

198e-2 include chronic inflammation with infiltration of plasma cells and neutrophils. Epithelial changes include ulceration, microabscesses, and elongation of rete ridges.

A diagnostic polymerase chain reaction (PCR) test was based on the observation that two unique base changes in the *phoE* gene eliminate HaeIII restriction sites, enabling differentiation of *K. granulomatis comb nov* from related *Klebsiella* species. PCR analysis with a colorimetric detection system can now be used in routine diagnostic laboratories. A genital ulcer multiplex PCR that includes *K. granulomatis* has been developed. Serologic tests are only poorly specific and are not currently used.

The differential diagnosis of donovanosis includes primary syphilitic chancres, secondary syphilis (condylomata lata), chancroid, lymphogranuloma venereum, genital herpes, neoplasm, and amebiasis. Mixed infections are common. Histologic appearances should be distinguished from those of rhinoscleroma, leishmaniasis, and histoplasmosis.

TREATMENT DONOVANOSIS

Many patients with donovanosis present quite late with extensive ulceration. They may be embarrassed and have low self-esteem related to their disease. Reassurance that they have a treatable condition is important, as is the need to administer antibiotics and monitor patients for an adequate interval (see below). Epidemiologic treatment of sexual partners and advice about how to improve genital hygiene are recommended.

TABLE 198e-1 EFFECTIVE ANTIBIOTICS FOR THE TREATMENT OF DONOVANOSIS

Antibiotic	Oral Dose
Azithromycin	1 g on day 1, then 500 mg daily for 7 days or 1 g weekly for 4 weeks
Trimethoprim-sulfamethoxazole	960 mg bid for 14 days
Doxycycline	100 mg bid for 14 days
Erythromycin	500 mg qid for 14 days (in pregnant women)
Tetracycline	500 mg qid for 14 days

The recommended drug regimens for donovanosis are shown in **Table 198e-1**. Gentamicin can be added if the response is slow. Ceftriaxone, chloramphenicol, and norfloxacin are also effective. Patients treated for 14 days should be monitored until lesions have healed completely. Those treated with azithromycin probably do not need such rigorous follow-up.

Surgery may be indicated for very advanced lesions.

CONTROL AND PREVENTION

Donovanosis is probably the cause of genital ulceration that is most readily recognizable clinically. Donovanosis is now limited to a few specific locations, and its global eradication is a distinct possibility.