Received a male of 14 years of age in my clinic, who consulted due to bullous, exudative, and pruritic lesion in the right foot plant, with an approximate diameter of 1.5 cm, well defined, 2 weeks of evolution [Figure 1]. Denies contact with chemical substances, friction or manipulation, or the realization of physical effort, or consumption of medications. Then, I used dermatoscopy of polarized light, which showed, reddish-brown structures divided into several segments, by whitish-yellowish lines that project into these structures as partitions, without being related to the ridges or grooves of the dermatoglyphis. Figure 2 show own dermatoscopic findings of larva migrans. With the diagnosis, the patient received oral ivermectin at 200 mcg/kg of weight, once a week, for 2 weeks with total improve.

Larva migrans is a cutaneous parasitosis caused mainly by the larvae of Ancylostoma braziliense and Ancylostoma caninum.[1-2] The diagnosis is eminently clinical, when finding linear, serpinginous, erythematous lesions, commonly on the feet [2,3] but occasionally the lesions can be bullous and thus make diagnosis difficult, as in this case. Then I present a male of 14 years of age who consulted by a bullous, exudative, and pruritic lesion in the right foot plant, with an approximate diameter of 1.5 cm, well defined, 2 weeks of evolution without apparent cause. I used dermatoscopy of polarized light, which showed, reddish-brown structures divided into several segments, by whitish-yellowish lines that project into these structures as partitions, without being related to the ridges or grooves of the dermatoglyphis, own dermatoscopic findings of larva migrans. With the diagnosis, the patient received oral ivermectin at 200 mcg/kg of weight, once a week, for 2 weeks.

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The findings in this patient coincide with that reported in the literature, in relation to translucent brown, and reddish-brown structures divided into segments that follow paths and reddish points, differentiated from bullous traumatic that usually shows vascular lagoons without partitions or segments, in this patient, an additional point in favor of the dermatoscopic diagnosis is the involution of the blister and itching when he take ivermectin treatment.

Therefore, I consider that, although the diagnosis of larva migrans is clinical, dermatoscopy could help in cases in which there is diagnostic doubt.

**DECLARATIONS**

1. Has your work involved experimentation on animals? 
   Do not
2. Do patients or human subjects intervene in their work? 
   Do not
3. Does your work include a clinical trial? Do not
4. Are all the data shown in the figures and tables included in the manuscript included in the results section and conclusions?

**REFERENCES**


Elsner was the first to diagnose larva migrans with dermatoscopy in 1997.\(^{[1,5]}\) And it was Zalaudek, in 2008, who in his study concluded that the dermatoscopic patterns of larva migrans are translucent reddish-brown structures divided into segments that follow paths, which are related to the body of the larva, and reddish spots, which are related to paths empty\(^{[1,3,5,6]}\) in lesions that have been subjected to treatment, as was also seen in our patient [Figure 3].