CASE SERIES

DERMATITIS CAUSED BY PAEDERUS FUSCIPES CURTIS, 1840 (COLEOPTERA: STAPHILINIDAE) IN STUDENT HOSTELS IN SELANGOR, MALAYSIA

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Abstract. We report a series of dermatitis cases caused by the staphilinid beetles, Paederus fuscipes Curtis, among university students staying in the residential college in Puncak Alam, Selangor, Malaysia from 1 January to 31 December 2010. A total of 360 cases (6.0%) were recorded in the Student Health Center throughout the year; the majority of patients stayed at a hostel near an oil palm plantation. Skin symptoms included erythema, edema, vesicular papules, painful blisters, burning sensation, pruritus, hyper pigmentation and peeling of skin. The commonly involved sites were the face, neck, shoulders and arms. Most students noticed the symptoms upon awakening in the morning. The patients were treated with fusidic acid cream and the symptoms resolved within 5 days. These beetles are nocturnally active and enter the room whenever a light source is available. The unintentional crushing of these beetles during sleep causes the release of its hemolymph (paederin) which is the cause of the dermatitis.

Keywords: Paederus fuscipes, dermatitis, student hostel, Malaysia

INTRODUCTION

Medically important beetles are mainly from the families Meloidae, Oedemeridae and Staphilinidae (Nikbakhtzadeh and Tirgari, 2008). The rove beetle, Paederus fuscipes Curtis, 1840, is a member of the family Staphilinidae, order Coleoptera (Li and Zhou, 2009). The genus Paederus is widely distributed worldwide and consists of approximately 621 species, with its only absence in Antarctica (Frank, 1988). The body sizes of the adult beetles are 7-10 mm long and 0.5 mm wide (George and Hart, 1990). They have a black head; the pronotum and abdominal segments III to VI are orange, the elytra is metallic blue and abdominal segments VII to VIII are black. The appendages are partly orange and partly black. The bright colors of Paederus are a warning sign (aposematism) to potential predators that they are venomous and inedible (Lott and Anderson, 2011). Paederus beetles breed in moist areas, wetlands and salt marshes.
among rotting vegetation; the beetles appear to be predacious (Triplehorn and Jonson, 2005). Although these insects are able to fly, they prefer to run; when running, they frequently raise the tip of their abdomen (Triplehorn and Johnson, 2005); this particular behavior is useful for identification (Vegas et al, 1996). Paederus beetles are beneficial insects in the agricultural sector because they prey on crop pests (Frank and Kanamitsu, 1987). A study conducted in Malaysia found that Paederus fuscipes is an aggressive leafhopper predator in rice fields (Manley, 1977).

Outbreaks of paederus dermatitis have been reported in various countries, including Argentina (Dallas, 1939), Australia (Todd et al, 1996), Brazil (Diógenes, 1994), China (Li, 1990; Jiang et al, 2008; Huang et al, 2009), the Congo (Vasudevan and Joshi, 2010), Ecuador (Campos, 1927), Egypt (Assaf et al, 2010), Guinea-Conakry (Vanhecke et al, 2010), India (Verma and Agarwal, 2006; Padhi et al, 2007; Gnanaraj et al, 2007), Iran (Zargari et al, 2003; Abbasipour and Taghavi, 2005), Iraq (Al-Dhalimi, 2008), Italy (Gelmetti and Grimalt, 1993; Veraldi and Süss, 1994), Japan (Armstrong and Winfield, 1969), Kenya (Van Schayk et al, 2005), Malawi (Deneyes and Zumpt, 1963), Namibia (Deneyes and Zumpt, 1963), Nigeria (George and Hart, 1990), Peru (Alva-Davalos et al, 2002), Sierra Leone (Qadir et al, 2006), South Korea (Kim et al, 1989; Kim et al, 1995), Sri Lanka (Kamaladasa et al, 1997), Sudan (Lewis, 1958), Taiwan (Huang et al, 2010), Tanzania (Fox, 1993; Mbonile, 2011), Thailand (Papasarathorn et al, 1961; Suwannahitatorn et al, 2007), Turkey (Sendur et al, 1999), Uganda (McCrae and Visser, 1975) and Venezuela (Rivas et al, 2001). Norton and Lyons (2002) even proposed the invasion of paederus dermatitis in Egypt by Paederus alfieri as the plagues that were mentioned in the Exodus.

In Malaysia, paederus dermatitis was first reported in 1919 (Raju, 2002). Mokhtar et al (1993) reported an outbreak among 12 medical students in Universiti Sains Malaysia at Kubang Kerian Campus, Kelantan. The second outbreak was reported in a primary school in Terengganu involving 36 pupils (Rahman and Norjaizah, 2008). In September 2002, two thousand people living in high rise flats and dormitories in Penang were affected by dermatitis caused by P. fuscipes.

We report a series of dermatitis cases caused by the staphilinid beetles, Paederus fuscipes, among the university’s students who stay in Puncak Alam, Selangor, Malaysia from 1 January to 31 December 2010.

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The cases of dermatitis were first noted in July 2009 at university hostels on Puncak Alam campus, Selangor (3° 12’ 12” N 101° 27’ 5” E) which is located about 47 km from Kuala Lumpur. There are 12 student colleges on the campus with around 6,000 students.

A total of 360 cases were recorded at the Student Health Center throughout the year (Fig 1). The majority of patients stayed in a hostel located near an oil palm plantation. The student ages ranged 18-20 years. The skin symptoms included erythema, edema, vesicular papules, painful blisters, burning sensation, pruritus, line lesions, hyper pigmentation and skin peeling.

The common sites of involvement were the face, neck, shoulders and arms (Fig 2), while the other parts of body, such as the periorbital region, chest, abdomen and legs were rarely involved. Most students noticed the symptoms
upon arising in the morning. Some of the students sought medical treatment at the Student Health Center, which is located on the campus, but many ignored their symptoms or self-treated, with antiseptic cream or calamine lotion. Those who saw the medical officer at the Health Center were prescribed fusidic acid cream and the symptoms resolved within five days. In some cases linear scars and hyperpigmentation developed and persisted after treatment.

The students found a large quantity of these beetles around their residences. The
beetles were found in their rooms, in the corridors, in the toilets and on the walls. Most of the students claimed to have no previous history of skin allergies. They had been warned by the senior students regarding the skin lesions caused by an ant-like insect, which they call *semut kayap*, *semut semai* or *charlie*. However, not all students were able to recognize the *Paederus* beetles correctly.

We carried out an entomological investigation to identify the etiologic agent that caused the dermatitis outbreak. Beetle specimens were collected from the student rooms, toilets and the hostel corridors. The specimens were preserved in 70% ethanol and then sent to the last author for identification. The beetles were subsequently confirmed to be *P. fuscipes* (Fig 3).

*Paederus fuscipes* is identified based on the features described by Lott and Anderson (2011).

**DISCUSSION**

Paederus dermatitis may affect people of any sex, age, race or socioeconomic status. The risk depends on the parson's activities and the insect habitat, exposed skin areas are at higher risk (Singh and Ali, 2007). The incidence of paederus dermatitis increases during the rainy season (Mokhtar et al, 1993; Vegas et al, 1996; Frank and Kanamitsu, 1987). Rahmah and Norjaiza (2008) noted there was more rainfall in February 2005 than February 2004; this could be an explanation for the increase in these beetles. In Tanzania, paederus dermatitis and conjunctivitis occurs during the rainy season in the north (Fox, 1993). Recently, Senel and Sahin (2011) stated global warming may cause an increase in the incidence of paederus dermatitis, since higher temperatures influence the ecological dynamics of the insect species.

In our study, the peak incidence was noticed from June to August 2010. This may be due to the matriculation of new students at that time. Many new students became aware of the skin condition for the first time, having never been exposed to this kind of skin condition before. The incidence decreased after September. Most of the patients did not seek treatment at the Health Center; as they may have gotten used to the situation, ignored the symptoms or self-treated. There was a semester break at the end of the year. Hence, only few cases were reported. We assume the actual incidence was higher but many cases were not reported to the Student Health Center.

The *Paederus* beetle does not bite or sting, but releases toxic hemolymph when it is accidentally crushed on the skin; this hemolymph produces an inflammatory reaction known as paederus dermatitis or
Paederus dermatitis among Malaysian university students

Paederus dermatitis is a self-limiting skin condition, that includes erythematous and bullous lesions on exposed areas of the body after contact with the hemolymph which contains paederin, a potent vesicant (Frank and Kanamitsu, 1987; Singh and Ali, 2007). Paederin (C_{25}H_{45}O_{9}N) is more potent than the venom of a black widow spider (Lactrodectus) and it is the most complex non-proteinaceous insect defensive secretion (Mullen and Durden, 2009). The synthesis of paederin relies on the activities of an endosymbiont bacterium in the female beetles (Piel, 2002); this bacterium is passed from the mother to the offspring in the eggshells, which are eaten by the emerging larvae (Kellner, 2003). Borroni et al (1991) found paederin caused a wide spectrum of histopathology changes, such as epidermal necrosis and blistering during the early phase and acanthosis with mitotic figures in the later phase. Ocular involvement, known as "Nairobi eyes", is usually secondary to rubbing eyes with hands contaminated with paederin. Edema, conjunctivitis and excess lacrimation are common symptoms (Fox, 1993). In some cases, paederus conjunctivitis can result in temporary blindness (Frank and Kanamitsu, 1987). An interesting account of keratitis among motorcyclists induced by Paederus beetles was reported by Huang et al (2010).

A dermatitis outbreak in Terengganu was initiated by a beetle invasion in a classroom of 36 schoolchildren, when they were attending a night class (Rahmah and Norjaiza, 2008). Similarly, an outbreak of paederus dermatitis was reported at a suburban hospital in Sri Lanka where the staffs have been working during the night shift two days prior to the onset of symptoms (Kamaladasa et al, 1997). In our case, the students tended to open the window at night to promote air ventilation and then switched on the fluorescent lights when they were studying. As a result, the Paederus beetles were attracted into the room and came into contact with humans.

Mokhtar et al (1993) found the face was the most common site of involvement, followed by the neck; pruritus was the most common symptom among 12 medical students. Rahmah and Norjaiza (2008) found 89% of cases presented with itchiness as their first symptom, followed by periorbital edema and erythematous vesicular plaques in 58% of cases. Sixty-six point seven percent of cases among schoolchildren presented with burning sensation. Mokhtar et al (1993) observed 83% of patients had a complete recovery while 16% had residual hyperpigmentation. Wang et al (2004) reported the scar caused by P. fuscipes could remain as long as nine months. The patients in our study had similar experiences. One student reported the degree of pruritus increased during sweating.

The adult P. fuscipes are commonly found in marshes, paddy fields and school fields (Armstrong and Winfield, 1969; Kamaladasa et al, 1997). In Terengganu, paederus dermatitis was reported to be associated with paddy fields (Rahmah and Norjaiza, 2008). There were no paddy fields near the hostels but the majority of affected patients came from the hostel adjacent to an oil palm plantation, suggesting the oil palm plantation might be a natural habitat for P. fuscipes. However,
the first author observed *P. fuscipes* on Shah Alam campus, Universiti Teknologi MARA (3º3'57"N 101º29'58"E), where it is urbanized and highly populated. We suspect these beetles are not confined to agricultural lands, but may also live in developed areas. A few cases of paederus dermatitis have also been noticed in the student hostel on the Shah Alam campus.

As a self-healing skin disorder, paederus dermatitis needs no specific treatment. Application of wet dressings and topical steroids should be sufficient. Antibiotics can be prescribed to prevent bacterial infection, if necessary (Gelmetti and Grimalt, 1993). Vasudevan and Joshi (2010) found the combination of steroid, antibiotic application and oral antihistamines was effective in treating 94% of cases. In our study, only fusidic acid cream was given to the students to prevent secondary infection. Some students did not attend the clinic but self-treated using calamine lotion, but they claimed it had little effect. The same observation was made by Fox (1993) where the patients in East Africa used toothpaste and mud to treat paederus dermatitis. These methods were found to be ineffective.

We recommend the installation of window mesh, fogging of insecticide, setting up physical traps, improving environmental sanitation and enhancing the public awareness to decrease the incidence of paederus dermatitis. This includes educating the students to recognize the *Paederus* beetle and avoid handling or crushing the insects. Washing skin exposed to the beetles with soap and water immediately can greatly diminish the effect of paederin. Rahmah and Norjaiza (2008) observed the beetle population is reduced by closing classroom doors and windows and fixing the screen to ventilation panes. Excess vegetation on the school compound should be cleared since the beetles live in this habitat. Rahmah and Norjaiza (2008) also suggested thermal fogging at the school and residual spraying on the walls of the classroom and ceiling around the lights since these beetles are susceptible to insecticides. The teachers in the school were advised to use aerosol insecticide spray whenever they detected *Paederus* beetles. Some students in our study made their own physical traps using adhesive tape to trap or immobilize beetles in their room. Adhesive can be placed near lights and trap beetles effectively at night.

*Paederus* dermatitis may be misdiagnosed. A student from Shah Alam campus was prescribed acyclovir. Other causes of allergic contact dermatitis (*eg*, millipede dermatitis) and liquid burns may be diagnosed instead (Gelmetti and Grimalt, 1993).

Awareness of this condition and its clinical features, especially during the rainy season, and a careful history taking (*eg*, contact with the insect) should enable the clinician to arrive at the right diagnosis. There may be variation in presentation and this problem should be kept in the differential diagnosis of dermatitis. This is the third case series report of *Paederus* dermatitis in Malaysia. We hope to enhance concern among the medical community about the presence of this beetle dermatitis in this region.

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