AMOEBIC VAGINITIS

BY

N. C. SEN, M.B., D.G.O., F.R.C.S.Ed.

Sanctoria Hospital, Burdwan, West Bengal

Amoebic vaginitis is rare. In a study of 200 cases of leucorrhoea Bickers (1943) observed that 0.5% were due to *Entamoeba histolytica*, but he did not report any case. Between 1916 and 1948 only fourteen cases have been recorded, notably by May (1943), Morse and Seaton (1943), Cleland (1944), de Rivas (1944), Weinstein and Weed (1948), and others. Most textbooks are silent about a condition which should receive more attention, particularly in the Tropics and subtropics, where the incidence of amoebic infestation is fairly high.

Case Report

A nulliparous Nepalese widow, aged 35, was seen in May, 1948. She complained of a profuse seropurulent vaginal discharge first noticed in January of that year. There was some soreness of the vulva and a slight burning sensation in the vagina and during micturition. The discharge was almost continuous, and there was no alteration in its character or amount before or after menstruation.

She had had a severe attack of dysentery, presumably amoebic, in December, 1947, when she was treated elsewhere and no specific remedy was administered. Soon afterwards she noticed swelling and pain in the perineum and the lower parts of both labia majora. The present symptoms followed and the discharge increased until she was forced to come to the hospital for treatment.

Pelvic examination had to be undertaken under general anaesthesia. The lower part of the right labium majus was slightly swollen. The fourchette presented a small ulcer in its right half. In the vagina there were many linear ulcers, lying mostly transversely in the furrows between the folds of mucosa. They were superficial, punched-out ulcers with slightly overhanging edges which bled easily. The bases were raw and red except for a few ulcers near the fornices covered with a thin yellowish slough. The cervix was slightly enlarged, soft, and ulcerated over the whole of its surface except for a small rim near the reflection of the vaginal mucosa on the portio. The external os could not be detected. The uterus was bulky, soft, and anteverted.

Examination of the thick seropurulent vaginal discharge, both dry and hanging-drop smears, disclosed many active forms of *E. histolytica*. The discharge was acid in reaction and presented a few pus cells, many eosinophils, red blood cells, and vaginal cells, with Gram-positive cocci and a few Gram-negative bacilli. Scrapings from the ulcers again revealed active *E. histolytica*. The discharge obtained by milking the urethra presented, both by dry and hanging-drop smears, active forms of *E. histolytica*. Biopsy of an ulcer showed evidence of subacute inflammation but no *E. histolytica*.

Examination of the stools revealed cysts of *E. histolytica*, but proctoscopy showed no ulcer in the lower anorectal canal. Other evidences of amoebiasis were the enlarged tender liver and slight tenderness and thickening of the descending and iliac colon. There were a few leucodermic patches in the region of the waist.

Treatment

Treatment with emetine hydrochloride was started. It was given in daily doses of 1 gr. (65 mg.) intramuscularly. The vagina was cleaned twice daily with warm normal saline douches. After five days the discharge and discomfort were much relieved and examination could be undertaken without anaesthesia. The ulcers were healed or healing. The cervical lesion looked smaller and the external os could be detected. The cervical discharge was aspirated and showed a few *E. histolytica* with very sluggish movement. They were almost round, and looked like the precystic forms of the parasite.

The patient was complaining of some vague hypogastric pain associated with frequent micturition. A catheter specimen

showed a number of entamoebae again moving sluggishly. No local treatment was given for this amoebic trigonitis or cystitis. Treatment with emetine was continued, and "stovarsol" vaginal compound was given every night after the saline douches. She was also given an alkaline mixture.

After 12 gr. (0.8 g.) of emetine in fifteen days the ulcers were completely healed and the patient felt perfectly well. No urinary symptoms remained, and examination of urine and vaginal discharge revealed no abnormality.

Discussion

Three points favour the diagnosis of amoebic vaginitis: (1) Vegetative forms of *E. histolytica* in the discharges and scrapings from the ulcer. (2) Rapid cure with specific amoebicidal drugs. (3) The punched-out character of the ulcers, with slightly overhanging edges and sometimes yellowish bases, situated mostly in the furrows between the folds of the vaginal mucosa, which shows very little inflammatory reaction.

Infection of the vagina is presumably by continuity and contiguity with the anorectal canal, and this may be helped mechanically by the method of ablation practised in Bengal to cleanse the part after defaecation.

The cervix is involved in about 70% of the reported cases, and the ulcer is usually placed eccentrically and away from the external os. The uterus is often enlarged, and it may be that many or all of the cases in which the uterus is enlarged, soft, and tender have some infection of the uterus. Uterine aspiration was not done in any of the reported cases.

Leucorrhoea due to *E. histolytica* may be fairly common in India. Cases should be investigated thoroughly from this point of view.

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Medical Memoranda

Perforation of Stomach in Scrotal Hernia

Owing to the rarity of this condition (only one other case of this type occurs in the literature: Jayle, 1893) I feel that the following is worthy of record.

CASE REPORT

The patient, a man aged 66, was sent into hospital for ? strangulated left inguinal hernia. He had had a left inguinal hernia for 35 years. Two months previous to his admission he had undergone prostatectomy here, with an uneventful recovery. At the time it was noticed that he had a small left inguinal hernia; since the operation he had been perfectly well. Twenty-four hours before admission the hernia had descended into the scrotal sac, and one hour before admission the patient experienced a sudden severe pain over the left inguinal region, accompanied by nausea and vomiting, the vomitus being gastric contents. The pain was continuous; he was crying out in agony, and disliked being moved. His last bowel motion had been twelve hours before admission, and he had passed urine that day.

Examination showed a well-covered muscular man. His general condition was reasonably good, but he was dehydrated. Temperature 96.4° F. (35.8° C.); pulse 126; respirations 44. He had a large scrotal swelling 12.5 cm. in diameter, which filled the whole of the scrotum. The scrotum was tender, but not excessively so, and was resonant on percussion. The patient complained of severe pain and tenderness over the region of the external inguinal ring. There was some slight abdominal rigidity. Peristaltic sounds were heard and the abdomen was generally resonant. The tongue was furred and dry, and the lungs and heart were normal. A diagnosis of strangulated left inguinal hernia was made, and the patient was given $\frac{1}{4}$ gr. (16 mg.) of morphine, was put on a glucose-saline drip, and was prepared for the theatre.