Case Reports

PRIMARY TUBERCULOSIS OF PENIS- A RARE CASE

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Introduction

Tuberculosis of the penis is an extremely rare disease [1]. It presents as ulcerative lesion of the shaft or glans mimicking malignant disease [2,3] or subcutaneous nodule [4].

This case is reported because of its extreme clinical rarity and to draw attention of unwary clinicians to the entity.

Case Report

A 70-year-old Hindu male reported with complaints of painful superficial ulcer over glans penis of 15 days duration. There was foul smelling discharge from the ulcer site. The lesion had started as a solitary painful swelling over the coronal sulcus which changed into ulcerative lesion in 7-10 days period. No past history of trauma was elicitable. He denied being promiscuous in behaviour. The patient was married and his wife gave no history suggestive of genital tuberculosis. No history of fever was present.

On examination, there was a shallow, tender, non-bleeding superficial ulcer of 1.2 X 1 cms in size having sloping undermined margins located over dorsal aspect of coronal sulcus. The base appeared pale pink, granulomatous and was covered with thick crust at a few areas. Palpation did not reveal any induration. The inguinal lymph nodes were palpable, non-tender, non-matted and firm. Scrotal contents, prostate and spine were normal. Rest of the systemic examination including lungs, was non-contributory.

He had haemoglobin 11 gm/dl, normal total and differential leucocyte count, raised ESR (25 mm fall 1st hour-Wintrobe) and normal chest skiagram. VDRL and HIV by ELISA method were negative.

Clinically, carcinoma of penis was suspected and biopsy was done. Histology revealed typical caseation tuberculous granulomata lined by epithelioid cells and Langhan's giant cells located subepithelialy (Fig-1). AFB could not be demonstrated by modified Fite Faraco's stain. The surrounding surface squamous epithelium appeared normal. Diagnosis of tuberculosis of penile skin was made.

The patient was followed up with further investigations. IVP was normal. Urine culture for AFB was negative. X-Ray spine was normal. Montoux test was positive (20 mm).

He was administered anti-tubercular therapy (ATT) in the form of Rifampicin, Pyrazinamide, Isoniazid and Ethambutol. Within

10 days ulcer showed signs of healing and in 6 weeks the ulcer had healed. He was instituted full course of ATT for 6 months.

Discussion

Primary tuberculosis of penis was initially described by Fournier in 1878 (cited by Lewis) [4]. The incidence of genital tuberculosis is rare. In a Japanese study done in a period of 9 years (1987 to 1995), 17 cases out of 16,363 out-patients (0.1%) were newly diagnosed to have genito-urinary tuberculosis. Five patients had genital as well as urinary tuberculosis (0.03%) while rest 12 had urinary tuberculosis [5]. Two cases amongst 40370 out-patients (0.004%) in 12 years period have been described in Indian series [6].

In our case, diagnosis of carcinoma was considered. The typical granulomata on histopathology with no evidence of malignancy of surface epithelium, helped to clinch the diagnosis of tuberculosis of penis. The diagnosis of orificial tuberculosis was not considered because of lesion being located away from urethral orifice, lack of characteristic histopathological changes and absence of AFB in sections.

Fig. 1 : Photograph shows caseating tuberculous granulomata in subepidermal region

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Tuberculosis of the penis may be of primary or secondary type depending on the absence or presence of co-existing tuberculous disease elsewhere in the body. In the present case, primary tuberculosis is believed to occur from coital contact and/or infected clothing as proposed by Narayana et al [7]. This report highlights the importance of keeping tuberculosis in mind while evaluating genital lesions. Histopathology needs to be done before embarking on definitive management.

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