Journal of Genital System & Disorders

Image Article

A SCITECHNOL JOURNAL

Scrotal Abscess with Unusual Cause

Bennani M*, Ziani J, Dahouki S, Elloudi S, Baybay H and Mernissi FZ

Mernissi Department of Dermatology, University Hospital Hassan II of Fez, Fes 30050, Morocco

***Corresponding author:** Bennani M, Department of Dermatology, University Hospital Hassan II of Fes 30050, Morocco, Tel: +212660120505; E-mail: mouniaabennani24@gmail.com

Received date: August 13, 2019; **Accepted date:** August 26, 2019; **Published date:** September 04, 2019

About the Case

A 25-years-old patient, with no notable pathological antecedents, and no notion of unprotected sexual intercourse admitted for a scrotal swelling evolving for 3 days, very painful, in a febrile context. It should be noted that the patient was living in a dormitory and had poor hygiene.

The dermatological examination revealed a renitent swelling located at the base of the penis, left lateralized, painful on palpation (Figure 1 arrows), and the penis was oedematous and infiltrated, unable to stay right (Figure 2).

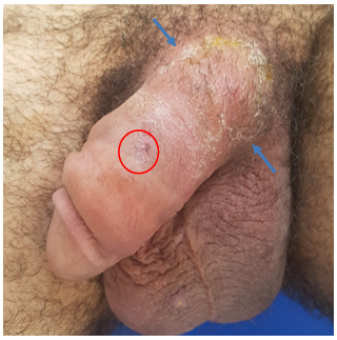

Figure 1: Image showing renitent tumefaction at the base of the penis (Arrows), with excoriated papules in the body of the penis (circle).

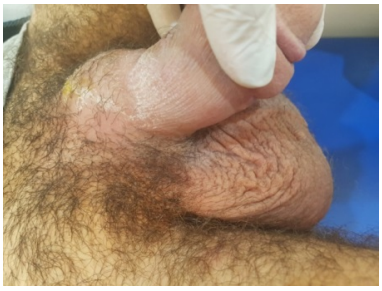

Figure 2: Profile view showing that the scrotal mass is responsible for fixity of the penis and its viscous attitude.

In addition, the patient complained about a generalized pruritus, involving the external genital tract, accentuated by night. At the dermatological examination, 2 small excoriated papules in the body of the penis, were spotted, and one of which was surmounted by hemorrhagic crust (Figure 1, circle)

The dermoscopy at one of these two papules objectified the presence of the scabious groove, at the end of which we found the deltaplane sign, evoking a scab (Figure 3).

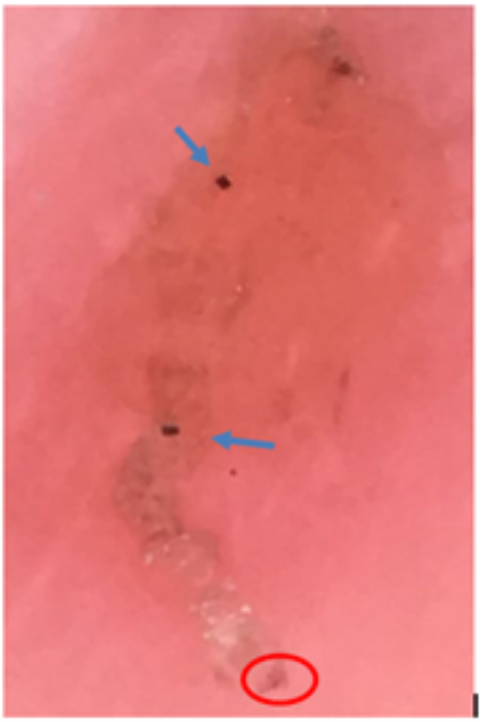

Figure 3: dermoscopic image of a penis papule showing a scabious groove (arows) with the 'delta' sign at his end (circle).

Ultrasound of scoratele tumefaction is back in favor of a scrotal abscess, and the diagnosis was a scrotal abscess secondary to a scabious chancre. The patient had the abscess drained, then treated with antibiotics based on amoxicillin-clavulanic acid, and benzyl benzoate associated with the hygienic rules for the treatment of scabies. A good improvement was seen after 7 days, with disappearing pruritus, and drying up of pus.

Scabies is an infectious disease caused by infestation with the parasite Sarcoptes scabiei var. hominis. The infestation occurs by skin-to-skin contact including sexual contact or, less commonly, by contact with infested fomites [1].

Classical scabies a occurs in patients with normal immune response; it manifests itself by : intense pruritus which is worse at night and gives disseminated erythematous papules on the periumbilical area, waist, genitalia, breasts, buttocks, axillary folds, fingers (including interdigital spaces), wrists and extensor aspects of the limbs. And sometimes nodules firm, 0.5 cm in diameter, usually on the male genitalia, who can sometimes be sexually transmitted performing scabies chancre, poor hygienic conditions may result in secondary bacterial infection as is the case with our patient [2].

Dermoscopic examination allows positive diagnosis, by identifying skin burrows, mites (the 'delta' sign at the end of the burrow represents the anterior body of the adult female mite), eggs and can orientate the site of skin scrapings [3].

Several treatments have been used for scabies, Benzyl benzoate lotion 10%–25% applied once daily at night on 2 consecutive days with re-application at 7 days, is among the first-line treatment before a classics scabies with level of evidence IV; grade C recommendation [4,5] and it was the treatment preconized in our patient, given its accessibility and low cost.

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