Genital manifestations of tropical diseases

J Richens

Genital symptoms in tropical countries and among returned travellers can arise from a variety of bacterial, protozoal, and helminthic infections which are not usually sexually transmitted. The symptoms may mimic classic sexually transmitted infections (STIs) by producing ulceration (for example, amoebiasis, leishmaniasis), wart-like lesions (schistosomiasis), or lesions of the upper genital tract (epididymo-orchitis caused by tuberculosis, leprosy, and brucellosis; salpingitis as a result of tuberculosis, amoebiasis, and schistosomiasis). A variety of other genital symptoms less suggestive of STI are also seen in tropical countries. These include hydrocele (seen with filariasis), which can be no less stigmatising than STI, haemospermia (seen with schistosomiasis), and hypogonadism (which may occur in lepromatous leprosy). This article deals in turn with genital manifestations of filariasis, schistosomiasis, amoebiasis, leishmaniasis, tuberculosis and leprosy and gives clinical presentation, diagnosis, and treatment.

This review concentrates on six infections that cause significant genital morbidity in tropical countries—namely, Bancroftian filariasis, schistosomiasis (especially infection due to *Schistosoma haematobium*) amoebiasis, leishmaniasis, tuberculosis, and leprosy (mostly the lepromatous form). The main emphasis is on clinical features. Investigative methods pertinent to genital disease are covered and the main aspects of therapy are mentioned in addition to specific advice about genital complications. For more detail on the investigation and treatment of these diseases, particularly standard therapies for tuberculosis and leprosy, readers should consult standard texts. A miscellany of other infectious and non-infectious conditions causing genital morbidity in the tropics is mentioned in the final section.

**METHODS**

Two earlier reviews of this subject were taken as a starting point. These suggested that filariasis, schistosomiasis, amoebiasis, and mycobacterial infections were the diseases that warranted most attention. Tuberculosis is included because of the rising incidence of this infection in the tropics and relatively high incidence of extragenital disease that has long been observed in many parts of the tropics. The author found that the most reliable strategy for retrieving relevant articles from Medline that described genital manifestations of these infections was to combine medical subject headings for individual infections with the headings genital diseases, male and genital diseases, female, and the latter terms to include all their subheadings. Genital tuberculosis cases are conveniently indexed in Medline under the heading tuberculosis, male genital, and tuberculosis, female genital. All abstracts were screened and the full text of individual articles read for all reviews and case series. References in articles were examined for to check for further pertinent articles. Individual case reports were not read unless they emphasised special features not previously reported or included useful reviews of the literature. The references selected are those that reflect the greatest experience in a specific area or which describe important new developments or observations.

**FILARIASIS**

Two species of filarial worm cause genital disease in humans. Much the most important is *Wuchereria bancroftii*, which accounts for 90% of filarial infections and is estimated to infect 100 million people in the tropics. Of these, 40% have disfiguring manifestations and 27 million men are estimated to suffer from genital deformity. Genital morbidity in women is much rarer. Bancroftian (lymphatic) filariasis has been ranked the second leading cause of disability in the world by the World Health Organization (WHO) and ranked second to HIV in Haiti as a public health issue for the community. Onchocerciasis, caused by *Onchocerca volvulus*, is remembered by most students of tropical medicine for an unusual complication known as the “hanging groin,” caused by a combination of inguinal adenopathy and skin atrophy that results in hanging folds of skin containing lymph nodes. Minor deformities of scrotal skin may also develop. Recent surveys in endemic areas reported hanging groin in 14% in Nigeria and pendular scrotum in 19% in Ethiopia. The remainder of this section will deal with the more important Bancroftian filariasis.

Filariasis occurs in Africa, Asia, South America, the Caribbean, and the Pacific. Transmission is through mosquitoes that transmit larvae that develop into adult worms in the human host. Recent studies have shown it often possible to identify nests of adults worms by ultrasound. The worms display a characteristic movement termed the “filarial dance.” In men the lymphatics of the spermatic cord are a favoured location. The adult worms release microfilaria into the blood in large numbers in the early part of the night, thus making detection of microfilaria in a night blood sample a convenient tool for diagnosis. The presence of
infection leads initially to asymptomatic lymphangectasia. The death of adult worms provokes acute inflammation and lymphatic dysfunction and the late effects of disease result from superimposed bacterial infection in areas of lymphatic dysfunction. The specific clinical features that result from these processes in the genital area are described in table 1. The psychosocial impact of filariasis (table 2) has been highlighted in recent research carried out in Brazil and Nigeria.

The diagnosis is usually made by demonstrating the presence of microfilaria in peripheral night blood samples, for which a variety of techniques are available. Adult worms within the scrotum can be demonstrated by ultrasound with a 7.5 MHz transducer. Demonstrating microfilaria becomes more difficult in late stage disease. Antibody and antigen detection techniques are available in special centres. One study conducted in an endemic area showed that 37% of men initially reported as amicrofilaraemic in a 60 μl capillary sample could be shown to have filariasis by testing larger blood volumes or by scrotal ultrasound for adult worms.

Diethylcarbamazine (DEC) in three divided doses of 6 mg/kg/day for 12 days kills adults and microfilariae. The death of worms can provoke quite intense systemic and local reactions but does not generally require withdrawal of treatment. DEC treatment alone does not produce regression of hydroceles. Ivermectin is effective only against microfilariae and has an important role in control programmes. Surgery for scrotal elephantiasis produces much more satisfactory results than surgery for elephantiasis of the legs. Studies from Ghana have shown that surgery for hydrocele brings marked improvements in physical and social wellbeing, increases capacity for work and community participation, and merits much greater attention than it has so far received in endemic areas. Aspiration followed by sclerotherapy with tetracycline offers a useful alternative method for dealing with thin walled hydroceles. Good skin care and prompt treatment of bacterial skin infections is important to stop the disease progressing.

**Schistosomiasis**

Schistosomiasis comprises a group of helminth infections characterised principally by extensive egg shedding into the bladder (mainly Schistosoma haematobium) or rectum (mainly *S mansoni* and *S japonicum*) by adults worms residing in nearby venous plexuses. The inflammatory reaction to soluble egg antigens released through pores in the walls of eggs that become lodged in tissue produces a wide array of symptoms, notably haematuria and bloody diarrhoea, and sequelae such as periportal fibrosis. Genital complications of schistosomiasis are less well known but may have important implications for control of cervical cancer and HIV in women. Both sexes may develop genital complications but, in contrast with filariasis, the genital morbidity is much greater in women than men. Schistosomiasis is acquired by exposure to water colonised by various species of snail which act as intermediate hosts and which release into the water motile miracidia capable of penetrating human skin. The disease is believed to infect 193 million people in the tropics, with 85% of infections occurring in Africa. Each of the *Schistosoma* species that infects humans has a specific distribution related to local snail ecology.

### Table 1 Male genital manifestations of infection with *Wuchereria bancroftii*

<table>
<thead>
<tr>
<th>Manifestations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphangiectasia of lymphatics round spermatic cords</td>
<td>Earliest sign of infection. Detectable by ultrasound in 80% of men found to have microfilaraemia. Initially asymptomatic</td>
</tr>
<tr>
<td>Acute hydrocele</td>
<td>Develops when adult worms die naturally or as a result of therapy</td>
</tr>
<tr>
<td>Chronic hydrocele</td>
<td>Detectable in up to 40% of males in areas hyperendemic for filariasis</td>
</tr>
<tr>
<td>Chylocele</td>
<td>Collection of chyle that forms when a lymphatic ruptures into a hydrocele</td>
</tr>
<tr>
<td>Lymph scrotum</td>
<td>Superficial scrotal lymphangiomatosis which may ooze chyle through deformed scrotal skin</td>
</tr>
<tr>
<td>Acute inflammation of scrotum and penis</td>
<td>May be triggered by death of adult worms or superimposed bacterial infection. Tender scrotal nodules or irregularity of spermatic cords may be felt</td>
</tr>
<tr>
<td>Elephantiasis of scrotum (fig 1)</td>
<td>Late hypertrophy and fibrosis that results from repeated bacterial infections. Urine flow not affected</td>
</tr>
<tr>
<td>Inguinal adenitis</td>
<td>Develops acutely when adult worms die. Also triggered by bacterial infections in genitalia or legs. Occasionally filarial abscess develops</td>
</tr>
</tbody>
</table>

### Table 2 Social impact of genital filariasis reported by Dreyer et al and Ahorlu et al

<table>
<thead>
<tr>
<th>Loss of physical intimacy</th>
<th>Difficulty in finding marriage partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conspiracy of silence, embarrassment, ridicule, loss of self esteem, reduced social interaction</td>
<td>Reduced work capacity</td>
</tr>
<tr>
<td>Reduced social interaction</td>
<td>Loss of inheritance</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>Dyspareunia in female partners resulting from penile deformity of infected male partners</td>
</tr>
</tbody>
</table>

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**Figure 1** Scrotal elephantiasis from Bancroftian filariasis. Patient being prepared for surgery in Papua New Guinea.
Mild disease shows signs of regression within 9 weeks of a single dose of praziquantel 40 mg/kg. Where more extensive lesions are present 4–5 doses at 48 hour intervals have been recommended.17

**Male genital schistosomiasis**

The ability of schistosomiasis to cause bleeding and egg deposition within semen was first clearly demonstrated by the intrepid Claude Barlow who deliberately infected himself with cercariae in 1944 and then observed the development of haemospermia and the appearance of schistosome ova in his own semen.26 MacKenna et al reported how seven men from New Zealand attended a sexual health clinic in Christchurch complaining of either yellow discoloration (three cases), reduction in semen volume (two cases), or consistency (two cases).30 All the men had swum in Lake Malawi while travelling in Africa. Treatment with single dose praziquantel led to recovery in all cases. Other reports have described the development of haemospermia and lumpy semen in men with schistosomiasis.31–33 Calculifications of the seminal vesicles and prostate may be observed on ultrasound.34 This author was able to make a rapid diagnosis of schistosomiasis in a young adult male who attended a sexual health clinic complaining of lumpy semen after returning from work in Africa where he reported swimming in Lake Malawi. He produced a fresh specimen of semen in the clinic which confirmed his description. One of the lumpy areas was squashed under a cover slip and eggs containing wriggling larvae were shown to the patient before starting therapy. There are a small number of case reports of lesions of schistosomiasis developing within the testes (simulating carcinoma35 or causing infection36), epididymis,37 and the penis.38 Male infertility resulting from such lesions is rare.39

**AMOEBIASIS**

The classic effects of infection with *Entamoeba histolytica* are the development of a colitis that gives rise to amoebic dysentery, colitis, and liver abscess when organisms enter the portal system. *E histolytica* has also been reported as a cause of genital ulcer. In a review of 148 case reports of genital amoebiasis confirmed by observation of *E histolytica* published between 1924 and 1997, Antony and Lopez-Po noted that 85% of reports were of genital infection in females, including infants.40 Female genital amoebiasis is characterised by a foul, bloody vaginal discharge. In one third abdominal pain was reported and 8.1% had genital ulceration, often mimicking carcinoma of cervix, although in some cases amoebiasis and carcinoma have been found together.41 Involvement of uterus42 and tubes43 has also been reported; 92% of cases were diagnosed in cervical cytology specimens and the remainder by ulcer biopsy. Eighty six per cent of cases in men presented as a painful, discharging ulcer (fig 3), again often mimicking carcinoma and the remainder with discharge or dysuria. The diagnosis in men was made by biopsy, culture, smear, or wet preparation. In addition to these methods serological tests and nucleic acid amplification tests are now available to diagnose amoebiasis. Genital amoebiasis lesions generally respond swiftly to a standard course of metronidazole treatment (800 mg three times daily for 5 days). Neglected cases have progressed to necrotising vulvitis requiring radical vulvectomy.44 The infection can be sexually transmitted45 and sexual partners of patients with genital amoebiasis should be examined and offered treatment.

**CUTANEOUS LEISHMANIASIS**

The leishmaniases are a group of diseases caused by protozoa of the *Leishmania* genus that affect 1–2 million people per year between latitudes 45° north and 32° south. Each species

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**Table 3  Clinical features of female genital schistosomiasis**

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinical manifestations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fallopian tubes</td>
<td>Infection can simulate pelvic inflammatory disease and lead to infertility and ectopic pregnancy</td>
</tr>
<tr>
<td>Uterus</td>
<td>Disturbed menstruation, fetal loss</td>
</tr>
<tr>
<td>Placenta</td>
<td>Second trimester abortion</td>
</tr>
<tr>
<td>Cervix</td>
<td>Ulceration, growths, sandy patches, cervices, discharge, post-coital bleeding, dyspareunia</td>
</tr>
<tr>
<td>Vagina</td>
<td>Growths, ulcers, sandy patches, recto- vaginal and vesico-vaginal fistulae</td>
</tr>
<tr>
<td>Vulva</td>
<td>Swelling, ulceration, wart-like growths, prunus, clitoral hypertrophy</td>
</tr>
</tbody>
</table>

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**Figure 2** Genital schistosomiasis (Gilles HM. Clinical Tropical Medicine and Communicable Diseases Vol 2, No1, 1987). Reproduced courtesy of HM Gilles and Elsevier Science Publications.
Cutaneous leishmaniasis of penis and scrotum.

Figure 4

Summarised in table 4.

Important genital manifestations of tuberculosis in men are

**GENITAL TUBERCULOSIS**

**Male genital tuberculosis**

Important genital manifestations of tuberculosis in men are summarised in table 4.
insensitive and investigation may demonstrate oligospermia or aazoospermia as well as elevated levels of luteinising hormone and follicle stimulating hormone and reduced testosterone. Patients with tuberculoid and other forms of leprosy occasionally develop skin lesions of the penis and scrotum that might be confused with STI. Leprosy is diagnosed by clinical findings (especially the presence of peripheral nerve thickening) supplemented by slit skin smears to look for acid fast bacilli. Most patients with leprosy are treated with multidrug regimens following the recommendations of the WHO.

MISCELLANEA

Brucellosis is an important cause of epididymo-orchitis among cattle dealers and those who drink unpasteurised milk in endemic areas. Isolation of Brucella melitensis from semen and sexual transmission to female partners has been reported. The diagnosis is suggested by associated fever and rheumatological symptoms and may be confirmed by culture, serology, and epididymal aspiration. Recommended treatment for brucellosis is 6 weeks of doxycycline with 3 weeks of streptomycin.68 The diagnosis is suggested by associated fever and rheumatological symptoms and may be confirmed by culture, serology, and epididymal aspiration.67 Recommended treatment for brucellosis is 6 weeks of doxycycline with 3 weeks of streptomycin.68

Physicians working in south and South East Asia will be familiar with so called semen loss syndromes, characterised by weakness, fatigue, and the conviction that this is linked to involuntary semen loss. Much has been written about this syndrome in India where it is referred to as “dhat,” or, more misleadingly, prostatorrhoea. No organic basis has been identified and it is most easily understood in terms of cultural concepts of semen and vitality. Depression scores are elevated among patients diagnosed with dhat. Rather more dramatic are occasional “epidemics” of a disease known as “koro,” characterised by a delusion in men that their genitalia are shrinking inwards and that they may die as a result. An outbreak in north eastern Thailand in 1976 led 200 people to attend hospital.

REFERENCES


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