



ORIGINAL RESEARCH PAPER

Dermatology

GENITAL TUBERCULOUS CHANCRE? - CASE REPORTS

KEY WORDS: Tuberculous chancre, anti-tuberculous treatment, Primary tuberculosis

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ABSTRACT

Five cases of sexually transmitted tuberculous chancre in men over urinary meatus reported here. All were nonreactive for syphilis and HIV. All were strongly positive with Mx test. In one case acid fast bacilli was able to be demonstrated. All the individuals were having genital ulcers for more than 4 months duration, more or less at the same site, not responding to either antibiotics or Acyclovir. The response to anti-tuberculous treatment was remarkably excellent in all these cases.

Even though genital tuberculosis, like epididymitis, endometritis are not uncommon, whereas ulcerative tuberculous lesions over genitals are not encountered so often. Secondary skin tuberculous lesions like Lupus vulgaris, Tuberculous verrucous cutis, scrofuloderma are also not commonly met with this site.

Tuberculous ulcers with inguinal adenitis were reported rarely in female genitals^{1,2}. Sporadic cases of Tuberculosis of penis also were reported³. Tuberculous chancre or primary tuberculous ulcers are described by Callomon and Wilson among the circumcised the penis of Jewish infants⁴ and also by Fitz Patrick text book⁵. Primary inoculation of Tuberculosis results from the inoculation of Mycobacteria into the skin or mucus membrane of a host, not previously infected with tuberculosis. Because the tubercle bacilli cannot actively penetrate the intact skin or mucosa, they are introduced into the tissue through minor abrasions or wounds. Rarely, infection may occur in healthy individuals after sexual contact with patients suffering from genital tuberculosis⁶. Herewith few such cases were being reported.

CASE REPORT:

A 23 year old unmarried man came with the complaints of burning sensation and slight pain over tip of penis since five months. Pain and burning increased with thrusting during intercourse. He had history of exposures with a known girl for the past one year. On examination the patient was a moderately built healthy individual without any other problem. Genital examination revealed an irregular slightly bluish tinged ulcer of 6 mm size extending from 5 to 7 clock position was seen over the inner aspect of urinary meatus with irregular and serrated edges. It is slightly tender on palpation. There was no induration felt on palpation. There was no palpable inguinal node.



Figure 1: meatal ulcer on Day 1

Patient was found to have multiple Molluscum Contagiosum lesions over scrotal skin.



Figure 2: Scrotal Molluscum Contagiosum

This patient was treated with antibiotics and tablets without any improvement before he came to my OPD and the ulcer was persisting for months and increasing in size. There is no tendency for spontaneous healing.

His blood tests for Syphilis and HIV were nonreactive. He had normal Leukocyte count and ESR with a marginal Lymphocytosis. His Mantoux test is strongly positive more than 15 mm. The scraping from the ulcers revealed acid fast bacilli with AFB stain.



Figure 3: Laboratory report

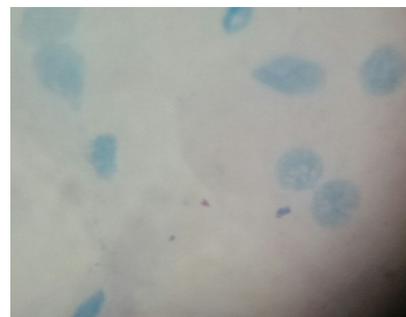


Figure 4: Smear showing Lepra bacilli in AFB stain

The patient was put on ATT. Patient felt the improvement from

the 4th day onwards and a complete healing occurred within 3 weeks in this case.



Figure 5: Day 4th

I had come across another 4 similar cases with similar presentation. All the other 4 patients were married individuals between the age group of 30-35. All were having history of extra marital contact and had ulcers for more than 4 months duration without any improvement with either antibiotics or anti-viral drugs and in all patients, ulcers were situated almost in the same site either over the meatal lip or inner aspect of meatus on ventral or ventrolateral aspect. This could be due to the trauma caused during sexual act during forcible thrust. All had strongly positive Mantoux test and responded well with ATT. Ulcer disappeared within 3-4 weeks duration and treatment continued for 6 months. There was no recurrence in any of these cases.

DISCUSSION:

Strong Mx positive, not responded to antibiotics and antiviral drugs, longer duration, no tendency for spontaneous healing and demonstration of Mycobacteria in one case and the complete response to anti-tuberculous treatment prompt the diagnosis of Tuberculous chancre. In secondary tuberculosis organisms cannot be demonstrated in the smear. The same site and more or less the same size could be due to the minor abrasions following forcible thrusts during intercourse with an infected woman. Shallow ulcer, starts as a papule, the ragged edges with a reddish blue hue are all more in favor of a tuberculous primary ulcer as described by Fitz Patrick's text book.⁶ Usually primary tuberculous ulcer would be associated with regional lymph node enlargement as in case of primary complex.⁶ But the lymphatics of glans penis or urethra are draining in deep inguinal nodes or internal iliac nodes and not in superficial inguinal nodes. So the superficial inguinal nodes were not palpable significantly in these cases. In all these cases the spouses or the contacts were not able to be brought for examination.

Histopathological examination from this site also was felt difficult and discomfort for these patients and the same was not attempted.

CONCLUSION:

Tuberculous chancre is not so common to encounter. But in countries like India and African countries, where still the incidence of Tuberculosis is highly prevalent, we should not forget to think of this possibility of sexually transmitted tuberculous chancre, especially when we come across a shallow genital ulcer persistent for months and not responded to antibiotics and antiviral drugs. ATT in these cases have a tremendous effect. The sex partner or partners have also to be brought, investigated and to be treated if necessary. Tuberculosis also can occasionally be transmitted through sexual route.

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