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# A case of syphilitic anal condylomata lata mimicking malignancy

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ABSTRACT

*INTRODUCTION:* Condylata lata in secondary syphilis is well known presentation and needs to be considered in differential diagnosis of perianal lesions. In England between 2013 and 2014 the overall incidence of infectious syphilis increased by 33% and is mainly seen in men who have sex with men.
*PRESENTATION OF CASE:* We report the management of a 49-years-old Caucasian homosexual man with perianal lesions that were suspicious of malignancy. After biopsies, colonoscopy, staging with computed tomography, magnetic resonance imaging and syphilis serology anal cancer was excluded and a diagnosis of syphilis was confirmed. He was referred to the sexual health clinic for the appropriate investigations and treatment.
*DISCUSSION:* This case highlights the consideration of treatable infectious syphilis pathology. The main differential diagnosis of perianal growths to consider is condylomata acuminata (warts caused by human papillomavirus), anal cancer, syphilis, chancroid, haemorrhoids, tuberculosis and lymphogranuloma venereum. To differentiate a biopsy is needed for histopathological examination. A dense plasma cell infiltrate and numerous spirochetes visualised by immunostaining confirms condylomata lata.
*CONCLUSION:* In UK, it is important for colorectal surgeons to be aware of syphilitic condylomata lata and consider this when dealing with perianal lesions. It is advisable to refer patients suspected of or diagnosed with syphilis to sexual health clinics to help improve outcome. In sexual health clinics additional investigations and treatment are available in addition to partner notification and follow-up can be offered.


## 1. Introduction

In England between 2013 and 2014 the overall incidence of infectious syphilis increased by 33% and is mainly seen in men who have sex with men [1]. Syphilis is the "great imitator" of skin diseases. There are 4 overlapping stages of syphilis commonly referred to as primary syphilis, secondary syphilis, latent syphilis, and tertiary syphilis. These stages are characterized by unique symptoms and clinical manifestations. In secondary syphilis genital lesions range from macules to condylomata lata. We report a case of condylomata lata, which presented to the surgical unit with suspected anal malignancy.

## 2. Presentation of case

A 49-years-old homosexual was referred to the colorectal clinic under the 2-weeks rule with a suspicion of anal cancer. He presented with perianal pain and peri-anal skin changes. He also had change in his bowel habit with diarrhoea and faecal incontinence. He had noticed some fresh blood on the toilet paper. He had loss of appetite with no weight loss. His past medical history was unremarkable. He was not taking any medication. Peri-anal examination revealed a 3 × 1 cm ulcerated tumour in the 12 o'clock position and a hard nodule at the 9 o'clock position (Fig. 1). He had biopsy of the lesion under local anaesthesia. His colonoscopy was normal to terminal ileum. Abdominal computed tomography scan showed a simple liver cyst with no other pathology. Pelvic Magnetic resonance imaging confirmed an anal nodule with incomplete examination distally. Initial biopsies showed an ulcerated plasma cell rich inflammation without definite mass effect suspicious of syphilitic lesion. He underwent repeat biopsy after multi-disciplinary team discussion that confirmed reactive epithelial changes, ulceration with fibrin, acanthosis, and prominent intraepithelial neutrophils with prominent dermal plasmacytic

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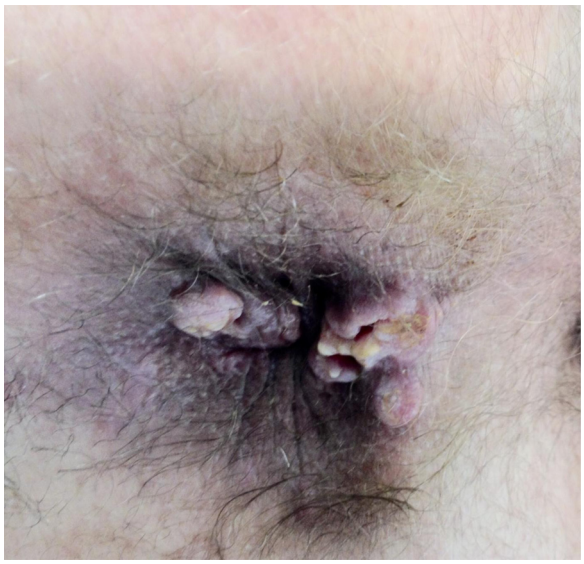

**Fig. 1.** Condylomata lata.

infiltrate. There was no evidence of granulomas, fungal hyphae or herpetic viral inclusions. There were no convincing features of obliterative endarteritis but in view of the marked plasma cell infiltrate, syphilis was a likely possibility (Fig. 2, a and b). The diagnosis was confirmed by serological testing with *Treponema pallidum* specific enzyme immunoassay, IgM Elisa, Serodia particle 1:1280 and the Venereal Disease Research Laboratory test (VDRL) 1:16, HIV-1 and HIV-2 serology were both negative. He was given benzathine penicillin 2.4 MU intramuscularly weekly for two weeks (three doses). He was also vaccinated for Hepatitis B. He failed to attend for his follow up appointments.

## 3. Discussion

Condylomata lata is not a rare entity and commonly described in the literature. It is worth considering as a possible aetiology. Squamous cell carcinoma of the anal margin or perianal skin is relatively uncommon. The main differential diagnosis of perianal growths to consider is condylomata acuminata (warts caused by human papillomavirus), anal cancer, syphilis, chancroid, haemorrhoids, tuberculosis and lymphogranuloma venereum [2,3]. Condylomata lata are the lesions of secondary syphilis. They are flatter, paler, and smoother than condylomata acuminata. Their surface erodes and is covered in a greyish, mucoid exudate. Anal squamous cell carcinoma is generally painful and may be tender and ulcerated where condylomata lata are not tender or ulcerated. To differentiate a biopsy is needed for histopathological examination. A dense plasma cell infiltrate and numerous spirochetes visualised by immunostaining confirms condylomata lata.

The common manifestations of secondary syphilis are rash (75–100%), lymphadenopathy (50–80%) and mucocutaneous lesions like mucous patches and condylomata lata (40–50%) [3,4]. Other symptoms common at this stage include fever, sore throat, malaise, weight loss, headache, meningismus and enlarged lymph nodes. Rare manifestations that occur in about 2% of patients include acute meningitis, hepatitis, renal disease, hypertrophic gastritis, patchy proctitis, ulcerative colitis, recto sigmoid mass, arthritis, periostitis, optic neuritis, interstitial keratitis, iritis and uveitis.

Condylomata lata are the most infectious skin lesions in syphilis as measured by the concentration of treponemes in the exudated serum. Less commonly, they can become huge, cauliflower-like and rarely, pedunculated. The common sites for condylomata lata are the genital and anal areas where the condylomas are usually smooth and moist [3,4]. In the modern era condylomata lata are commoner in sites adjoining chancres [5], so may be spread by direct contact rather than vascular dissemination. Patients with a previous history of syphilis are more likely to present with condylomata lata [6].

In our patient, a very high index of suspicion and sexual history may have helped to consider condyloma lata as the diagnosis. The first-choice treatment for all manifestations of syphilis remains penicillin. For people known to have allergic manifestations to penicillin, alternatives like doxycycline or tetracyclines have been used. On treatment the rash resolves first; it may take a few months for condyloma lata and about a year for moth-eaten alopecia to resolve completely. We would expect resolution of our patient's symptoms but this could not be confirmed, as he did not attend his follow up appointments.

## 4. Conclusion

In UK, it is important for colorectal surgeons to be aware of syphilitic condylomata lata and consider this when dealing with perianal lesions. It is advisable to refer patients suspected of or

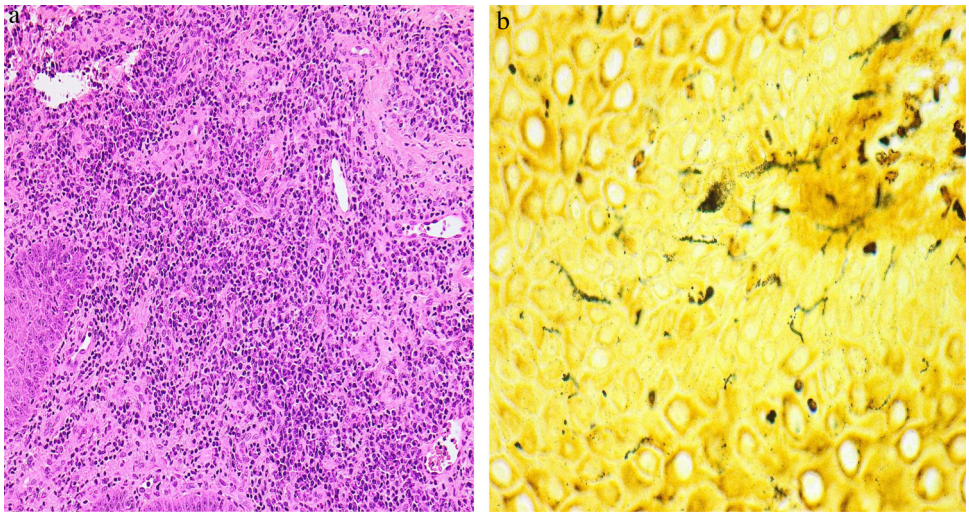


**Fig. 2.** (a) [High power]—anal squamous epithelium with profuse profuse plasmacytic infiltrate. (b) Teeming with *Treponema pallidum* on Warthin-Starry stain.

diagnosed with syphilis to sexual health clinics to help improve outcome. In sexual health clinics additional investigations and treatment are available in addition to partner notification [7] and follow-up can be offered.

## Conflicts of interest

None to declare.

## Funding

None.

## Ethical approval

Not required.

## Consent

Patient consented and written consent obtained.

## Authors contribution

Dr. Sarup Tayal and Mr Fadlo Shaban were the contributors in writing the case report.

Mr Fadlo Shaban, Dr Kaushik Dasgupta and Mr Mohamed Tabaqchali provided clinical care and were involved in the review and preparation of the manuscript. Images were courtesy of the photography and pathology department, with patient consent. All authors read and approved the final manuscript for submission.

## Research studies

None required.

## Guarantor

Dr.Sarup Tayal accepts full responsibility for the work.

## References

[1] Public Health England. Sexually transmitted infections and chlamydia screening in England, 2014. Health protection agency report. Vol. 9, No. 22, 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437433/hpr2215_STI_NCSP_v6.pdf.

[2] P.A. Gearhart, T.C. Randall, R.M. Buckley, Human Papillomavirus Differential, Diagnoses 2015;http://emedicine.medscape.com/article/219110-differential.

[3] C. Mullooly, S.P. Higgins, Secondary syphilis: the classical triad of skin rash, mucosal ulceration and lymphadenopathy, Int. J. STD AIDS 21 (8) (2010) 537–545.

[4] M.R. Sanchez, Syphilis, in: T.B. Fitzpatrick, A.Z. Eisen, K. Wolff (Eds.), Dermatology in General Medicine, 5th ed, McGraw-Hill, New York, 1999, pp. 2551–2581.

[5] Sexually Transmitted Diseases, in: D. Musher, K.K. Holmes, P.A. Mardh, P.F. Sparling (Eds.), 3rd ed., McGraw-Hill Co., New York, NY, 1999, p. 481.

[6] A.M. Rompalo, M.R. Joesoef, J.A. O'Donnell, et al., Clinical manifestations of early syphilis by HIV status and gender: results of the syphilis and HIV study, Sex. Transm. Dis. 28 (2001) 158–165.

[7] K.S. Kohl, T.A. Farley, J. Ewell, et al., Usefulness of partner notification for syphilis control, Sex. Transm. Dis. 26 (1999) 201–207.