A case of *Giardia lamblia* proctitis presenting in a V.D. clinic

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Attendance at a British venereal disease clinic does not require referral from a family doctor; accordingly, when a patient presents spontaneously, there is a reasonable assumption that he suspects sexually acquired disease. Asian immigrants are still prone to conceal the truth of their sexual activities, particularly if homosexual activity is involved, and it is against this background that the following case is recorded.

**Case report**

A 34-year-old crane-driver from East Pakistan first attended the special clinic of his own accord on January 20, 1971, complaining of vague urinary and abdominal symptoms. On further questioning he admitted having had a yellow discharge from the anus for 6 months. There was no history of diarrhoea, dyspepsia, or weight loss. He denied having had any extramarital sexual contact, heterosexual or homosexual.

**Examination**

He was a healthy-looking man, but very apprehensive and anxious. He did not look anaemic and there were no abnormal signs in any system. The abdomen was soft and not tender and no mass was palpable. Proctoscopy showed that the rectal mucosa was inflamed and there were flecks of purulent discharge. No discharge was seen at the urethral meatus. The blood pressure was 120/80 mm Hg.

**Laboratory investigations**

Rectal smears showed pus cells but no gonococci on three occasions. Three culture specimens from the rectum gave no growth of gonococci.

Hb 16-6 g. per cent.  
WBC 9,000 per cu. mm. with normal differential count  
Wassermann reaction, Kahn test, and Reiter protein complement-fixation test: all negative.

Urine: clear with no abnormality  
Stool: three fresh samples showed no *Entamoeba histolytica* or *Balantidium coli*, but cysts of *Giardia lamblia* were readily identified.  
Serum proteins (g./100 ml): normal  
Electrophoretic pattern: normal  
Blood urea: 30 mg./per 100 ml.  
Plasma electrolytes (mEq./litre): sodium 136, bicarbonate 26, potassium 5  
Chest x ray: normal  
Barium meal: normal

**Family**

The patient lived with his brother. Three stool specimens from this man showed no *Giardia lamblia*.

**Treatment**

Metronidazole 200 mg. was given three times a day orally for one week. Symptoms and signs cleared rapidly. Three follow-up stool examinations, showed no parasites or ova of *Giardia*.

**Discussion**

*Giardia*, one of the protozoan intestinal parasites, exists in two forms: vegetative and cystic. Locomotion is by flagellae and multiplication is by longitudinal fissure.

*Giardiasis*, which is common in Asia and the South Pacific, is said to affect 16 per cent. of tropical peoples and 4 per cent. of Caucasians. It is also common among children in the industrial areas of the U.S.A. where it is a recognized cause of malnutrition (Manson-Bahr, 1966).

The parasite often inhabits the duodenum and may cause distension, flatulence, and epigastric pain simulating peptic ulcer. In some cases it causes ulceration of the duodenum which can be seen radiologically on barium meal examination. Commonest of all is jejunal infection which is a recognized cause of diarrhoea. More extensive bowel infestation is less usual and may give rise to malabsorption, especially in children.

There was no clinical or biochemical evidence of malabsorption in the present case.

**Summary**

A patient who presented himself at the special clinic complaining of discharge from the anus was thought at first to be an undeclared passive homosexual, but investigations excluded gonorrhoea and syphilis.

There was evidence of proctitis which was believed to have been caused by infestation with *Giardia*.
*Giardia lamblia*. The condition responded promptly to treatment with metronidazole. The giardiasis did not appear to be complicated by duodenal ulceration or malabsorption.

The case is presented in order to alert venereologists to the possibility of giardiasis in the differential diagnosis of proctitis.

**Reference**

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