CASE REPORT: COBBLESTONE

Perianal Crohn's disease masquerading as perianal warts

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Sex Transm Infect 2002;**78**:302–303

We describe a case of severe perianal Crohn's disease masquerading as perianal warts in a non-sexually active adolescent girl presenting to a genitourinary medicine clinic. Perianal Crohn's disease should always be suspected in children and adolescents presenting with perianal skin manifestations to any healthcare settings in order to avoid delay in diagnosis and treatment of this chronic disabling condition.

CASE REPORT

A 13 year old, white girl initially presented to her general practitioner (GP) with a 3 month history of constipation and pain during defaecation. She was embarrassed by her condition, and was therefore not examined by her GP. She was treated with Xyloproct ointment and laxatives, with no improvement. Three days later, she presented to her local accident and emergency department (A&E), where she was diagnosed as having perianal warts.

She was subsequently referred to the genitourinary medicine (GUM) clinic. The under age protocol was followed for assessment. She denied any form of sexual contact. On examination, there were multiple, swollen, warty looking skin tags with ulceration in the perineal and perianal region. On further questioning, she disclosed a history of infrequent vomiting, reduction of appetite and weight loss of 3 kg in 1 month. There was no history of diarrhoea, abdominal pain, or fever. Mixed anaerobes and *Staphylococcus aureus* from the ulcers were isolated. A sexually transmitted infections screen was negative.

Perianal Crohn's disease (PD) was suspected and she was further investigated by a paediatric gastroenterology team. At gastroduodenoscopy and colonoscopy, she was found to have ulceration and inflammation of the oesophagus, stomach, duodenum, and colon. A colonic biopsy contained poorly formed granuloma with patchy active chronic inflammation extending throughout the lamina propria (fig 1).

The patient was initially treated with appropriate antibiotics, topical tacrolimus, and oral modulen and infliximab infusions. A month later she suffered from severe constipation secondary to excruciating pain caused by PD. This failed to respond to conservative measures. She therefore underwent sigmoid colectomy for diversion of faecal stream. Her general condition and PD improved significantly. She is currently doing well and receiving psychological support to help her cope with the colostomy.

DISCUSSION

PD is a disabling manifestation of Crohn's disease. The diagnosis is based on the history, contrast radiology of bowel, colonoscopy, and biopsy.^{1–3} The differential diagnosis of perianal lesions in a sexually active individual

Figure 1 Biopsy with poorly formed granuloma with patchy active chronic inflammation.

include condylomata lata, lymphogranuloma venereum, and perianalwarts. A wide variety of cutaneous granulomatous conditions such as sarcoidosis, deep fungal infections, mycobacterial infections, hidradenitis suppurativum, actinomycosis, and malignancy should also be excluded.⁴ The presence of active granulomatous inflammation of the upper and lower gastrointestinal tract in a non-sexually active girl together with a good response to specific therapy, confirmed the diagnosis of PD in our patient.

In this case, there was a delay in diagnosis of PD primarily due to lack of recognition of the underlying condition. Factors contributing to this included the patient's embarrassment, a consequent delay in examination, and an initial diagnosis of perianal warts. Although it is unusual for a case of PD to present to a GUM clinic, awareness of this condition is important as these lesions can predate the other symptoms of Crohn's disease. This case also highlights the importance of prompt recognition of PD in children and adolescents presenting with perianal skin manifestations in any healthcare settings in order institute therapy without delay, thus to avoid further morbidity.

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Accepted for publication 1 May 2002

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ECHO

Progressive multifocal leucoencephalopathy in disguise

Please visit the Sexually Transmitted Infections website [www.sextransinf.com] for link to this full article.

Patients with AIDS and progressive multifocal leucoencephalopathy (PML) may be missed if they present with atypical symptoms, as shown by a case study.

The study is the first to report progressive myoclonic ataxia caused by PML. This exceptional presentation confounded diagnosis because of atypical symptoms and neurological lesions confined for the first few months to the grey matter of the brain. PML typically produces lesions in the white matter. Reports of similar imaging findings in AIDS patients are growing, and the report's author call for MRI diagnostic criteria for PML to be expanded and for PML to be listed in the differential diagnoses for all patients with HIV, since prospects of improved outcome with new treatments rest with a correct early diagnosis.

The case describes the disease course over 13 months in a 36 year old white man positive for HIV-1 and hepatitis C, taking zidovudine, who presented initially with gait ataxia and intention tremor in his arms, worsening to myoclonic ataxia, then tetraparesis and physical deterioration, followed by death from pneumonia. Imaging throughout showed lesions only in the grey matter of the brain, except in the final months. Pathological examination of the brain and in situ hybridisation for JC virus confirmed PML.

PML is a rare disease in which oligodendrons are destroyed by JC virus, a common infective agent in childhood, which persists in latent form. The virus can be activated by infection with HIV-1, and it may be present in up to 5% of AIDS patients.

▲ *Journal of Neurology, Neurosurgery and Psychiatry* 2002;**72**:653–656.

Brain necropsy. (A) Coronal section of the basal ganglia showing demyelinating lesions and cavitation in the right thalamus (Luxol fast blue stain). (B) Demyelinating lesion with reactive astrocytes, macrophages, and oligodendroglial nuclear inclusions (Luxol fast blue stain (x400)). In situ hybridisation for JC virus, with positive oligodendroglial nuclei (x300).