Perianal Irritant Contact Dermatitis In High Anal Fistula

Pankaj Srivastava Dr.*

*Om Surgical Center & Maternity Home, drpankajbns@gmail.com

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Abstract

We report fulminant irritant contact dermatitis (ICD) affecting perianal area in a 36-year-old male with high anal fistula. ICD is usually associated with hemorrhoids and anal fissures. Anal fistula rarely causes perianal dermatitis.

KEYWORDS: Irritant dermatitis, contact dermatitis, anal fistula, perianal dermatitis
INTRODUCTION

Irritant contact dermatitis (ICD) is an inflammation of the skin typically manifested by erythema, mild edema, and scaling. ICD is a nonspecific response of the skin to direct chemical damage that releases mediators of inflammation predominately from epidermal cells. The irritants cause the immediate death of epidermal cells as manifested by chemical excoriation and cutaneous ulcers. ICD is commonly associated with hemorrhoids and anal fissures (1-2) but rarely seen with anal fistula (3).

CASE DETAILS

A 36-year-old male presented with a history of pus discharge through a perianal opening for the last 4 years. Two years before, he also developed a slowly growing exuberant skin lesion in his perianal area particularly in the right side. The lesion was well demarcated and exudative. The perianal area became lichenified and appeared white with fine fissures. The lesion was mirror imaged to the left side also.

On examination, the lesion was well defined with sharp edges [Figure-1]. The surface was wet and uneven due to presence of multiple vesicles and ulcers. Many cracks or fissures were also present. Skin over the surrounding area was normal. There was no such skin lesion found anywhere else. One opening of anal fistula was also detected at the 11 O’ clock position, 2 cm away from the anal margin. On probing, the internal opening of the fistula was negotiated above the Hilton’s line. It was classified as high anal variety. There was constant pus discharge through the external opening of the fistula.
Biopsy from the lesion showed hyperkeratosis with areas of parakeratosis, moderate-to-marked epidermal hyperplasia (acanthosis), and elongation of the rete ridges. Some areas also showed superficial ballooning, necrosis and neutrophil infiltration.

Blood profile revealed normal cell count and hemoglobin. ESR was 14 mm/hr. Other routine investigations, urine analysis, and serum chemistry were found to be normal. HIV and Mantoux tests were negative. Fistulogram confirmed the clinical diagnosis of high anal fistula.

The anal fistula was treated with the medicated seton therapy. The skin lesion was simultaneously treated with oral antibiotics, antihistaminics, and topical corticosteroid preparations. The luke warm sitz bath was also applied twice daily throughout the treatment. There was complete remission of skin lesion after 3 months.
DISCUSSION

This case was presented because of its rarity and the fact anal fistula can cause irritant contact dermatitis in the perianal skin due to persistent discharge of pus through the external opening. The most probable mechanism of the dermatitis could be deposits of the pus mixed with mucus and microscopic stool contents onto the perianal skin.

REFERENCES