional archives, author indexes, and contemporary bibliographies.	A verified full citation and biographical note, or a documented negative archival result.
Standardized human case registry	Case reports cannot estimate frequency or regional clustering.	Age, sex, province, date, travel history, local soil/sand exposure, animal contact, lesion site, diagnostic basis, treatment, and response.	A comparable national dataset distinguishing imported cases from probable local acquisition.
Human–veterinary linkage	Transmission depends on dog and cat hookworm reservoirs.	Map human cases alongside local animal infection and deworming data.	Risk maps and targeted prevention strategies for beaches, parks, gardens, and rural settings.
Environmental sampling	Soil and sand contamination is central to transmission.	Standardized sampling at beaches, playgrounds, gardens, agricultural sites, and rural areas.	Evidence-based identification of environmental hotspots.
Climate and seasonality	Case counts alone cannot establish climate-related causation.	Link cases to temperature, rainfall, humidity, occupation, and exposure opportunities using appropriate denominators.	Regional models that test, rather than assume, climate-related changes.
Clinical education and differential diagnosis	Atypical sites, local acquisition, larva currens, and CLM mimics may be overlooked.	A practical diagnostic checklist including travel history, migration rate, pruritus, morphology, black filament, dermoscopy, and immune status.	Earlier diagnosis, appropriate therapy, and fewer unnecessary anthelmintic treatments.

veterinary and environmental findings, and monitoring climate and seasonality without inferring causation from case counts alone. Travel medicine remains relevant, whereas public health strategies for strongyloidiasis should remain distinct.^{27,28}

Strengths and Limitations

This study combines direct review of a poorly accessible Turkish source with an updated, structured scoping search and a publication-level comparison of acquisition context, lesion site, treatment, and contribution. It also explicitly distinguishes verified history, an unverified archival lead, true CLM reports, and a clinically relevant CLM mimic.

The study was not a registered systematic review, and older Turkish publications may still be missing. The 1947 source and Şekban's biographical details could not be verified. The 1981 article is interpreted as a historical document without

access to the original records or diagnostic material. Most modern evidence consists of case reports, and publication bias precludes estimates of incidence, geographic burden, or temporal trends. Emerging reports of treatment-refractory CLM further support careful follow-up but cannot be generalized to Türkiye without local data.²⁹

CONCLUSION

Kurtoğlu's 1981 report demonstrates that the history of CLM in Türkiye is older and more layered than digital databases alone suggest. The 1947 Şekban citation remains an important historical trace awaiting archival confirmation. The history of CLM in Türkiye cannot be written without considering older Turkish medical periodicals and local archives. Modern publications provide evidence of both travel-associated and probable locally acquired disease, but stronger surveillance is required before the national burden or climate-related changes can be quantified.

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REFERENCES

- Lee RJ. Case of creeping eruption. *Trans Clin Soc Lond* 1874;8:44-5.
- Royal College of Physicians. Robert James Lee (1841-1924). Inspiring Physicians. <https://history.rcp.ac.uk/inspiring-physicians/robert-james-lee> Accessed September 3, 2026.
- Kurtoğlu S. Kutanözlara migrans: Bir olayın raporu. *Sağlık Dergisi (SSYB)* 1981;55(1-3):33-7.
- Heukelbach J, Feldmeier H. Epidemiological and clinical characteristics of hookworm-related cutaneous larva migrans. *Lancet Infect Dis* 2008;8(5):302-9. [CrossRef]
- Caumes E, Danis M. From creeping eruption to hookworm-related cutaneous larva migrans. *Lancet Infect Dis* 2004;4(11):659-60. [CrossRef]
- Tian Y, Monsel G, Paris L, Danis M, Caumes E. Larva Currens: Report of Seven Cases and Literature Review. *Am J Trop Med Hyg* 2023;108(2):340-5. [CrossRef]
- Yavuzer K, Ak M, Karadağ AS. A case report of cutaneous larva migrans. *Eurasian J Med* 2010;42(1):40-1. [CrossRef]
- Çalışkan E, Uslu E, Turan H, Başkan E, Kılıç N. Cutaneous larva migrans: report of three cases from the Western Black Sea Region, Turkey. *Mikrobiyol Bul* 2016;50(1):165-9. Turkish. [CrossRef]
- Oral A, Ölmez Ö, Bambul N. A case of cutaneous larva migrans in Turkish patient. *Int J Clin Med Imaging* 2016;3(4):1000457. [CrossRef]
- Aktaş H, Güleç AI, Ergin C, Sürücü F. Zosteriform cutaneous larva migrans in a nontropical geography: successful treatment with oral albendazole. *J Turk Acad Dermatol* 2016;10(1):16101c7.
- Sönmezer MÇ, Erdinç Ş, Tülek N, Babür C, Büyükdemirci A, İlgar T, et al. Cutaneous larva migrans in Turkey: an imported case report. *Mikrobiyol Bul* 2017;51(1):94-9. Turkish. [CrossRef]
- Rastgar L, Işık M, Tatlıparmak A, Aksoy B, Koç E. Cutaneous larva migrans: a rare tropical dermatosis. *DOD Clinical Case Reports* 2018;2(1):1-4.
- Kökçü Karadağ Şİ, Hancıoğlu G, Öztürk F. A pediatric case of cutaneous larva migrans in Turkey. *J Pediatr Inf* 2020;14(3):e145-7. [CrossRef]
- Subaşı Gökşin Ş, Aksoy S, Duygulu Ş. Atipik yerleşimli kutanöz larva migrans olgusu. *Muğla Sıtkı Koçman Üniversitesi Tıp Dergisi* 2020;7(1):57-9.
- Önder S, Öztürk M, Güngör HK, Erdem H. A case of cutaneous larva migrans from Turkey. *Dermatol Rev/Przegl Dermatol* 2021;108(4):325-8. [CrossRef]
- Can İ, Yürekli A. Effect of global warming on dermatology practice: The increase in cases of cutaneous larva migrans in the eastern Black Sea region of Turkey. *J Cosmet Dermatol* 2022;21(9):3929-33. [CrossRef]
- Aydın A, Yenilmez E, Görenek L. Two Cases of Cutaneous Larva Migrans and a Literature Review of the Condition. *Balkan Med J* 2024;41(5):413-5. [CrossRef]
- Güven M, Öner Arkan Ş, Şavk E, Uslu M. Cutaneous Pili Migrans in a 17-Month-Old Girl: Not to Be Confused with Cutaneous Larva Migrans. *Turk Arch Pediatr* 2026;61(7):656-7. [CrossRef]
- Sunderkötter C, von Stebut E, Schöfer H, Mempel M, Reinelt D, Wolf G, et al. S1 guideline diagnosis and therapy of cutaneous larva migrans (creeping disease). *J Dtsch Dermatol Ges* 2014;12(1):86-91. [CrossRef]
- Hochedez P, Caumes E. Hookworm-related cutaneous larva migrans. *J Travel Med* 2007;14(5):326-33. [CrossRef]
- Caumes E, Carriere J, Datry A, Gaxotte P, Danis M, Gentilini M. A randomized trial of ivermectin versus albendazole for the treatment of cutaneous larva migrans. *Am J Trop Med Hyg* 1993;49(5):641-4. [CrossRef]
- Bouchaud O, Houzé S, Schiemann R, Durand R, Ralaimazava P, Ruggeri C, et al. Cutaneous larva migrans in travelers: a prospective study, with assessment of therapy with ivermectin. *Clin Infect Dis* 2000;31(2):493-8. Erratum in: *Clin Infect Dis* 2001;32(3):523. [CrossRef]
- Caumes E. Treatment of cutaneous larva migrans. *Clin Infect Dis* 2000;30(5):811-4. [CrossRef]
- Bowman DD, Montgomery SP, Zajac AM, Eberhard ML, Kazacos KR. Hookworms of dogs and cats as agents of cutaneous larva migrans. *Trends Parasitol* 2010;26(4):162-7. [CrossRef]
- Del Giudice P, Hakimi S, Vandenbos F, Magana C, Hubiche T. Autochthonous Cutaneous Larva Migrans in France and

- Europe. *Acta Derm Venereol* 2019;99(9):805-8. [CrossRef]
26. Stufano A, Foti C, Lovreglio P, Romita P, De Marco A, Lia RP, et al. Occupational risk of cutaneous larva migrans: A case report and a systematic literature review. *PLoS Negl Trop Dis* 2022;16(5):e0010330. [CrossRef]
27. Kuna A, Olszański R, Sikorska K. Cutaneous Larva Migrans as a frequent problem in travellers. *Int Marit Health* 2023;74(4):259-64.
28. World Health Organization. WHO guideline on preventive chemotherapy for public health control of strongyloidiasis. Geneva: World Health Organization; 2024. <https://www.who.int/publications/i/item/9789240094024> Accessed September 3, 2026.
29. Currie BJ, Hoopes J, Cumming B. Cutaneous Larva Migrans Refractory to Therapy with Ivermectin: Case Report and Review of Implicated Zoonotic Pathogens, Epidemiology, Anthelmintic Drug Resistance and Therapy. *Trop Med Infect Dis* 2025;10(6):163. [CrossRef]