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SYNDROMIC APPROACH TO A CASE OF BALANOPOSTHITIS

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The newly introduced simplified syndromic approach for the management of sexually transmitted diseases was used in a case of balanoposthitis. Gram staining from the glans penis confirmed the case as bacterial balanoposthitis. Topical zinc-sulphadiazine cream was found to be very effective in curing bacterial balanoposthitis within seven days.

Key Words: Balanoposthitis, Sulphadiazine

Introduction

Simple, short and effective treatments have been recommended for the management of sexually transmitted diseases (STDs).[1] The National AIDS Control Organisation (NACO) has suggested 'careful monitoring of treatment efficiency wherever possible'. However, the above publication does not include balanoposthitis in the list of syndrome-based STDs.

Case Report

A 40-year-old sexually active married man presented with mildly itchy papulo-pustular lesions on the glans penis and prepuce. He had extramarital sexual contact with a woman seven days prior to the appearance of penile lesions.

On examination, superficial papulo-pustular lesions on erythematous background were present on the anterior surface of the glans penis and adjoining part of the prepuce. (Fig.1) There was no inguinal lymphadenopathy and tenderness. He was prescribed antifungal cream (clotrimazole 1%), but did not respond. Then he was prescribed co-trimoxazole tablets and acyclovir cream topically. The glans penis became more erythematous and burning sensation appeared. At this stage, routine investigations like urine for pus cells, VDRL test and ELISA, direct KOH mount for fungal elements were done. All were negative. Then swab was taken from glans penis and gram staining was done. Smear showed plenty of pus cells, occasional gram-positive cocci, likely to be staphylococci. No other micro-organisms were seen. The patient was asked to clean the genitalia properly by boric acid solution and apply zinc-sulphadiazine cream. After two days of topical application of the cream, the lesions were reduced markedly (Fig 2). By fifth day of application, the lesions disappeared almost completely (Fig 3). By seventh day, the patient got cured.

Discussion

Staphylococcus aureus may cause balanoposthitis. D'souza et al found 10 different strains of mixed microorganisms in 100 cases of penile ulcers and in 54 cases *Staphylococcus aureus* was isolated predominantly.[2] Depending on "syndromic" findings and simple laboratory investigations, once the bacterial cause is identified, patient may be put on topical zinc-sulphadiazine cream for seven days (twice a day application), as this simple "syndromic approach" to bacterial balanoposthitis has been found highly effective. As observed by NACO,[1] It is usually impossible to make a reliable aetiological

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diagnosis on clinical grounds only, but laboratory support to confirm a clinical diagnosis is not available for the majority of the STD patients in the country. The attending doctor may consider the "syndromic approach" and manage a case of balanoposthitis with zinc-sulphadiazine cream as first choice.

The NACO publication on STD[1] did not include balanoposthitis in the list of "syndromes" of STDs. There is no mention about the management of a case of balanoposthitis. Hence it is expected that, the simple "syndromic approach" taken in management of the present case may be considered in dealing with patients with balanoposthitis.

References

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2. D'souza K, Deodhar LP, Tendulkar UM. A microbiological study of penile ulcer with clinical correlation. Ind J Dermatol Venereol Leprol 1992; 58 : 246-50.

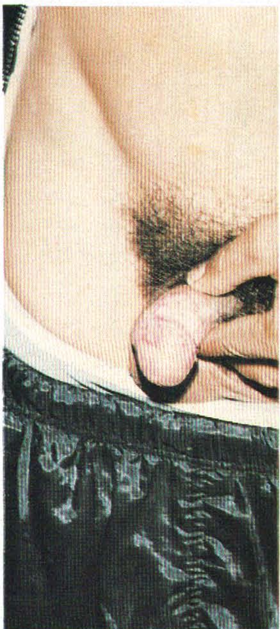

Fig. 1. Before treatment.

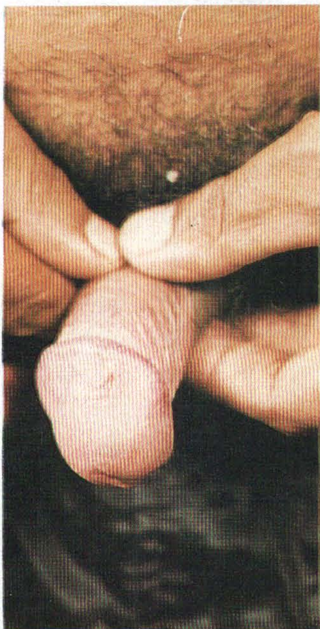

Fig. 2. During treatment.

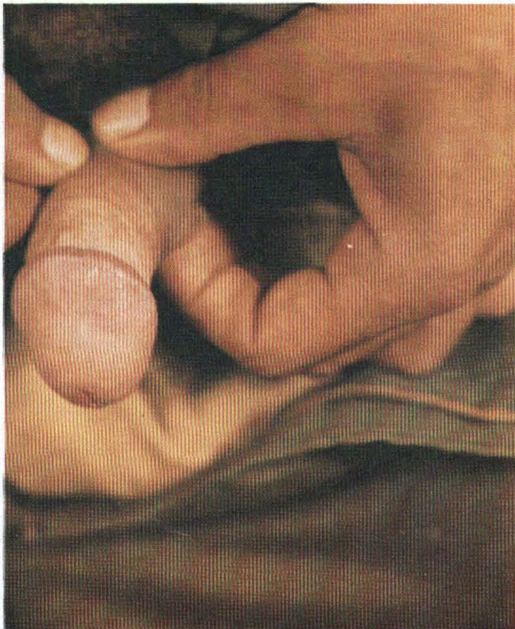

Fig. 3. After 5 days of treatment.