

VAGINAL AMOEBIASIS

A Case Report

by

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Amoebic dysentery is a very common ailment in the tropical countries but the reported incidence of genital tract infection is very low. It is quite possible that some of these cases are not diagnosed and others have had treatment for dysentery before reporting to the gynaecologist.

There are case reports off and on from various institutions and by various authors but it is difficult to give the incidence due to the rarity of this manifestation. Bicker's (1943) studied 200 cases of leucorrhoea and observed 0.5% due to *E. Histolytica*, but did not report any case. Dass and Mittal (1962) studied 420 cases of leucorrhoea and only one case of amoebic vaginitis was discovered, giving an incidence of (0.25%). Hector and Esther report only 24 cases of genital amoebiasis in 100,000 women screened in 5 years, giving a very low incidence of the infection. Bhudri has so far reported the highest incidence of 11.3% in 123 cases

of vaginal discharge examined from the posterior fornix. It is not possible for us to give the incidence in our cases as no such screening has been done so far and the case report is an accidental one though we have become more aware of such an entity, even though rare.

Apparently, this has no relation to age or parity. The youngest patient reported in the literature was a 12 years old unmarried girl who came with a history of loose stools with blood and blood-stained vaginal discharge of 6 months' duration and the oldest patient was 70 years old with post-menopausal blood-stained vaginal discharge.

There are case reports by Misra, Talwalkar and Israel in the Indian Journal of obstetrics and gynaecology. Talwalkar and Israel reported cases of a 17 years old unmarried girl who came with history of leucorrhoea a 54 years old postmenopausal widow who complained of blood-stained discharge and a patient of 60 years of cancer cervix with recto-vaginal fistula with this infection.

Most of the patients came with a history of dysentery i.e. loose stools with or without blood, and vaginal discharge which was either offensive, purulent, blood-stained or yellowish

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in colour. History of dysentery is said to be present in more than 80% of the cases.

Amoebic infection is seen in liver, lungs, mouth, nose, ovaries, fallopian tubes, urinary tract, perineal regions and in the lower genital tract. Amoebae have also been reported in the uterine wall as well.

Mode of infection is possibly due to close proximity of the organs, improper cleansing habits, recto-vaginal fistula and probably coitus. Extract mechanism is of course not clear in spite of the high incidence of amoebic dysentery existing in our country. It is considered that high pH of the vagina may be one of the defence mechanisms for the low occurrence in the lower genital tract. This has been very well discussed by Sinha who has reviewed the literature regarding the mode of infection in the vagina.

Case Report

Mrs. S. D., aged 39 years, was seen on 1.11.66 in the out-patients department with the complaint of blood-stained vaginal discharge per vaginam for one month. The discharge was slight in the beginning but gradually increased. There was a history of loose stools with blood and mucus off and on for the same duration. Her periods prior to this complaint were regular with normal flow.

She had 7 full-term normal deliveries. Last delivery was 8 years ago. Following first delivery, she had hemiplegia affecting the right half in the post-partum period, from which she recovered fairly well. Besides this, there was nothing particular in the past or in the family history. On examination, the patient was well nourished and well built.

A speculum examination showed an irregular, friable ulcer on the posterior lip of the cervix with blood-stained discharge (Fig. 1). The uterus was

anteverted and normal in size with a tubo-ovarian mass in the left fornix, other fornices being clear. Rectal examination did not show any infiltration in the parametria besides a small tender mass in the left fornix. Provisionally, a diagnosis of cancer cervix was made and the patient was admitted for investigations and treatment. On 2.11.66 she was re-examined. Vaginal findings were the same but speculum examination showed multiple superficial ulcers on the posterior vaginal wall involving the middle or upper third of the vagina with marked congestion of the mucosa. There were similar ulcers on both the lips of the cervix as well, with healthy areas in between. Amoebic infection was suspected and a smear was immediately taken.

Investigations: Direct-swab—was negative. Aspiration of the discharge from the ulcers in the vagina was done and wet smears were immediately examined which showed trophozoites of *E. Histolytica* besides streptococcus - pyogenes, staphylococcus - pyogenes and *B. Proteus* on culture. Rectal swab also showed vegetative forms of *E. Hystolytica*. Cervical swab was negative and cervical biopsy showed chronic cervicitis with no evidence of amoebae. Vaginal biopsy from the ulcers showed only superficial epithelium with no pathology. Blood haemoglobin—9.5 gm. %, W.B.C. 9600/cm. ESR for the 1st hour—10 mm. uterine aspiration could not be done. Smegma was negative for any evidence of amoeba.

As the patient was having loose stools she was immediately put on the treatment and sigmoidoscopy could not be attempted.

Treatment. Terramycin capsules 250 mgm. four times a day, for 7 days with B. Complex tablets thrice a day for 7 days. This was followed by mexaform tablets, 2 thrice a day, for 7 days and chloroquin tablets, 1 twice a day for 1 week. Injection emetine hydrochloride were given $\frac{1}{2}$ gr. twice a day. Total dose of 7 grs. was injected. They were not given in the beginning as patient had low blood pressure even though electrocardiogram was normal.

Clinically and symptomatically, there was marked improvement at the end of this regime. Vaginal and rectal discharges were both negative on repeated examina-

tions. Frequency of stools was controlled and vaginal discharge became much less. Speculum examination showed that ulcers though still present were rapidly healing. Vaginal mucosa looked healthier and less congested. Patient was discharged on chloroquin I tab. twice a day for 10 days and to report later for check up.

The patient was very keen to go home, hence was discharged. She was re-admitted on 27.1.67. Vaginal and rectal swabs were taken but were negative for any evidence of infection.

She had a laparotomy on 1.2.67 for the persistent pain in the lower abdomen. Total hysterectomy with removal of the tubo-ovarian mass and right salpingectomy was performed. Postoperative recovery was uneventful. Histo-pathological report showed adenomyosis with cystic glandular hyperplasia, chronic cervicitis and both fallopian tubes showed perisalpingitis. Tubo-ovarian mass showed non-specific chronic inflammatory reaction. No evidence of amoeba was seen in any of the sections.

Comments

Vaginal amoebiasis is a rare entity and is always a secondary infection from the gastro-intestinal tract. This case was diagnosed only by its significant snail tract appearance of the ulcers in the vagina and cervix. Even though rare, the possibility of such occurrence must be kept in mind so as not to miss it as response to treatment is very satisfactory.

Perisalpingitis following amoebic infection has been reported probably due to direct extensions from the bowels but no such evidence was

detected in our hospital in hundreds of sterilizations and other salpingectomies done. Bhudri has quoted an incidence of 0.75% in cases of surgically excised tubes.

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