An unusual case of giant chancroid ulcer

Sir,

Chancroid is a sexually transmitted infection caused by *Haemophilus ducreyi* with declining incidence. A typical chancroid lesion is characterized by the triad of undermined ulcer edge, purulent dirty gray base and moderate to severe pain. All the three features are present in <50% of the sufferers. There are various variants such as papular, dwarf, transient, follicular, giant, serpiginous, and phagedenic.

A 28-year-old married male presented with painful bilateral groin ulcers of 1-month duration. He denied a history of any extramarital exposure, any ulceration on external genitalia, or any swelling in the groin before the onset of ulcer. There were extensive dermatophytic infection and striae all around the ulcer with history of use of multiple of over the counter topical steroids. Ulcers were around 15 cm × 8 cm × 3 cm, undermined and with necrotic slough [Figure 1]. Grams stain demonstrated gram-negative bacilli and culture, *Escherichia coli*. Biopsy from the lesion showed the characteristic layers seen in chancroidal ulcer—an ulcer covered by a scale crust made of fibrin, necrotic cellular debris, and acute inflammatory cells, below which shows diffusely mixed infiltrate of neutrophils and their nuclear dust along with lymphocytes, plasma cells, and histiocytes; blood vessels under the surface show abundant fibrin and scant leucocytoclasia [Figure 2]. Ulcer characteristics and biopsy findings pointed to the diagnosis of chancroid. Tests were done to rule out HIV, syphilis, and tuberculous ulcer.

The patient was treated with injection ceftriaxone 250 mg intramuscularly daily for 3 weeks and regular

**Figure 1:** Ulcers below and parallel to the inguinal ligament on either groin, with undermined erythematous edges and necrotic slough on base and surrounding skin showing dermatophytic infection and striae

**Figure 2:** (H and E stain, ×10 magnification) Ulcer covered by fibrin, necrotic debris, red blood cells, neutrophils, and their nuclear dust below which there is mixed infiltrate of lymphocytes, neutrophils and their nuclear dust, plasma cells and histiocytes
dressing, oral and systemic antifungals for surrounding dermatophytoses, with clinical healing in 4–5 weeks. Partner evaluation was done and the patient was followed up every month for any recurrence.

A history of sexual intercourse and the formation of painful genital ulcers and the development of unilateral, unilocular, fluctuant bubo, with or without a sinus, are the classic indicators in the diagnosis of chancroid. The primary lesion, rarely seen in clinical practice, is a papule on an erythematous background, which becomes a pustule and then to a painful, soft ulcer with undermined margins. Giant chancroid is a rare variant of chancroid and usually occurs with the disease process, autoinoculation or by rupture of an inguinal bubo. Out of the different variants, transient chancroid is the type where the ulceration resolves rapidly in 4–6 days and is succeeded by acute regional lymphadenitis with suppuration in 10–20 days.[3] Our patient could have had a transient chancroidal ulcer which he could have missed noticing.

Chancroid ulcers pose a great diagnostic difficulty in terms of isolating the organism. A definitive diagnosis of chancroid requires the identification of *H. ducreyi* on special culture media that is not widely available and with sensitivity is <80%.[4] Centers for disease control (CDC) has proposed a diagnostic criteria for chancroid.[5] The CDC recommends azithromycin 1 g orally or intramuscular ceftriaxone 250 mg is the preferred treatment.

**Declaration of patient consent**
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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There are no conflicts of interest.

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**Letters to Editor**

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