

Coscione, S; Kositz, C; Marks, M (2017) Head Lice: An Under-Recognized Tropical Problem. The American journal of tropical medicine and hygiene, 97 (6). pp. 1636-1637. ISSN 0002-9637 DOI: https://doi.org/10.4269/ajtmh.17-0656

Downloaded from: http://researchonline.lshtm.ac.uk/4645732/

DOI: 10.4269/ajtmh.17-0656

Usage Guidelines

 $Please \ refer \ to \ usage \ guidelines \ at \ http://researchonline.lshtm.ac.uk/policies.html \ or \ alternatively \ contact \ researchonline@lshtm.ac.uk.$

Available under license: http://creativecommons.org/licenses/by/2.5/

Images in Clinical Tropical Medicine Head Lice: An Under-Recognized Tropical Problem

Suny Coscione,¹ Christian Kositz,¹ and Michael Marks^{1,2*}

¹Clinical Research Department, Faculty of Infectious and Tropical Diseases, London School of Hygiene & Tropical Medicine, London, United Kingdom; ²The Hospital for Tropical Diseases, Mortimer Market Centre, Mortimer Market, London, United Kingdom

Head lice, caused by infestation with Pediculus humanus capitis, is an extremely common problem in tropical countries. Pediculus humanus capitis is an obligate human ectoparasite. Morphologically, head lice are indistinguishable from Pediculus humanus corporis, the human body louse, although they are slightly smaller. Unlike body lice, head lice have not clearly been proven to be vectors for infectious agents. Adult head lice develop through three nymphal stages (Figure 1) and feed on blood from the scalp two to six times a day causing discomfort and pruritus. On examination, the eggs (nits) are more commonly identified than adult lice (Figure 2). The complete life cycle takes 15–20 days, and adults survive up to 1 month. Adults mate once, and a fertilized female then produces 3 to 4 eggs per day (Figure 3) for the remainder of their lives. Nymphs must feed immediately on hatching, and therefore, nits located more than 1 cm from the scalp are considered nonviable. Infestation results in distress, social stigma, and absence from school.¹ Like other ectoparasitic infections, the



 $\mathsf{F}_{\mathsf{IGURE}}$ 2. Examination of an individual's hair containing both an adult louse (A) and eggs (B). This figure appears in color at www.ajtmh. org.



FIGURE 1. Nymph and adult stages of *Pediculus humanus capitis*. This figure appears in color at www.ajtmh.org.

prevalence of head lice may be high amongst children in remote and rural settings.² In these settings, access to treatment is frequently limited, and many individuals rely on traditional medicine. There is increasing resistance to pyrethroids and malathion, the most commonly used first-line topical agents.³ More recently, both oral and topical ivermectin^{3,4} have shown promise for treating head lice, but access to these drugs to treat head lice is nonexistent in low-income settings. Mass treatment of scabies, onchocerciasis, or lymphatic filariasis



FIGURE 3. Microscopic image of an egg (nit) attached to a human hair. This figure appears in color at www.ajtmh.org.

^{*}Address correspondence to Michael Marks, Clinical Research Department, Faculty of Infectious and Tropical Diseases, London School of Hygiene & Tropical Medicine, Keppel Street, London, United Kingdom. E-mail: michael.marks@lshtm.ac.uk

might have an impact on head lice although data specifically examining this hypothesis are lacking, and there is a risk that resistance to ivermectin might develop.⁵

Received August 17, 2017. Accepted for publication August 28, 2017.

Financial support: M. M. is supported by a Wellcome Trust Clinical Research Fellowship (102807) and a National Institute for Health Research Clinical Lectureship.

Authors' addresses: Suny Coscione and Christian Kositz, Clinical Research Department, Faculty of Infectious and Tropical Diseases, London School of Hygiene & Tropical Medicine, Keppel Street, London, United Kingdom, E-mails: sunymarzetti@hotmail.com and christian.kositz@gmail.com. Michael Marks, Clinical Research Department, Faculty of Infectious and Tropical Diseases, London School of Hygiene & Tropical Medicine, London, United Kingdom and The Hospital for Tropical Diseases, Mortimer Market Centre, Mortimer Market, London, United Kingdom, E-mail: michael.marks@lshtm.ac.uk.

This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted

use, distribution, and reproduction in any medium, provided the original author and source are credited.

REFERENCES

- Frankowski BL, Weiner LB, Committee on School Health the Committee on Infectious Diseases, American Academy of Pediatrics, 2002. Head lice. *Pediatrics* 110: 638–643.
- Lesshafft H, Baier A, Guerra H, Terashima A, Feldmeier H, 2013. Prevalence and risk factors associated with pediculosis capitis in an impoverished urban community in lima, Peru. J Glob Infect Dis 5: 138–143.
- Pariser DM, Meinking TL, Bell M, Ryan WG, 2012. Topical 0.5% ivermectin lotion for treatment of head lice. N Engl J Med 367: 1687–1693.
- Chosidow O, Giraudeau B, Cottrell J, Izri A, Hofmann R, Mann SG, Burgess I, 2010. Oral ivermectin versus malathion lotion for difficult-to-treat head lice. N Engl J Med 362: 896–905.
- Diatta G, Abat C, Sokhna C, Tissot-Dupont H, Rolain J-M, Raoult D, 2016. Head lice probably resistant to ivermectin recovered from two rural girls in Dielmo, a village in Sine-Saloum, Senegal. Int J Antimicrob Agents 47: 501–502.