Syphilis incognito: Resurgence of the covert devil – keeping the eyes open

Sir,

This is in reference to the article "syphilis incognito: Resurgence of the covert devil" published in your esteemed journal.[1] I read it with great interest and thoroughly agree with the authors' views. I would also like to share my experience. Recently, I came across a 30-year-old male, who was referred to our department on account of a reactive venereal disease research laboratory (VDRL) test (during a routine medical examination for job appointment in a foreign country). He showed his VDRL test reports from two laboratories, both of them reported him to be reactive, but none of them mentioned the titer. He was then treated with some injections, but no documentation was available. Therefore, a fresh sample was sent for VDRL (in serial dilutions), Treponema pallidum hemagglutination assay (TPHA) and human immunodeficiency virus (HIV). VDRL test was reactive up to 1:4 dilution, TPHA was positive, and HIV serology was negative. On history and examination, he revealed a history of unprotected sexual exposure few years back and was also suffering from recurrent episodes of herpes genitalis, which used to subside over 4–5 days without any treatment. Although no sign or symptom of syphilis was noted, the patient was diagnosed with syphilis of unknown duration and treated with three doses of benzathine penicillin. He is presently in regular follow-up.

I would like to focus on following points:

Screening

As there has been an increase in a number of asymptomatic cases or syphilis incognito, there should be no lacuna in the screening programs – whether antenatal, before surgery and blood donation. Furthermore, every patient presenting with any other sexually transmitted disease (STD), must be screened for syphilis. The very basic and golden rule in the context of STDs must not be forgotten – "one STD means possibility of another STD."

Ordering and interpreting venereal disease research laboratory test

- A nonreactive VDRL test: Most of the laboratories at present, do not perform the test in sequential dilution. This may result in false negative result due to prozone phenomenon. It is usually associated with secondary and early latent syphilis, early neurosyphilis, HIV coinfection, and pregnancy.[2,3] Although the incidence is low (0.2%–2%),[2] one must be aware of this possibility. Furthermore, approximately, 30% of patients with late latent or late syphilis, nontreponemal tests are negative.[4] Therefore, a negative VDRL test must be interpreted with care, and the clinician should not refrain from ordering VDRL test in sequential dilution and specific treponemal tests to confirm the diagnosis. If, however, a definite diagnosis could not be established, it is always better to treat the patient (and partner) to further prevent the spread of this "covert devil"
- A reactive VDRL test: Many laboratories report VDRL test simply as "reactive," without mentioning the titres. This defeats the very purpose of this test as it is not possible to follow-up the patient if the baseline titer is unknown. Such approach by the laboratories needs to be abolished, and the quantitative test must be performed at least for all "reactive" sera.

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Conflicts of interest

There are no conflicts of interest.

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