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Fournier's Gangrene: a Case Report

Sir,

Fournier's gangrene is a rare necrotizing fasciitis of the genitalia, characterized by acute onset in healthy young males and by rapid progression (1). At present, its cause is ascribed to a synergistic polymicrobial infection. Individuals suffering from diabetes and chronic alcoholism are mainly affected, and the disease appears to have a mechanism connected with hypersensitivity, like Shwartzman phenomenon (2).

CASE REPORT

A 52-year-old debilitated alcoholic man with cirrhosis following hepatitis C infection and hypersplenism was referred to us by a surgeon for massive swelling and erythema with skin necrosis localized in the right thigh, hip, groin and genitalia (Fig. 1). There was no scrotal or inguinal crepitus. The condition had first appeared in the groin some days after crosssectionomy for chronic venous insufficiency of the lower limbs and had progressed rapidly. Laboratory tests showed an erythro-

cyte sedimentation rate of 29 mm/h, and increased fibrinogen and α_2 globulin. Thrombocytopenia was present. Ecography of the scrotum showed hypoechoic tissue with indistinct margins. Microbial culture from the infected site gave a mixed growth of *Pseudomonas maltophilia* and *Escherichia coli*.

A broad-spectrum antibiotic therapy, consisting of meropenem, metronidazole, teicoplanin and ceftazidime, was administered according to antibiotic sensitivity testing and chemical progression, together with a supportive therapy with albumin, phytomenadione and antithrombin.

Surgical debridement was performed and topical medication with rifamicin solution and gentamycin cream was applied. Resolution of the disease, leaving scarred skin, occurred within 2 months (Fig. 2).

DISCUSSION

About 400 cases of Fournier's gangrene have been reported. It is more common in males (85%) than females. Its progression is rapid and it is lethal in 20–30% of cases. The condition is



Fig. 1. Skin necrosis in the right groin, thigh and genitalia.



Fig. 2. Resolution of the disease with skin scarring after 2 months.

often preceded by an infectious inflammatory or neoplastic genitourinary or colorectal pathology, or by surgery or other surgical procedures in these sites.

Fournier's gangrene has been described following various anogenital injections as well as mechanical, chemical and thermal trauma. Predisposing factors are debilitating chronic pathologies, diabetes and immunodeficiency. Sonographic characteristics include thickening of the scrotal skin and sometimes gas in the subcutaneous tissues (3). Although originally considered idiopathic, this syndrome is now known to be caused by a synergistic polymicrobial infection.

The scrotal area is the first site of involvement. The testes and the skin of the anal margin are spared since they have an alternative blood supply. Recent observations suggest that a local Schwartzman phenomenon might have an important role in the pathogenesis (4). Response to corticosteroid therapy might confirm the pathogenetic immunoallergic hypothesis (2).

The most serious complications are septicaemia and disseminated intravascular coagulation.

The introduction of new antibiotics has not significantly reduced mortality (5).

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Buschke-Loewenstein Tumour is not a Low-grade Carcinoma but a Giant Verruca

Sir,

Buschke-Loewenstein tumour is a giant condyloma that is clinically malignant despite its benign histopathological features. In this report we present a case of a neglected Buschke-

Loewenstein tumour which is the largest in the published literature.

CASE REPORT

A 50-year-old male patient presented in November 1996, with a giant genital warty lesion, which had been present for 20 years. The lesion, initially localized in the left inguinal region, had gradually increased in size over the years. The patient finally sought medical attention because of increased size, bleeding and pus drainage from the huge mass, which made coitus practically impossible. Examination revealed a cauliflower-like tumour, 38 × 11 cm in size, centred in the left inguinal fold and extending to the perianal region and mons pubis (Fig. 1). Dermatopathological examination of H & E sections revealed marked hyperkeratosis, acanthosis and papillomatosis of the epidermis. Hypergranulosis with coarse keratohyaline granules and some koilocytes were present in the superficial layers of the epidermis consistent with Buschke-Loewenstein tumour. Slight crowding and atypia in the keratinocytes were present within several high power fields, although in general dermatopathological features were consistent with ordinary condyloma. Immunohistochemistry with streptavidin biotin peroxidase technique (Biogenex) using polyclonal HPV antibodies failed to reveal positive staining.

The patient was treated with wide surgical excision, which provided satisfactory functional and cosmetic results.

DISCUSSION

Buschke-Loewenstein tumour occurs predominantly in uncircumcised men, often below 50 years of age. It is usually localized to the glans penis, vulva, perineum and perianal region (1–3). In 1948, Ackerman described a similar neoplasm of the oral mucosa and used the term verrucous carcinoma to describe locally aggressive, exophytic, low-grade squamous



Fig. 1. The giant condyloma, 38 × 11 cm in diameter.