

Condyloma lata

Andrew Walkty^{a,b,*}, Lauren Shute^a, Sate Hamza^c, John M. Embil^{a,b}

^a Department of Medical Microbiology and Infectious Diseases, Max Rady College of Medicine, University of Manitoba, Winnipeg, Manitoba, Canada

^b Department of Medicine, Section of Infectious Diseases, Max Rady College of Medicine, University of Manitoba, Winnipeg, Manitoba, Canada

^c Department of Pathology, Max Rady College of Medicine, University of Manitoba, Winnipeg, Manitoba, Canada



ARTICLE INFO

Article history:

Received 22 October 2021

Received in revised form 26 October 2021

Accepted 26 October 2021

Available online xxxxx

Keywords:

Syphilis

Condyloma lata

A previously healthy 47-year-old male presented to a community hospital emergency department (Manitoba, Canada) with nodular cutaneous lesions involving the right side of his scrotum, the right thigh, the left inguinal crease, and his penis. The lesions were malodorous and had been progressing over a period of approximately two months. The patient denied having fever, rash, arthralgias, or urinary symptoms. He was sexually active with female partners, and reported he last had unprotected sex one week before presenting to care. He was not forthcoming regarding the number of partners with whom he had sex over the preceding six months. The patient was born in Laos, but had lived in Canada for over thirty years. He denied recent travel and recreational drug use, and was currently working in the home renovation industry.

On inspection, the patient had a large verrucous/nodular lesion measuring approximately 3 cm in maximal diameter involving the right side of the scrotum (Fig. 1). Many other nodular lesions were observed in the inguinal regions and on the penis. The lesions were not tender to palpation. Small inguinal lymph nodes were present bilaterally. The remainder of the physical examination was unremarkable. The patient was referred to an Infectious Diseases out-

patient clinic. One of the lesions was biopsied, and he underwent testing for sexually transmitted infections. The biopsy demonstrated prominent irregular epidermal hyperplasia, with a mixed inflammatory infiltrate in the subjacent dermis. An immunostain for *Treponema pallidum* was positive (Fig. 2). The histopathology was consistent with a diagnosis of condyloma lata. The patient was subsequently found to be positive for syphilis on serology (RPR titre of 1:128). Serologic testing for HIV, hepatitis B, and hepatitis C was negative. He was treated with a single dose of benzathine penicillin G 2.4 million units intramuscularly.

Syphilis is an infection caused by the spirochete *T. pallidum* subspecies *pallidum* [1]. In Manitoba, the rate of infectious syphilis has increased from 9.2 per 100,000 in 2014 to 57.9 per 100,000 in 2018 [2]. The clinical stages of syphilis are primary, secondary, early non-primary non-secondary, and unknown duration or late [3]. Condyloma lata may be seen as a manifestation of secondary syphilis in approximately 6 to 23% of patients [1,3–6]. The lesions are highly infectious [3,4]. They present as moist papules or nodules, with a smooth, verrucous, or hypertrophic surface [3]. Condyloma lata most commonly

* Correspondence to: MS673B, Microbiology, Health Sciences Centre, Winnipeg, MB, R3A 1R9, Canada.

E-mail address: AWalkty@sharedhealthmb.ca (A. Walkty).



Fig. 1. Nodular/verrucous cutaneous lesions involving the right side of the scrotum and inguinal regions.

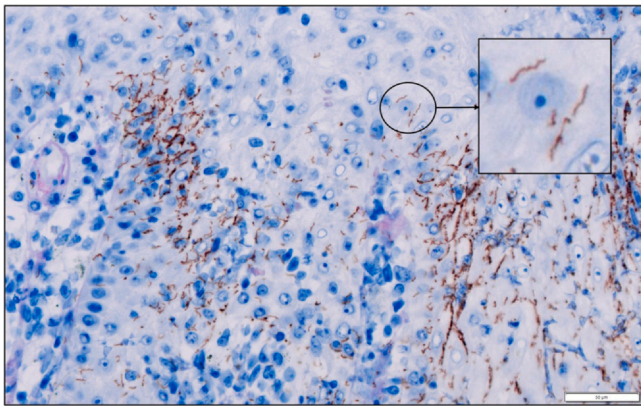


Fig. 2. Immunohistochemical staining of a lesion biopsy specimen using commercial anti-*Treponema pallidum* antibodies demonstrated coiled spirochetes.

occur in the anogenital area, the medial thighs, or inframammary creases (areas of skin apposition) [3]. The differential diagnosis includes condyloma acuminata and malignancy (e.g., squamous cell carcinoma) [3,4]. Syphilis is typically diagnosed by serology, but a diagnosis can also be confirmed by immunohistopathology or nucleic acid amplification if biopsy of a lesion is obtained [1,7]. Condyloma lata are treated with a single dose of benzathine penicillin G (i.e., treat as for secondary syphilis) [1,7]. Given the rise in syphilis cases occurring across Canada and elsewhere in the world, it is important for clinicians to be aware of this less common but classic presentation such that diagnostic testing is performed and treatment initiated in a timely manner.

Funding

The authors did not receive any funding for this work.

CRediT authorship contribution statement

LS and JME: clinical management of the patient, writing and editing the manuscript. AW: writing, editing the manuscript. SH: obtaining pathology images, editing the manuscript.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images.

Declaration of Competing Interest

The authors report no conflicts of interest.

References

- [1] Ghanem KG, Ram S, Rice PA. The modern epidemic of syphilis. *N Engl J Med* 2020;382:845–54.
- [2] Manitoba Health, Seniors and Active Living. Communicable disease management protocol: syphilis. <https://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf>. (Accessed 28 September 2021).
- [3] Forrestel AK, Kovarik CL, Katz KA. Sexually acquired syphilis: historical aspects, microbiology, epidemiology, and clinical manifestations. *J Am Acad Dermatol* 2020;82:1–14.
- [4] Pourang A, Fung MA, Tartar D, Brassard A. Condyloma lata in secondary syphilis. *JAAD Case Rep* 2021;10:18–21.
- [5] Chapel TA. The signs and symptoms of secondary syphilis. *Sex Transm Dis* 1980;7:161–4.
- [6] Mindel A, Tovey SJ, Timmins DJ, Williams P. Primary and secondary syphilis, 20 years' experience. 2. Clinical features. *Genitourin Med* 1989;65:1–3.
- [7] Public Health Agency of Canada. Canadian guidelines on sexually transmitted infections. Syphilis: key information and resources. <https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/syphilis.html>. (Accessed 28 September 2021).