

Urethral Myiasis



Figure 1. Presence of larvae in the surface of the urethral catheter, demonstrating the possible form of migration through the urethra

Figure 2. Withdrawal of the urinary catheter showing the remaining larvae.

A 71 year-old male, with a previous stroke (4 months ago) and poor mobility came to the hospital and was reported by relatives with complaints of pruritus and pain in the periurethral area for seven days, with evidence of a small organism in the surface of the urethral catheter (Figure 1) In the hospital, there was a presence of larvae after traction of the urethral catheter and it was possible to manually remove the larvae of the urethral orifice; cistostomy was carried out with withdrawal of the urinary catheter and extraction of the remaining larvae (Figure 2). With the end of the removal and 3 days after systemic treatment with oral Ivermectin 12mg, was found no evidence of the larvae in the urethra through cystoscopy control. Based on the characteristics of the mature larvae they were identified as genus *Chrysomyia*.

Urethral myiasis is exceptionally rare, even in sites usually protected by clothes, inaccessible for the flies. Urogenital myiasis is usually associated with patients in poor general condition, with low mobility and ulcerating lesions [1]. It could be external or internal, and the invasion for the maggot could be obligatory, facultative, and sometimes accidental.

Many species of dipterous flies among the genera *Chrysomyia* and *Cochliomyia* have been reported to be the most important obligatory myiasis producers among humans and/or domestic animals [2].

The explanation of the urinary myiasis in the patient was that the flies deposited their eggs around the catheter or genital orifice and after hatching in a few hours, the larvae may have migrated through the urethra where they matured [1,3,4].

Signs and symptoms related are: haematuria, bladder irritated symptoms, pruritus, dysuria, fever and elimination of larvae in urine. Severity of myiasis depends on the location of the infestation, lesions and tissue inflammation [1].

According to Gopalakrishnan et al. [2], a progressive and continuous necrosis of muscles occur associated with larval growth and invasion. The pathogenicity results from inflammation and toxin secreted by the larvae which prevents healing.

The treatment involves the use of several antiseptics, suffocating and mercury [5]. Such substances were used in the form of lavage, inhalations, instillations, and in smaller number of cases, systematic way. Some studies show the use of Ivermectin to eradicate the larvae of myiasis cavity without endangering the patient [6]. A broad antibiotic cover is recommended to prevent secondary infections.

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