Secondary syphilis: An unusual presentation

Sir,

Salient mucocutaneous manifestations of secondary syphilis include condylomata lata, mucous patch, and patchy "moth-eaten" alopecia.[1] We hereby report an atypical presentation of secondary syphilis, wherein the patient did not have any other manifestation of the disease.

A 35-year-old male presented with multiple, itchy, violaceous papules and plaques on medial thighs bilaterally and on scrotum for 2 months [Figure 1a]. He had few similar lesions elsewhere too. There was a history of repeated unprotected sexual exposure with commercial sex workers in recent past. There was no history of any urethral discharge and burning micturition, rash on the body, or any constitutional symptom; however, there was a history of a painless ulcer on glans penis 4 months before presentation and the ulcer had healed in 4–5 weeks with self-medication with topical and systemic antibiotics. On examination, there were multiple, firm, moist, nontender, flat-topped papules and plaques on the scrotum and medial thighs. Few similar lesions were noted in the left axilla too. Of note, axillary lesions were remarkable for eroded surface [Figure 1b]. There was no rash on the body (including penis), and palms, soles, mucosae, scalp, and nails were unremarkable. He had multiple, discrete, nontender, shotty lymph nodes (about 1–3 cm in diameter) of the vertical and horizontal groups of superficial inguinal lymph nodes. The cervical, submental, suboccipital, and submandibular lymph nodes (about 1–3 cm) were also enlarged. The epitrochlear lymph nodes were not enlarged. A provisional diagnosis of condyloma lata was made, and lichen planus was considered as differential diagnosis. The hematological and biochemical investigations were normal. The venereal disease research laboratory test was reactive in a titer of 1:64. Serological testing for HIV was negative. A biopsy from the lichenoid plaque showed epidermal hyperplasia with a diffuse infiltrate consisting of lymphocytes, plasma cells, and histiocytes in the dermis. Epidermis was notable for focal aggregation of neutrophils [Figures 2 and 3]. Based on the history, examination findings, and serological results, a final diagnosis of condyloma lata was made. He was treated with a single dose of benzathine penicillin 2.4 million units (1.2 million units given in each buttock) after sensitivity testing. He was advised sexual abstinence and was asked to bring his wife for examination.

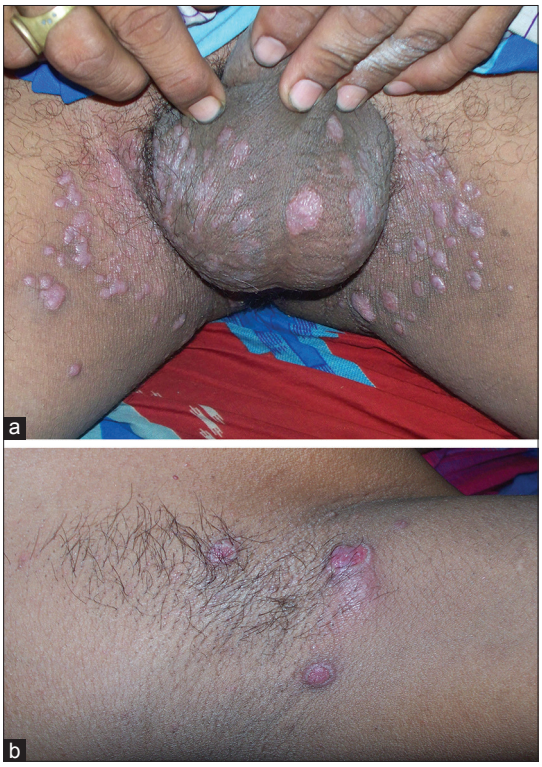

Figure 1: (a) Multiple violaceous papules and plaques on the scrotum and medial thighs and (b) multiple violaceous plaques with eroded surface on the axilla

Narang *et al*. reported two cases of secondary syphilis with annular lichenoid plaques on the scrotum associated with generalized lymphadenopathy, fever, and malaise.[1] Almost two decades ago, syphilis was initially missed in a Caucasian female who presented with an uncommon variant of syphilis, "lues maligna," characterized by noduloulcerative skin lesions, fever, meningism, and a relapsing course.[2] To further add to the

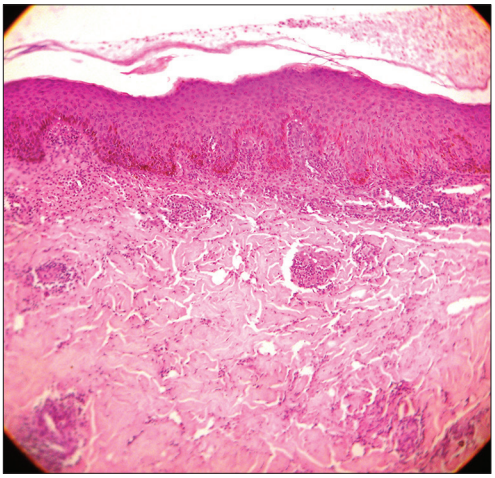

Figure 2: Photomicrograph showing epidermal hyperplasia with a diffuse infiltrate consisting of lymphocytes, plasma cells, and histiocytes in the dermis. Note the focal aggregation of neutrophils in the epidermis (H and E, ×100)

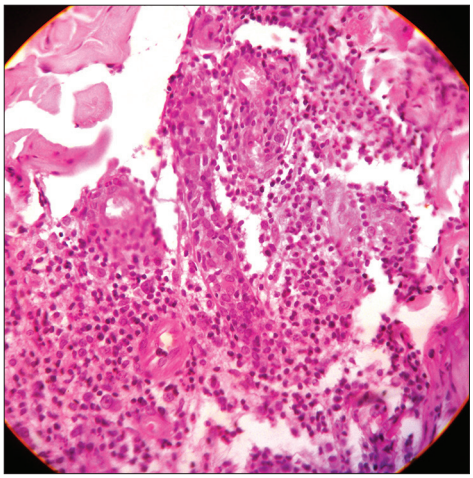

Figure 3: Photomicrograph showing diffuse dermal lymphohistiocytic infiltrate. Note the presence of plasma cells (H and E, ×400)

dilemma, there is a report of three patients who had secondary syphilis with severely pruritic skin lesions; and this presentation contradicts several modern literatures, wherein the lesions of secondary syphilis are described as nonpruritic.[3] Pruritus in secondary syphilis is more commonly noted in papular, follicular, and lichenoid variants.[4] Another interesting presentation was reported in an illustrative case of an apparently healthy 38-year-old man with a history of alopecia universalis; later developing extensive, mildly itchy, infiltrated annular verrucous lesions of the scalp, perioral, lumbar, perianal, and genital areas. Positive syphilis serology and magical response to penicillin confirmed a diagnosis of extensive annular and verrucous late secondary syphilis.[5] Thus, the presentation of syphilis, aptly described as "the great imitator," can be extremely confusing at times.

Condyloma lata may be the sole manifestation of secondary syphilis, as in our case. Lesions usually progress from red, painful, and vesicular to "gun metal gray" as the lesions resolve. Their surface may be smooth, papillated, or covered with cauliflower-like vegetation. The common sites are the genital and anal areas where the condylomas are usually smooth and moist. Hypertrophic condyloma lata have been reported in the axillae, umbilicus, nape of the neck, and inner thighs.[6] Considering the recent decline in the incidence of syphilis, such lesions are likely to present infrequently. In some cases, as seen in our case, condyloma lata may be the only physical sign of syphilis; therefore, it is important that a high index of suspicion is maintained when evaluating lesions in patients at epidemiologic risk for syphilis. To conclude, clinical presentations might be misleading, and any suspicion should be dealt accordingly with appropriate investigations.

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Conflicts of interest
There are no conflicts of interest.

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