IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 16, Issue 10 Ver. IV (Oct. 2017), PP 01-03
www.iosrjournals.org

Non venereal genital dermatoses in men –A study of 100 cases

*Dr.Karunakaran
Professor, Department of Dermatology &Venereology,, Government Mohan Kumaramangalam Medical College & Hospital, Salem.
Correspondence author: Dr.Karunakaran

Abstract
Background:
Aims And Objectives Of The Study: To study the clinical pattern, aetiological factors, percentage of various non-venereal genital dermatoses and to assess which dermatoses have a predilection for external genitalia or as a part of generalized involvement.
Materials & Methods: *A series of 100 adult patients with non-venereal dermatoses of the external genitalia were screened amongst male patients attending skin and venereal disease OPD at Government Mohan Kumaramangalam Medical College & Hospital, Salem India over a period of 12months.Patients having age below 13 years were excluded from the study.*
Results: *The majority of patients (78%) were in age group of 21-50 years and which constitutes about bulk of total patients.pearly penile papules , venereophobia are the most commonly occurring non venereal dermatoses in men.*
Conclusion: *The commonest presenting symptoms were pearly penile papules (30%).The study has been quite useful in understanding the clinical and aetiological characteristics of various types of non-venereal dermatoses in men.*
Keywords: *non venerereal dermatoses, pearly penile papules, venereophobia*

Date of Submission: 14-09-2017 Date of acceptance: 10-10-2017

I. Introduction

Non - venereal Skin problems are common in genitourinary clinics. However, careful dermatological history taking, complete cutaneous examination, and sometimes a skin biopsy usually allow accurate diagnosis and satisfactory medical and surgical management in most case

II. Materials And Methods

100 male patients with non-venereal dermatoses of the external genital attending skin and venereal disease OPD at *Government Mohan Kumaramangalam Medical College & Hospital, Salem India over a period of 12months.*Patients having age below 13 years were excluded from the study.
The clinical diagnosis was confirmed with laboratory procedures like microscopy
(KOH preparations, Tzanck smear) and histopathological evaluation whenever necessary.

III. Discussion

Non - venereal Skin problems are common in genitourinary clinics. However, careful dermatological history taking, complete cutaneous examination, and sometimes a skin biopsy usually allow accurate diagnosis and satisfactory medical and surgical management in most cases.

NORMAL VARIANTS:

Skin tags, naevi, non- viral papillomas, comedones and hemangiomas may be regarded as normal variants and are frequently found in the genital area.(1,2)

Sebaceous gland prominence, Tyson glands, sebaceous hyperplasia, ectopic sebaceous glands are common normal variants of the skin of the scrotal sac and penis. Pearly, pink penile papules are common and may be found in up to 15-20 % of men presenting as flesh colored, smooth, rounded papules (1-3mm)occurring predonminantly around the coronal margin of the glans, often arranged in rows or rings.

Approximately 35% men will have pearly penile papules in the third decade of their life. They can be mistaken for warts by both patients and physicians and are a reason for anxiety for adolescent boys and young adults. In some studies, a relationship with human papillomavirus has been suggested; however, in later work it has been repeatedly confirmed that there is no casual relationship.

Angiokeratomas (of Fordyce) are less commom and are blue to purple, smooth papules on the scrotum orpenile shaft that appear and multiply during life.

PEDICULOSIS:

Pediculosis pubis or public lice (crabs) can cause severe pubic and genital with little in the way of physical sings unless the hairs are examined very carefully for nits and the base of individual hairs searched with a hand lens for the louse(1-2 mm in size). Sometimes grey – blue maculae caerulae are seen. Classically, there is an itchy eczematous eruption with lichenification, excoriations, and secondary impetiginisation. In hairy men, the abdomen, chest, axillae, and thighs are also involved.

SCABIES:

Itch is a predominant symptom of this infestation with the mite sarcoptes scabei. It can be intense and characteristically keeps patients awake at night. Usually, there is a rash of diagnostic distribution and morphology. Some patients with chronic scabies may have itch in the anogenital region only.

BURNING SCROTUM SYNDROME:

In this genital dysesthesia syndrome, patients report itching or burning of the genitialia or scrotum, and complain of persistent or variable redness of the scrotal skin. (3-7)

There may be no signs or a striking erythema may present. The possibilities of misuse of topical steroids, scrotal rosacea urticaria, dermographism, glucagonoma and of zinc deficiency should be considered.

V**ITILIGO**:

Vitiligo follows loss of melanocytes probably due to autoimmune destruction. The genitalia are very commonly affected in men and it is quite unusual for the genitalia to be the only site involved. Wood's light demonstrates the contrast between the normal and the pigmented skin.

LEUKOPLAKIA:

This is a term used for a white patch or plaque. It is vital to separate vitiligo, post-inflammatory hypopigmentation, lichen sclerosus, warts, and penile carcinoma in situ (PCIS).

LENTIGINES:

Pigmented macules appear on the glans and shaft of the penis. They are usually benign. Occasionally, they may be large, with irregular edges, multifocal, variegated pigmentary patterns, arousing concern about atypical melanocytic profiferation and scral lentiginous meloanoma. Under these circumstances, they should be biopsied.(8)

IRRITANT CONTACT DERMATITIS:

The irritant should be identified and eliminated or reduced. Advice must be given about soap substitutes, mousturizers, towels and toilet paper. Topical corticosteroid ointments with or without antibiotic and anticandidal agents are employed to control the local disease.

ALLERGIC CONTACT DERMATITIS:

This comes about by contact induced type IV cell mediated hypersensitivity after prior sensitization to the agent concerned. The symptoms are Pain, burning or itching and the sings are of acute - erythema, swelling, vesiculation or chronic - erythema, scaling and lichenification eczema appearing about a week after first contact with the allergen, or within a few hours or longer if already allergic.

ATOPIC DERMATITIS:

Atopic dermatitis (AD) is a common dermatosis, and is associated with a personal and familial predisposition to dry skin and other atopic diseases such as rhinitis, asthma, and conjunctivitis. Twenty percent of the population may be atopic and upto 10% of children may get atopic eczema presenting as itchy, red scaly lesions on the face and flexures from the age of about 2 months.

LICHEN SIMPLEX:

Lichen simplex presents as itchy, red patches or plaques of lichenified skin and is common on and around the male genitalia including the penile shaft and scrotum.

ZOON PLASMA CELL BALANITIS:

Zoon plasma cell balanitis is a disease of the uncircumcised man. It does not occur on the keratinized penile shaft or foreskin of an uncircumcised men and it not seen in circumcised men at all.

FIXED DRUG ERUPTION:

Fixed drug eruptions (FDE) are red, swollen plaques sometimes with central blister formation, erosion, and ulceration. The symptoms are itch or burning. The genitalia are classical sites for this, are the face and extremities. Healing is with post – inflammatory hyperpigmentation.

CANDIDOSIS:

Candidosis (thrush) presents as an intertrigo or balanoposthitis. Burning and soreness are more likely than itch. Coalescent red patches or plaques involve the often with superficial erosions. Pustulosis may extend our onto the skin of the abdomen, buttocks or thighs from the irregularly marginated intertriginous lesions. Medical causes include diabetes mellitus, iatrogenic immunosuppression, and systemic antibiotic treatment. Although it is indisputable species responsible. Tinea is a common disease of the pelvic girdle especially of the groins and is not always spread from the feet.

HIDRADENITIS SUPPURATIVA:

Painful genital skin involment with fibrous bridges, comedones, folliculitis, furunculosis, deep discharging sinuses, nodules, cysts, and scars in the groins and axillae is pathognomonic. The disease may involve the natal cleft and buttocks. It is more common in black subjects. It affecta the axilla preferentially in women and the perineum in men.

SQUAMOUS CELL CARCINOMA:

Itch, irritation, pain, bleeding, discharge,ulceration or the discovery of a lump reveal squamous cell carcinoma.(9)

Conclusion

Pearly penile papules (30) are the most common non venereal dermatoses in men.Venereophobia (15%), pruritus (17%), sore (12%) and growth (11%). Inflammatory disorders comprised about more than half of the cases (58%), infection and infestation (23%), benign tumors and cysts (11%), pigmentary disorders (7%). The commonest genital dermatoses was psoriasis (17%) followed by superficial dermatophytosis (16%), stevens-johnson syndrome (7%), pemphigus vulgaris (7%), steatocystoma multiplex (5%) and vitiligo (5%)squmous cell carcinoma 1%.

References

[1]. Bunker CB, Neil SA. The genital perianal and amblical regions. In T Burns, S Breathnach, N Cox C Griffiths, eds. Rook's Text book of Dermatology 8th ed. New York: Wiley-Blackwell; 2010;71:1-102
[2]. Bunker CB. Male Anogenital Skin Disease. Londan: Saunders,2004
[3]. Bunker CB. Topics in penile dermatology. Clin Exp Dematol 2001 ;26:469-79.
[4]. Bunker CB, Neil SA. The genital perianal and umblical regions. In T Burns, S Breathnach, N Cox C Griffiths, eds. Rook's Text book of Dermatology 8th ed. New York: Wiley-Blackwell; 2010;71: 1-102
[5]. Bunker CB. Male Anogenital Skin Disease. Londan: Saunders,2004
[6]. Fisher BK. The red Scrotum syndrome Cutis 1997; 60; 139-141.
[7]. Markos AR. The male genital skin burning syndrome (Dysaesthetic Peno Scroto- dynia). Int J STD AIDS 2002; 13:271-2.
[8]. Abbas O, Kibbi AG, Chedraoui A, Ghosn S. Red scrotum Syndrome: successful treatment with oral doxycycline. J Dermatol Treat 2008;19:1-2.
[9]. Kaporis A, Lynfield Y. Penile Lentiginosis J. M Acad Dermatol 1998; 38:781.
[10]. Micali G, Nasca MR, Innocenzi D, Schwartz RA. Penile cancer. J Am Acad Dermatol 2006; 54;369-91.

*Dr.Karunakaran. "Non venereal genital dermatoses in men –A study of 100 cases." IOSR Journal of Dental and Medical Sciences (IOSR-JDMS) 16.10 (2017): 01-03