CASE REPORTS

CASE REPORT OF GRANULOMA INGUINAL FROM PUNJAB

By

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Granuloma inguinale is a chronic, slowly progressive, granulomatous ulceration of low infectivity. This connition was first recognised in India by McLeod in 1882. It has since been reported in almost every country.

In India, the disease is more prevaient in its southern states. Cases have also been reported from Assam, Bengal, Orrissa and eastern parts of Unithd Provinces. Curjel (1916) reported 20 cases of this disease in women of Himachal Pradesh who came under her observation at Ripon Hospital, Simla. Singh (1962) came across 10 cases in Delhi during a period of 7 years from 1955 to 1961. But, for some unknown reasons, this disease has not, so far, been reported from Punjab and hence was believed not to exist in this part of the country. In view of this, it will be of interest to record a case which has recently been recognised at V. J. Hospital, Amritsar in a Punjabi.

CASE REPORT

S. S., aged 17 years, unmarried, was transferred from Civil Hospital, Hoshiarpur to our Institution on 5-4-1964 for proper diagnosis and treatment of his perianal ulceration and difficulty in defecation.

About a year ago, when patient was returning home at midnight after seeing a cinema, has was caught hold of by a policeman and subjected to sodomy forcibly (used as a passive agent). He felt severe pain during defecation after this incidence and noticed two nodular swellings on 3rd or 4th day on posterior part of his anal margin. Though pain during defecation gradually subsided, nodules persisted as such for nearly 8 months but then they ulcerated. The resultant ulcer gradually enlarged and encircled whole of the anal margin. His defecation, once again, became painful and he started passing ribbon-shaped stools. He was admitted in Civil Hospital, Hoshiarpur and treated with penicillin for nearly 25 days. With that treatment, his ulcer started healing, and when it got reduced to less than half of its original size patient was discharged from the hospital. But the disease soon relapsed and he had to be re-admitted. As treatment with penicillin for 17 days had no appreciable effect during his second admission into that hospital, he was transferred to this Institution.

He denied vigorously of being ever subjected to sodomy or having ever indulged in a sexual intercourse before. There was also no past history of pulmonary tuberculosis or of dysentry.

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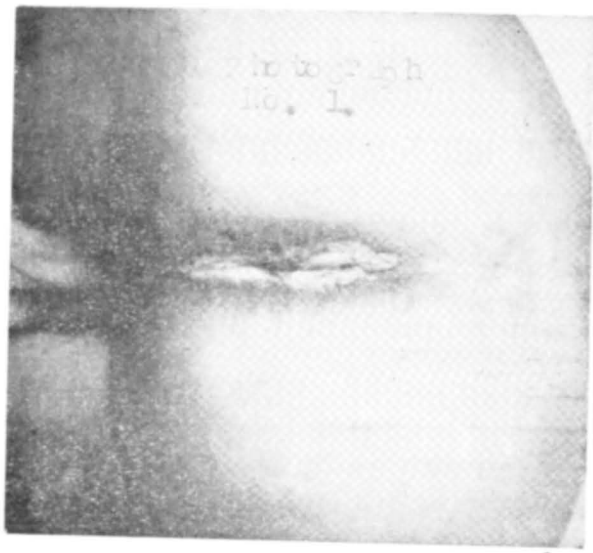
General physical examination : Revealed presence of a few lymph nodes in posterior cervical, superficial inguinal, and supra-trochlear regions, which were small, discrete and non-tender.

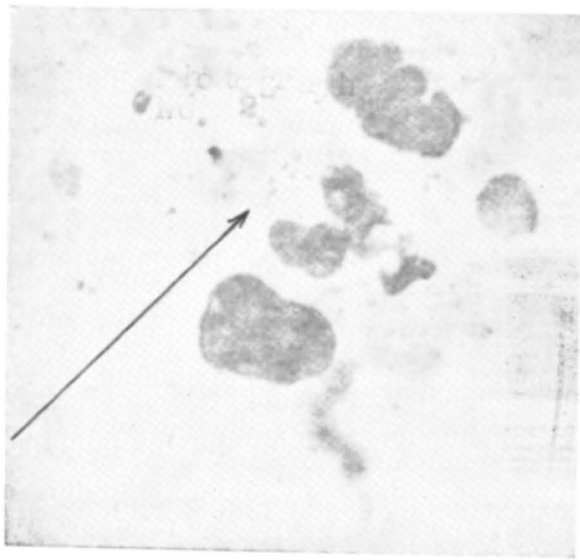
Systemic examination: Revealed no significant abnormality.

Local examination: Revealed an oval ulcer encircling whole of the anal margin and obscuring the anal opening. Margin of the ulcer was irregular; its floor was covered with slough and purulent discharge, removal of which revealed red granulation tissue; and its base was indurated. The ulcer was not adherent to the under-lying structures. Examination of genitalia did not reveal any ulcer, or scar, or discharge per urethra.

INVESTIGATIONS

Urine :	No abnormality was detected either on naked-eye or on microscopic examination.
Stools :	Showed ova Ankylostoma duodenale but no cysts or vegetative forms of Entamoeba histolytica.
Haemoglobin :	13.0 Gms%
Total leucocyte count :	7800/c.mm.
Differential leucocytes count :	Polymorphonuclear leucocytes = 64% Lymphocytes = 36% Monocytes = 0% Basophils = 0%
E. S. R. (Wester-green method)	8 mm.
Blood S. T. S. (V. D. R. L. and Kahn)	Negative.
D. G. I. Examination :	Showed fuso-spirochaetes but no treponema pallidum on repeated examinations.
Examination of discharge and scrapings from the ulcer:	
1. Direct :	No vegetative form of Entamoeba histolytica seen.
2. After Ziehl-Neelsons staining :	No acid-fast bacilli seen.
3. After Leishmans' staining :	Showed numerous extra-cellular and intra-cellular donovania granulomatis.
Histopathological examination :	Showed normal layers of epidermal cells, underneath which there was intense inflammatory infiltrate, mostly peri-vascular in distribution. It consisted, predominantly of plasma cells and round cells.





Treatment and Progress: Patient was put on penicillin once again on 8-4-1964. Purulent discharge disappeared and ulcer started looking heaithy. Fuso-spirochaetes could no longer be demonstrated in a tissue smear but numerous extracellular and intra-cellular dovonania granulomatis could be recognised instend. Patient was then switched on to chloromycetin on 14-4-1964. With this, ulcer gradually healed, stools assumed a normal shape and and only a pinkish but hypo-pigmented scar with an irregular hyper pigmented border was left in perianal region on 27-5-1964 when cholormycetin was discontinued· Proctoscopic

examination on that date revealed that mucosa of the rectum and anus was absolutely healthy and intact.

DISCUSSION

If cannot be denied that, though very scarce, this disease does exist in Punjab. The disease had not been indentified earlier because it was not even suspected to exist in this part of the country.

This case did not pose any diagnostic problem as causative organisms could be easily recognised in a tissue-spread from the lesion. But it is well-known that the disease can often be mistaken for other venereal diseases, e. g. lymphogranuloma venereum, syphilis, chancroid etc. As a matter of fact, other venereal diseases may simultaneously be present along with this disease in the same patient. It may also closely simulate early stages of cancer of these regions, and that may be so not only clinically but also histopathologically.

The difficulty in defecation experienced by our Patient was not due to concurrent lymphogranuloma venereum, as anal mucous membrane was not at all involved. It was probably due to spasm of the external anal sphinctor.

The lesion remained dormant for nearly 8 months and then it became active. The quick spread afterwards along with necrosis was due to the superadded infection with fuso-spirochaetes which could be demonstrated in D. G. I. Examination and which is a well-known complication.

Mode of transmission of the disease is still uncertain. The infrequent involvement of the marital partner has led many workers to doubt its venereal origin. Goldberg (1959, 1962, 1964), who had earlier demonstrated that donovania granulomatis is a faecal organism with its natural habitat In the intestinal tract by his cultural and serologic studies, is of the view that granuloma inguinale is not necessarily a venereal disease but other methods of transmission can also be responsible to a certain extent. Transfer of the organisms from intestinal tract to the skin of the genitals, anal and even other regions, as suggested by him, occurs either by venereal transfer or by auto-innoculation. This latter process may not even be associated with coitus and hence is not venereal in the strict sense. The venereal transfer, on the other hand, may be through normal heterosexual coitus (if the vaginal tract is contaminated with faeces or faecal organisms) or through heterosexual rectal coitus which, in his opinion, is practised often enough to account for transmission of the disease and presence of anal or peri-anal lesions in a passive pederast is not a conclusive proof of its venereal transfer, but rather favours faecal transmission through auto-innoculatlon.

SUMMARY

(1) A case-report of grauuloma inguinale in perianal region in a Punjabi is presented.

(2) Its mode of transmission is discussed.

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