

Mutilating granuloma inguinale after rape

A case report

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Summary

A woman with extensive mutilating lesions of genital granuloma inguinale following rape is described. As far as is known granuloma inguinale has not previously been reported in a rape victim.

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Destructive and deforming lesions involving the external genitalia may be caused by carcinoma, tuberculosis, lymphogranuloma venereum, amoebiasis and granuloma inguinale. Such cases have become increasingly rare in the antibiotic era.

Granuloma inguinale has been recognised in South Africa at least since 1914¹ but received little mention in published reports until the 1980s when it re-emerged, particularly in the eastern Transvaal² and Natal.³ Although generally regarded as a sexually transmitted disease (STD), auto-inoculation has been implicated as a mode of transmission.⁴ The manner of transmission, late presentation, and unusual presenting symptoms prompted this report.

Case report

An 18-year-old unmarried Zulu girl from a rural area gave a history of faecal incontinence for 1 week. Examination revealed extensive genital ulceration involving both labia, extending over the perineum to the anus. Subcutaneous swelling with lymphoedema and clitoral hypertrophy were present together with multiple satellite areas of ulceration 2-3 cm in diameter in both inguinal regions. Examination under anaesthesia found the uterus, cervix and adnexa to be normal. The anal sphincter was lax but intact and no rectovaginal fistula was found.

Serological tests for syphilis were negative by the rapid plasma reagin and *Treponema pallidum* haemagglutination assay methods. Serological examination for lymphogranuloma venereum was negative by *Chlamydia* micro-immunofluorescence testing. When examined histologically, punch biopsy specimens showed a mixed acute inflammatory picture with Donovan bodies in sections stained by the Giemsa, haematoxylin and eosin and Warthin-Starry methods. A tissue smear was negative for Donovan bodies.

On further questioning, the patient volunteered that she had been raped vaginally 2 years previously after which progressive ulceration had developed. There had been no other sexual exposure and the patient denied being sexually abused as a child. While in the ward it was noticed that she was quiet, withdrawn, did not communicate with other patients and appeared depressed.

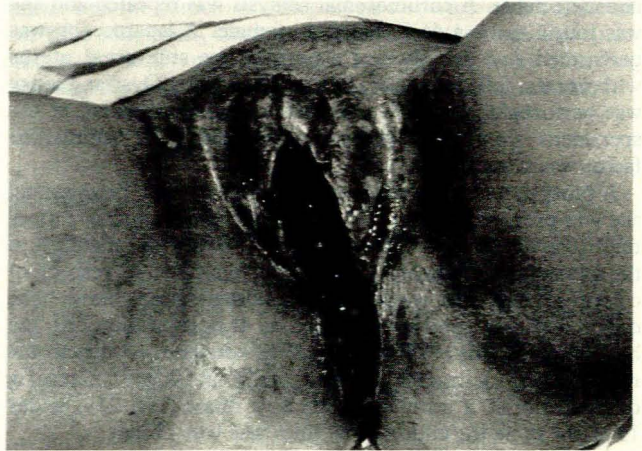


Fig. 1. External genitalia showing esthiomene, extensive ulceration and satellite lesions.

Treatment was commenced with erythromycin 500 mg 4 times a day. Continence of faeces was restored after 2 days and improvement of the ulceration was noted daily until she absconded after 2 weeks. Repeated attempts to contact her were unsuccessful.

Discussion

A variety of STDs have been found in rape victims in the UK⁵ and North America⁶ but little is known of the situation in Africa. In Durban about 300 rape cases are referred to the District Surgeon each year (R. Maller — personal communication). It is accepted in most communities that 90% of the victims do not report rape but may present later to medical agencies with diverse symptoms.⁷ Those who reach hospital in rural areas may be examined purely on a medicolegal basis with no back-up services for counselling.

The psychological effects of rape may be devastating both immediately and in the long term. A rape trauma syndrome may exist in which initial shock is followed by feelings of apathy, suppression and denial.⁸ Factors that delay recovery include lack of social support, lack of self-esteem, economic stress and the age of the victim.⁹ Depression is common, being found in 41% of victims 1 - 2,5 years after the episode.¹⁰ In this case, the patient was depressed and had not sought medical help at any stage. The subsequent worsening of her condition had probably further delayed her presentation because of the shame she undoubtedly felt. In the past, many patients with granuloma inguinale have been deserted by partners and relatives and have committed suicide in despair.¹¹

Long-term antibiotic therapy in mutilating granuloma inguinale is effective and in the case described by Fritz *et al.*,¹² in which penile, scrotal and inguinal tissue was destroyed, healing was achieved after 6 weeks' treatment with tetracycline. In severe cases, surgical techniques involving full skin cover by direct myocutaneous and sliding flaps may be effective,¹³ but disease worsening may occur by surgical inoculation.

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Granuloma inguinale ulcers bleed readily and take longer to heal than other causes of ulceration in Africa. Counselling may be necessary to reinforce the need to continue with treatment until lesions are healed. It is to be expected that this condition will assume increasing importance now that human immunodeficiency virus (HIV) infection with genital ulceration as a risk factor has been recognised in the local population.¹⁴

When delay in presentation occurs in patients with STDs, psychological or psychiatric factors should be sought. Follow-up facilities should be established in hospitals for rape victims. The role of the psychiatric or family-planning sister could be expanded to include such a counselling service.

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