BRIEFS

CHANCROID: A REVIEW FOR THE FAMILY PRACTITIONER

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Chancroid, as the name implies, is like a chancre. Unlike the painless chancre of syphilis, it is painful, darkfield negative, and does not respond to penicillin therapy. The number of cases have continued to rise in recent years. Because it can cause irreversible anatomical destruction, making the correct diagnosis is important and can prevent chronic morbidity. (*J Natl Med Assoc.* 1991;83:724-726.)

Key words • chancroid • sexually transmitted disease • darkfield

Chancroid is a sexually transmitted disease caused by the bacterium *Haemophilus ducreyi*. It stains positive on Gram's stain, and very few white cells are seen.

Few cases have been reported in the United States over the past 10 years; however, a dramatic increase in reported cases has occurred during the past 2 years. In 1980, a total of 788 cases of chancroid were reported; in 1986, 3045; and in 1987, 4998 (Unpublished data. Centers for Disease Control.). Little attention is given to this condition for a number of reasons, primarily because of the emphasis on acquired immunodeficiency syndrome (AIDS), and secondly, gonorrhea, chlamydia, and syphilis are much more prevalent in the United States today.

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This article reviews chancroid to help practitioners be more aware of its clinical presentations.

Chancroid has an incubation period of 3 to 5 days (Unpublished data. Centers for Disease Control). A small inflammatory papule develops and becomes postular, resembling the syphilis chancre. The classic chancroid is superficial, shallow, painful, and has a ragged edge. The base is covered by necrotic tissue and bleeds easily if debrided. In contrast with the syphilis chancre, the chancroid lesion is painful, tender, and not endurated.

Pain occurs on the areas surrounding the lesion, as well as on the lesion itself. There is rarely any discharge. Sometimes, an infected syphilis chancre can also be painful. Diagnosis can be easily differentiated. The darkfield will be positive in syphilis and negative in chancroid. A Gram's stain will be positive in chancroid, showing gram-positive organisms with very few white cells. Again, the VDRL and FTA are positive in syphilis and negative in chancroid. Concurrent with this would be the development of bubos. These are very large painful swellings in the inguinal area. The lymphadenopathy of chancroid is very noticeable, particularly in the inguinal area. It is not uncommon to have lymphadenopathy the size of a lemon or even an orange (Figures 1-3). Chancroid is painful, and when it reaches this stage, the patient quite often is febrile.

CASE REPORTS

Case 1

A 22-year-old man presented with massive lymphadenopathy. On physical examination, a painful sore

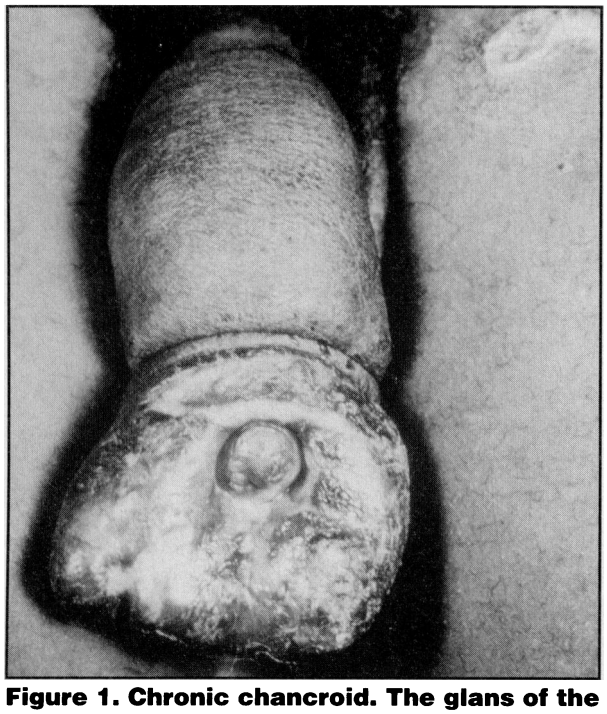

Figure 1. Chronic chancroid. The glans of the penis is nearly destroyed, and treatment required long-term (6 months) therapy. This patient needed plastic surgery to provide a cosmetically acceptable organ. (Photograph courtesy of the Centers for Disease Control, Venereal Disease Branch.)

on the glans of the penis was found. The lymphadenopathy was unilateral and 6 cm in diameter. He was afebrile. The patient was treated with erythromycin 500 mg (four times a day) and co-trimoxazole double strength tablets (one tablet twice daily), both for 10 days. He responded very well and was completely cured.

Case 2

This patient was the brother of the patient in case 1 and had had sexual contact with the same female. He had been seen previously and was misdiagnosed as having a *Staphylococcus* abscess. A chancre was noted and was thought to be syphilis. He was treated with 2.4 mU of penicillin G benzathine IM as well as 600 000 units IV every day and 1 g of cefazolin sodium. There was no response. The patient was seen by an infectious disease consultant who diagnosed chancroid. He was treated with co-trimoxazole, 10 cc IV, every 6 hours. He became afebrile in 24 hours. He was discharged on an oral regimen of co-trimoxazole, double strength, one tablet twice a day for 9 days.

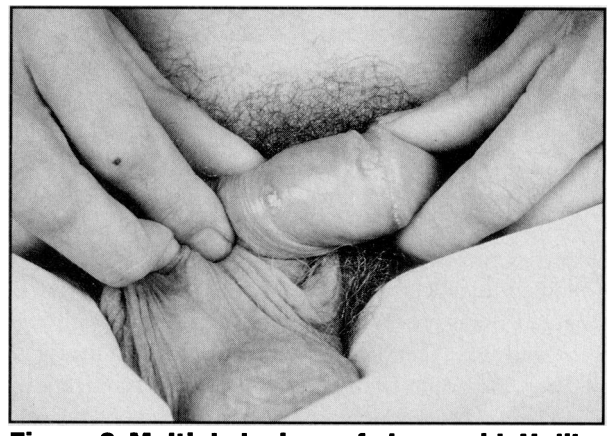

Figure 2. Multiple lesions of chancroid. Unlike syphilis, chancroid lesions may be multiple and painful.

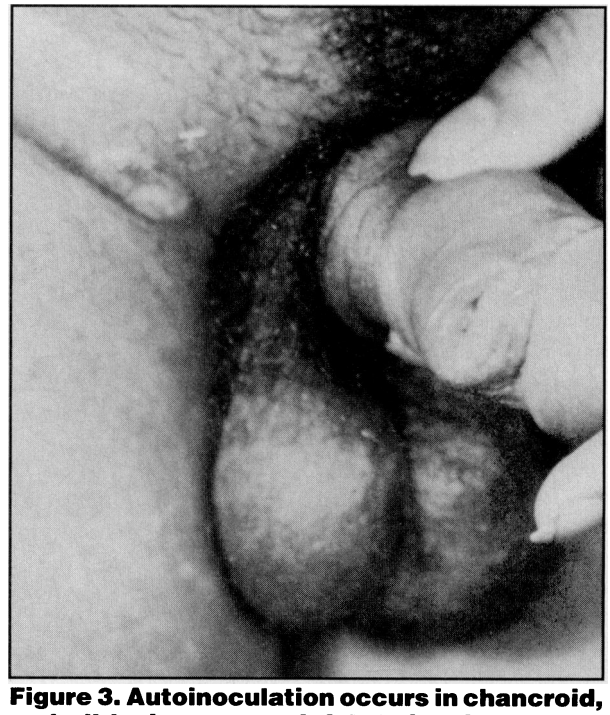

Figure 3. Autoinoculation occurs in chancroid, and all lesions are painful. This will become more anatomically distorted if not treated appropriately.

Case 3

A 22-year-old woman was admitted with a painful swollen left inguinal area as well as left labial swelling. Upon examination, she had a painful chancre-like lesion in the center of the left part of the labia. She had been treated with penicillin G benzathine 2.4 mU and had been hospitalized because her temperature ranged from 103°F to 104°F daily. She was diagnosed as

having chancroid and treated with IV co-trimoxazole and effervesced on the second day of treatment. She was discharged on an oral regimen for 12 days. The patient recovered completely and had no sequelae.

Case 4

A 41-year-old man was HIV-positive, but a reverse helper suppressor:ratio showed no symptoms of AIDS. The initial diagnosis was oral herpes with lesions on the tongue. He was previously treated with IV acyclovir for 1 week and had taken oral acyclovir unsuccessfully for 2 weeks prior to the IV therapy. On further examination, the patient was found to have two nonhealing oral lesions that were crater-like with no purulent drainage. Gram's stain revealed gram-positive organisms but no white cells. A culture confirmed *H ducreyi*. The patient was treated with co-trimoxazole orally and responded very well.

TREATMENT

The treatment of choice in early cases of chancroid is erythromycin 500 mg orally four times a day for 10 to 14 days or co-trimoxazole one tablet twice a day for 10 to 14 days. In patients who have been hospitalized because of debilitating lymphadenopathy and fever, IV co-trimoxazole 10 cc every 6 hours is the treatment of choice. In most cases, patients should have a quick response and can be discharged within 1 to 2 days. They must take oral medication for the remaining 8 or 9 days.

It is important that the physician should consider and recognize chancroid. Many laboratories do not culture *H ducreyi*, and it is likely to be missed. If someone presents with a large palpable inguinal node, it is best to aspirate and not do an incision and drainage. If a painful chancre is present, the physician should be suspicious of chancroid. Chancroid becomes chronic and progresses. It does not disappear if untreated or if treated incorrectly for syphilis or some other disease.

If a patient has been treated for syphilis and the lesion remains after 1 week, then chancroid should be considered. Reexposed syphilis should not cause the same lesion to remain. The one instance in which the physician has to be careful is with an HIV-positive person. HIV-positive individuals with syphilis may require more aggressive and longer therapy (Table).

TABLE. EVALUATION OF CHANCROID VERSUS SYPHILIS

Symptom	Chancroid	Syphilis
Chancre initially present	+	+
Initial chancre is painful	+	×
Chancre remains after treatment with penicillin G benzathine	+	×
Ingiunal adenopathy present	+	+
Unilateral large inguinal adenopathy	+	×
Responds to treatment with co-trimoxazole or erythromycin	+	×