CUTANEOUS AMOEBIASIS*

By

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INTRODUCTION

Amoebiasis is a very common disease. Where sanitation standards are low its incidence is high. S. S. Misra (1968) reports an incidence varying from 8.8% to 58% in different parts of India. Though it is primarily an intestinal infection its most common extra intestinal manifestations involve the liver, lung or both. R. Subramaniam (1968) in a review of 577 cass of amoebiasis reported 144 cases of hepatic involvement, 65 cases of pulmonary involvement, two cases of hepato-pulmonary involvement and 366 cases of intestinal infection alone. Nasse first described involvement of the skin by amoebae in 1892.

Amoeba cannot invade intact skin. But in patients with poor general health who have active visceral disease cutaneous involvement can occur in three ways–viz (1) by extension (2) by inoculation and (3) by allergic sensitisation.

Involvement of the skin by extension can occur following surgery of visceral (liver) abscess. More commonly perianal extension of colonic and rectal disease may result in large painful ulcerations with ragged, deep red, undermined swollen edge with the floor covered with purulent discharge.

Inoculation of the skin is rare and occurs when torpid amoebic abscess bursts through the skin causing ulceration of the skin. Inoculation of the male and female genitalia can also occur in persons with poor personal hygiene.

Cutaneous manifestations due to allergic sensitisation in ameobiasis may cause anal pruritus, urticaria, rosacea-like disease, buccal melanosis and desquamative erythema from emetine injections.

Wilson and Harewitz 1919 described amoebic ulceration of arms, genitalia and ulcers of penis. In India Rajam and Rangiah were the first to report a similar case, as far back as in 1938.

CASE No. 1 (Sept. 1967)

A boy aged 16 years, was referred to the Dermatology Department as a case of rectal lymphogranuloma venereum, On examination he had a granulomatous ulcer in the anal canal involving the anal margin and the skin of the perinume. (Fig. 1). Inguinal lymph glands were not enlarged. The ulcer was extremely painful. He gave a history of passing loose motions from 15 days and a previous history of dysen-

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try two years back. Examination of the smears from the ulcer for acid fast bacilli and Bacillus Donovani was negative. S.T.S. was also negative. Wet film preparation from the floor of the ulcer showed large numbers of motile ameobae (Fig. 2). He was treated with a course of emetine hydrochloride., 30 mg i.m. daily for 10 days. The pain dis-appeared in the first three days and ulcer healed completely in 10 days.

CASE No. 2 (July 1968)

A boy aged 18 years, working in a hotel was referred to the Dermatology Department as a case of condyloma late. He gave history of dysentry 2 years ago. On examination, he had an ulcer in the anal canal, extending half an inch beyond the anal margin. The duration of the ulcer was 6 months. He had no clinical signs of secondary syphilis. Smears from the floor of the ulcer for acid fast bacillus, and Bacillus Donovani were negative. S.T.S. was also negative. Wet film examination of the ulcer floor showed amoebae. A course of emetine hydrochloride 30 mg i.m. daily for 10 days was given. The ulcer healed within 10 days.

CASE NO. 3 (June 1964)

A women aged 35 years, (widow) a servant-maid, by occupation, presented the complaint of burning micturition and profuse vaginal discharge of 2 years duration. The discharge was described by her as curdy and foul smelling. She gave a history of having suffered from dysentry at frequent intervals for the previous 4 to 5 years.

On examination rectal mucosa was normal, vaginal canal was diffusely inflammed, tender and covered with thick discharge. No vaginal fistula was found. Wet film of the vaginal discharge revealed large numbers of active amoebae. A diagnosis of amoebic vaginitis was made and a course of emetine hydrochloride 30 mg i. m, daily for 10 days was given. The vaginal inflammation and discharge cleared.

The purpose of this communication is to emphasise that in the differential diagnosis of perianal ulcerations besides lymphogranuloma venerum, Donovanosis, Tuberculosis and Malignancy, amoebic ulcerations should also be kept in mind.

Secondly, in the differential diagnosis of chronic vaginal discharge particularly in women with poor sanitary habits, amoebiasis should also be kept in mind, though it my be a very rear cause.

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