DOI: 10.14260/jemds/2015/487

CASE REPORT

PENILE TUBERCULOSIS PRESENTING AS PHIMOSIS

Mahalakshmi V[1], Yuwarani M[2], C. D. Narayanan[3], Sudha R[4]

HOW TO CITE THIS ARTICLE:
Mahalakshmi V, Yuwarani M, C. D. Narayanan, Sudha R. "Penile Tuberculosis Presenting As Phimosis". Journal of Evolution of Medical and Dental Sciences 2015; Vol. 4, Issue 19, March 05; Page: 3383-3385,
DOI: 10.14260/jemds/2015/487

SUMMARY: We report a case of penile tuberculosis presenting as phimosis. A dorsal slit revealed an ulceroproliferative growth which resembled Carcinoma. The diagnosis of tuberculosis was based on histopathology. Successful treatment was achieved by Antituberculosis therapy. We report this case because of its unsual presentation and its rarity.
KEYWORDS: Penile Tuberculosis, Phimosis, Anti tubercular therapy.

CASE REPORT: A 62 year old male, diabetic presented with pain in the penis, discharge per urethra and burning micturition since 3 months. No past history of Trauma was elicitable.He gave no history of exposure to the risk of S.T.D. There was no history of fever, loss of weight, or appetite. The patient was married and his wife gave no history suggestive of genital tuberculosis.

On Examination there was phimosis, mucoid discharge from meatus and nodular induration on coronal sulcus. Inguinal Lymphnodes were discrete firm, nontender and mobile. A surgery referral was sought. A dorsal slit by the surgeon revealed an ulceroproliferative growth on glans measuring 3cmx2cm with minimal slough. Systemic examination was normal. We entertained a clinical differential diagnosis of Carcinoma penis, Tuberculous ulcer and Donovanosis.

Investigations revealed RBS-383 mg/dl, Mantoux test-20mm, ESR-60mm/hr, Urine routine-Glycosuria, Urine C/S-Sterile. Three consecutive urine samples obtained were microscopically negative. Haemogram , LFT, RFT, and chest X-ray-Normal. Dark ground Illumination was negative. Gram stain –Showed Pus cells. Tissue smear for Donovanosis was negative. VDRL was nonreactive. ELISA for HIV was negative. Ultrasound abdomen showed simple renal cortical cysts bilaterally.Intravenous Ureterography was normal. X-ray spine was normal. A biopsy was done from the lesion. Histology revealed granulomas composed of epitheloid cells, Langhans giant cells, and dense inflammatory infiltrate of lymphocytes suggestive of tuberculosis. The patient was started on antitubercular treatment. He showed good response.

DISCUSSION: Tuberculosis of the penis is an extremely rare disease. In 1848, Fournier described the first case of a patient with multiple penile ulcers and regional lymphadenopathy,[1] Lewis reviewed 110 cases in the literature before 1946. Lal et al reviewed 29 cases occurring from 1946 through 1971. From 1971 to 1992 an additional 16 cases have been described in the literature. Penile TB may present with strictures fistulae, ulcers or papulonecrotic skin lesions.

Our patient presented with phimosis.[2] Phimosis from the greek word (muzzle) is a condition where the male foreskin cannot be retracted from the head of the penis.[3] Some authors use the term 'physiologic' and 'pathologic'.

To distinguish between these types of phimosis[4.] Pathologic phimosis has several causes like Balanitis xerotica obliterans,[5] scarring caused by 'forcible' retraction of foreskin[4] and balanitis.[6] Some studies found phimosis to be a risk factor for urinary retention[7] and carcinoma of the penis.[8] Phimosis may occur after other types of chronic inflammation (Eg. balanoposthitis), repeated catheterization

DOI: 10.14260/jemds/2015/487

or forceful foreskin retraction.[9] Phimosis may also arise in untreated diabetics due to the presence of glucose in their urine giving rise to infection in the foreskin.[10]

Our patient was a diabetic who presented with phimosis and a dorsal slit revealed the underlying ulceroproliferative lesion. This case is reported due to the unusual presentation of phimosis. This report highlights the importance of keeping tuberculosis in mind while evaluating genital lesions. Histopathology needs to be done before embarking on a definitive management.

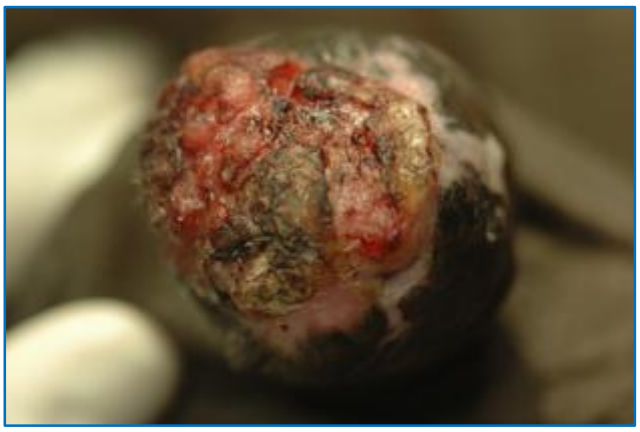

Fig. 1

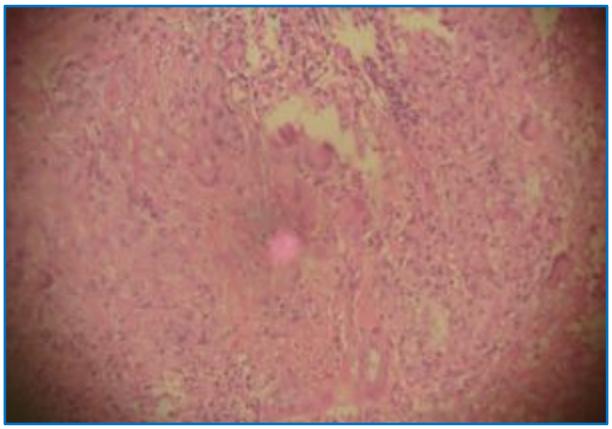

Fig. 2

REFERENCES:

1. Ramesh V, Vasanthi R, Tuberculosis Cavernositis of the penis. Case report, Genitouro Med. 1989; 65; 58-9.
2. Lewis EL. Tuberculosis of the Penis; a report of 5 cases, and a Complete Review of the Literature. J. Urol. 1946; 56: 737-45.
3. Lal M.M, Sekhon G.S, Dhall J.C., Tuberculosis of the penis. J. Indian Med. Association. 1971; 56; 316-8.

DOI: 10.14260/jemds/2015/487

4. Mc Gregor TB' Pike JG, Leonard (March 2007) "Pathologic and Physiologic phimosis; approach the phymotic foreskin. Can fam physician. 53 (3) 445-8.
5. Buechner SA (September 2002) "common skin disorders of the penis". BJU Int. 90 (5) 498-506.
6. Edwards. S (JUNG 1996) Balanitis and Balanoposthitis; a review Genitourin. Med. 72(3) 155-9.
7. Minagawa T. Mureta.Y (June 2008) 'A case of urinary rentention caused by true phimosis' (In Japanese) Hinyokika Kiyo. 2008 Jun; 54 (6) 427-9.
8. Daling JR, Madeleine MM, Johnson LG et al (Semptember 2005) 'Penile cancer, importance of circumcision human papilloma virus and smoking in situ and invasive disease. Int J. Cancer. 116(4) 606-16.
9. Cantu Jr. S. Phimosis and Paraphimosis at emedicinie.
10. Bromage Stephen J. Anne Crump and Ian Dearce (2008), Phimosis as a presenting feature of diabetes BJU International 101 (3) 338-340.

AUTHORS:

1. Mahalakshmi V.
2. Yuwarani M.
3. C. D. Narayanan
4. Sudha R.

PARTICULARS OF CONTRIBUTORS:

1. Professor, Department of Dermatology, Sri Ramachandra Medical Centre & Research Institute.
2. Senior Resident, Department of Dermatology, Sri Ramachandra Medical Centre & Research Institute.
3. Professor, Department of General Surgery, Sri Ramachandra Medical Centre & Research Institute.
4. Professor, Department of Dermatology, Sri Ramachandra Medical Centre & Research Institute.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:
Dr. Mahalakshmi Veeraraghavan,
8 F, Ramaniyam Gallery,
63, East Coast Road,
Thriuvanmiyar, Chennai-41.
E-mail: maha_raghu@yahoo.com

FINANCIAL OR OTHER COMPETING INTERESTS: None

Date of Submission: 27/01/2015.
Date of Peer Review: 28/01/2015.
Date of Acceptance: 23/02/2015.
Date of Publishing: 05/03/2015.