Journal of Musculoskeletal Pain

ISSN: 1058-2452 (Print) 1540-7012 (Online) Journal homepage: informahealthcare.com/journals/imup20

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To cite this article: Deise Marcela Piovesan, Marcus Franck, Sérgio Kalil Moussalle & Henrique Luiz Staub (2011) Transient Oligoarthritis after Myiasis Infection in an HLA-B27 Positive Patient, Journal of Musculoskeletal Pain, 19:1, 56-56, DOI: 10.3109/10582452.2010.538822

To link to this article: https://doi.org/10.3109/10582452.2010.538822

Published online: 20 Dec 2010.

Journal of Musculoskeletal Pain, Vol. 19(1), 2011

ISSN: 1058-2452 print / 1540-7012 online
DOI: 10.3109/10582452.2010.538822

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LETTER TO THE EDITOR

Transient Oligoarthritis after Myiasis Infection in an HLA-B27 Positive Patient

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To the Editor,

Conceptually, myiasis is the infestation of living tissue by the larvae of flies in the order Diptera. The cutaneous form of the disease predominates. The human myiasis is a common parasitosis of rural areas, particularly in tropical countries. It usually affects individuals with precarious hygiene habits, as well as patients with psychiatric disease, diabetes, and immunodeficiency. The furunculoid myiasis, prone to fistulization, is caused by larvae of the flies *Dermatobia hominis*, *Cochliomyia hominivorax*, and *Oestrus ovismmatory*. Secondary myiasis usually establishes in damaged skin and is caused by flies of genera *Callitroga*, *Lucilia*, and *Musca* (1). Arthritis following myiasis infestation is unusual, and we herein report such a case.

The patient, a 44-year-old white male with no previous rheumatologic history reported a fly bite in his ear during a tennis match. Two days later, severe pain in the ear was noted. Myiasis was diagnosed by the otolaryngologiststst. The ear drainage yielded a large amount of larvae. Unfortunately, pathologic study of the larvae could not be carried out to identify the genera of fly responsible for this episode of myiasis.

Forty days later, the patient developed refractory pain in the left temporomandibular joint and swelling, increased heat, and severe pain of the left ankle and right knee. Laboratory tests included eosinophilia [1000 cells/mm^3] and an erythrocyte sedimentation rate of 36 mm in the first hour. Antinuclear antibodies and rheumatoid factors were absent. Typing for HLA-B27 was positive. A chlamydia trachomatis immunoglobulin IgG, IgM, and IgA tests were negative. A radiogram of the sacroiliac joints was normal. Treatment with a non-steroidal anti-inflammatory drug for 48 h was not helpful. A 15-day prednisolone course, starting from 20 mg, was highly effective. Arthrocentesis was not carried out due to the rapid clinical improvement following corticotherapy.

Myiasis could be symptomatic by itself or it can be associated with a bacterial co-infection. *Campylobacter jejuni* (2) and salmonella (3) infections, for instance, can deflagrate reactive arthritis, mostly in HLA-B27-positive patients. In these circumstances (2,3), eosinophilia is rare.

Only one case of reactive arthritis after myiasis infection was described in the literature (4). In the present case, the asymmetric oligoarthritis responsive to corticotherapy may have resulted either from a definite myiasis [eosinophilia being of interest] or from an undocumented bacterial co-infection in a HLA-B27-positive individual.

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Submitted: July 9, 2010; Revisions Accepted: July 13, 2010