Multiple Punched Out Ulcers and Scars over Glans: A Common Disease at Uncommon Site

Sir,

A 40-year-old man presented with multiple asymptomatic ulcers over glans penis for the past 5 years. The ulcers used to heal with scarring. He denied any history of unprotected sexual exposure, any history of genital lesions, or discharge in his spouse; there was no history of trauma, drug intake, fever, cough, and constitutional symptoms with no personal or family history of tuberculosis. The patient was never vaccinated with Bacillus Calmette-Guérin.

Examination revealed multiple, indurated, nontender, well-defined ulcers of size 0.5 cm × 0.5 cm over the ventral and dorsal aspects of the glans. Multiple punched-out depressed scars were also present [Figure 1a]. Bilateral inguinal nontendered lymphadenopathies were present. Erythrocyte sedimentation rate was highly raised (50 mm in the 1st h). Tuberculin (Mantoux) test was strongly positive (20 mm × 20 mm). Ziehl–Neelsen (ZN) stain of the pus did not demonstrate any acid-fast bacilli (AFB). Punch biopsy revealed ulcerated epidermis with wedge-shaped area of necrosis, surrounded by a poorly formed granulomatus infiltrate composed of lymphocytes and macrophages [Figure 1b]. ZN stain for AFB was negative. Tissue cultures for bacteria and fungus were negative. He was treated with antituberculous treatment (ATT) for 6 months. Six weeks after the initiation of therapy, the existing lesions showed healing [Figure 1c].

Papulonecrotic tuberculids (PNTs) are characterized by recurrent eruptions of asymptomatic, dusky red papules, which ulcerate and crust, and heal after a few weeks with varioliform scarring.[1] This is explained by the hematogenous dissemination to the skin of mycobacterial antigens from an internal tuberculous focus in a hypersensitive patient.[2] Penile tuberculid is an extremely rare condition with majority of cases reported from Japan and South Africa.[3] A correct diagnosis of PNT on glans can be done on basis of characteristic irregular depressed scars, histopathological finding of tuberculous granuloma, and a good response to ATT.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

Research quality and ethics statement
The authors followed applicable EQUATOR Network (https://www.equator-network.org/) guidelines, notably the CARE guideline, during the conduct of this report.

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Conflicts of interest
There are no conflicts of interest.

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Figure 1: (a) Multiple ulcers and scar over glans; (b) ulcerated epidermis with wedge‑shaped area of necrosis, surrounded by a poorly formed granulomatous infiltrate composed of lymphocytes and macrophages (H and E, ×10); (c) posttreatment
Sir,

Malaria is a worldwide disease with large areas of endemicity in sub-Saharan Africa, Asia, and South America. Caused by infection with *Plasmodium* parasites, malaria affects around 200 million people, resulting in more than 400,000 deaths each year.

A 31 year old gentleman, was presented with high-grade fever with chills and rigor of 2 weeks duration, nonproductive cough with acute onset of breathlessness for 10 days. Modified Medical Research Council (MMRC) Grade 2 which was progressed to MMRC, Grade 4 and required noninvasive ventilation.

Blood investigations showed neutrophilic leukocytosis, thrombocytopenia (platelet: 54,000/µL), and arterial blood gas (ABG) suggestive of mild acute respiratory distress syndrome (ARDS). Chest X-ray showed features of ARDS [Figure 1].

Peripheral smear showed a normocytic normochromic blood picture with neutrophilic leukocytosis and mild eosinophilia. Trophozoite and schizont forms of *Plasmodium vivax* and few forms of *Plasmodium falciparum* were noted.

He was started on intravenous artesunate, oral primaquine, and other supportive measures. After 5 days of artesunate therapy, he symptomatically improved. Platelet count improved to 1 lakh/µL. Few days later, he got discharged from the hospital in a stable condition.

Malaria is an important curable cause of ARDS. Malaria is transmitted through the bites of infected female *Anopheles* mosquitoes. The symptoms can range from nonlethal uncomplicated malaria with fever, headache, and vomiting, to life-threatening complications, such as cerebral malaria, and malaria-associated ARDS.

Malaria-associated ARDS has been commonly found in patients infected with the *P. falciparum* or *P. vivax*. Malaria ARDS is also reported with other *Plasmodium* species such as *Plasmodium knowlesi*, *Plasmodium ovale*, or *Plasmodium malariae*. [3-5]

The prevalence of ARDS in mixed infection (*P. falciparum* + *P. vivax*) ranges from 2.1% to 3%. [6]

Increased alveolar-capillary permeability, resulting in intravascular fluid loss into the lungs, appears to be the key pathophysiologic mechanism resulting in ARDS. [7]

Initially, we were in a diagnostic dilemma, and investigations showed thrombocytopenia. ABG was suggestive of mild ARDS. Dengue Ns1, IgM, and leptospira IgM were negative, and we did not have a clue to the diagnosis and patient condition deteriorated and required noninvasive ventilation. Later on, his wife gave a travel history to Jizan Province of Saudi Arabia, so we suspected malarial ARDS since it is endemic area. Among travelers returning from endemic areas, malaria should be considered a possible etiology when they present with ARDS. ARDS in malaria is a disease with a high mortality. Early institution of antimalarial treatment can be lifesaving.