Worst Souvenir Ever? The Increasing Trend of Travel-Related Dermatoses

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After the spring break and winter escape to sunnier climes, many of us may be seeing an upswing in a variety of skin conditions picked up by patients along with their key chains, T-shirts, and other vacation mementoes. In fact, figures indicate that after fever and diarrhea, dermatoses are the third most common cause of morbidity in returning international travellers,[1,2] and most of these are infectious in nature.[2]

According to United States travel-related surveillance data, the number of international tourists reached 1 billion in 2012, a sharp increase of 48% from the year 2000.[3] Canadians also increased their international footprint. Statistics Canada reported that Canadians made 65.2 million trips abroad in 2012, an increase of nearly 40% from 2003.[4]

Research findings presented at last year's annual Canadian Dermatology Association meeting (Toronto, June 2014) affirmed the upward trend of globetrotting Canadians and the accompanying spike in the number of "vacation dermatoses" being seen by our colleagues.[5] Michael S. Stevens, a dermatology resident at the University of Toronto, reported that more than 16% of 6639 patients seen at a CanTravNet site over a 3-year surveillance period were diagnosed with dermatoses contracted during international travel, making it the second most common health complaint after gastrointestinal symptoms. The most common skin problems included arthropod bites, rashes, cutaneous larva migrans, skin and soft-tissue infection, and pruritus of unknown origin. Not surprisingly, the geographic regions most frequently visited by this group of patients included the Caribbean, Central America, Sub-Saharan Africa, and South East and South Central Asia.

If our cry for sun protection and the avoidance of sunburn is not enough to dissuade travellers from seeking sunny beaches, a brush with something alive might do the trick. One example includes cutaneous larva migrans, the most common acquired tropical dermatosis.[6] Usually contracted by barefoot beachgoers who encounter cat or dog feces containing hookworm larvae, any part of the body coming into contact with contaminated soil or sand is at risk.[7]

Tungiasis is another common skin affliction, again the result of bare skin contact with sand or soil. In this case, the exposure is to a burrowing flea (*Tunga penetrans*) and results in an increasingly erythematous, pruritic and painful reaction that lasts 4 to 6 weeks, reflecting the life cycle of the flea.[7] Clinical symptoms appear after the flea has implanted itself under the skin, so patients may not be able to pinpoint when they first contracted the condition. In a similar fashion, myiasis can resemble common conditions such as furunculosis, boils, and infected cysts.[8] As for the clinician, unless she or he is thinking about a tropically acquired dermatosis, the diagnosis and treatment can be delayed or missed completely.

Adding to the diagnostic challenge is the fact that the time between exposure and clinical symptoms can vary considerably. Some conditions present within a few days of contact (eg, cutaneous larva migrans), whereas others may emerge clinically only after weeks or months have passed (eg, cutaneous tuberculosis, atypical mycobacterial diseases, and tropical mycosis).[9] In some rare cases, the diagnosis can be delayed by years from the date of travel.[10]

We can predict that with increased travel, dermatologists will see a corresponding increase in the number of travel-related dermatoses presenting to the clinic. In addition, we must remember that this pertains not only to snowbirds but also to those individuals who work in developing countries and those who visit relatives in faraway places. Consequently, dermatologists will play an increasingly important role in global public health surveillance. This underscores the importance of our need to be vigilant about unusual dermatoses, especially in those who have recently travelled abroad.

Prevention still remains an elusive goal when it comes to travel-acquired dermatoses, but in addition to sunscreen, perhaps we should continue to stress the simple advice to "cover up" by wearing closed-toe shoes, socks, long pants, shirts with long sleeves, and a hat. The perfect vacation wardrobe—for a dermatologist!

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References

1. Herbinger KH, Siess C, Nothdurft HD, et al. Skin disorders among travellers returning from tropical and non-tropical countries consulting a travel medicine clinic. *Trop Med Int Health*. 2011;16(11):1457-1464. doi: 10.1111/j.1365-3156.2011.02840.x.
2. Fischer M, Reinel D. Vacation and tropical dermatoses [in German]. *Hautarzt*. 2012;63(5):396-403. doi: 10.1007/s00105-011-2258-y.