ejpmr, 2024, 11(6), 339-340

SJIF Impact Factor 7.065

EUROPEAN JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

www.ejpmr.com

Case Study

ISSN 2394-3211

EJPMR

CASE REPORT: SECONDARY SYPHILIS MASQUERADING AS LEUKOCYTOCLASTIC VASCULITIS

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Article Received on 09/04/2024 **Article Revised on 30/04/2024** **Article Accepted on 21/05/2024**

ABSTRACT

Syphilis is a sexually transmitted infection caused by *Treponema pallidum subspecies pallidum*. It presents itself in two forms: congenital and acquired. The acquired form is further classified as primary, secondary and tertiary form. It can present in the form of various cutaneous lesions mimicking other dermatological diseases and thus, it has been appropriately termed as "a great imitator". The present case report shows that the initial presentation of syphilis was a macula-papular as well as vasculitic rash with a relatively rapid onset. However, on history taking and examination a clinical suspicion of secondary syphilis was established, which was later proved through histopathology. A high index of suspicion is the key to diagnosis to such tricky cases.

KEYWORDS: The present case report shows that the initial presentation of syphilis was a macula-papular as well as vasculitic rash with a relatively rapid onset.

INTRODUCTION

He who knows syphilis, knows medicine Syphilis is a sexually transmitted infection caused by *Treponema pallidum subspecies pallidum*. It presents itself in two forms: congenital and acquired. The acquired form is further classified as primary, secondary and tertiary form. The presentation secondary syphilis is highly varied. It can present in the form of various cutaneous lesions mimicking other dermatological diseases and thus, it has been appropriately termed as "a great imitator".[1] The following case report highlights the unusual presentation of secondary syphilis. It also emphasizes on the fact that a high index of suspicion is the key towards diagnosis in such cases.

CASE REPORT

A 39 year old male, truck driver by occupation presented in the Dermatology OPD with the chief complaints of mildly painful, non-pruritic red raised lesions all over the body. The lesions were insidious in onset, and rapidly progressed to involve the whole body over a period of 4 days. On extensive history taking the patient revealed history of unprotected sexual contact 3 months back.

However, there was no history of prior genital/ oral lesions (suggestive of primary syphilis). The patient also complained of weight loss.

A thorough examination of the patient was done which revealed multiple, well defined, erythematous papules (0.5 X 0.5 cms) all over body with central necrosis in few lesions. Some vasculitic lesions were also present on the palms and soles. On examination of the oral mucosa, there was presence of multiple whitish papules. Examination of the genital mucosa revealed erythema on glans penis as well as erythematous papules on shaft. On lymph node examination, B/L axillary and inguinal lymph nodes were enlarged significantly. They were soft, discrete, non tender and mobile.

On the basis of preliminary history taking and examination, the following differentials were thought of: LCV to rule out HSP, PLEVA and secondary syphilis. Bedside tests were performed and Buschke-ollendorf sign was positive. On further investigations it was found that the VDRL was reactive with a titre of 1:32 and TPHA was positive. Rest of the examinations were found to be within normal limits.

To establish the diagnosis, a biopsy was done for histopathological examination as well as DIF microscopy. The following differential diagnoses were considered: LCV to rule out HSP, PLEVA and secondary syphilis. On histopathological examination, the stratum corneum had lamellated orthohyperkeratosis with presence of mild spongiosis. There was characteristic

presence of dense superficial and mid perivascular lymphohistiocytic infiltrate with plasma cells in lichenoid pattern suggestive of secondary syphilis. However, on DIF microscopy, there was presence of Ig A fluorescence quantified as 2+ in the perivascular region suggestive of vasculitis. Finally, a diagnosis of secondary syphilis was established and the patient was given IM Injection Benzathine Penicillin: 2.4 MU (1.2 MU each buttock). Drastic improvement was observed within 1 month and the patient was counselled regarding disease prognosis.

DISCUSSION

Secondary syphilis is a disease with various cutaneous, mucosal as well as systemic manifestations. Lesions of secondary syphilis vary from macular, maculo-papular, papular, pustular, nodular and many more. Thus, it has been rightly been given the title of "Great Masquerader". It has also been established that among many diagnoses it may also clinically/ histologically can mimick PLEVA as well as small vessel vasculitis. Henoch schonlein purpura or cryoglobulinemia has also been rarely reported in cases of syphilis.[2] The present case report shows that the initial presentation of syphilis was a macula-papular as well as vasculitic rash with a relatively rapid onset. However, on history taking and examination a clinical suspicion of secondary syphilis was established, which was later proved through histopathology. However, the DIF confirms that Secondary syphilis may also present as a vasculitic rash. Syphilis is well known to reserve surprises in clinical presentation as well as supplementary investigations. A high index of clinical suspicion and knowledge of varied presentation is the key to diagnosis of secondary syphilis. Coupled with this, the importance of meticulous history taking cannot be ruled out. The recent trend of increasing cases of STDs necessitates a wholesome approach towards the diagnosis and early treatment initiation.[3] Along with that, the emphasis towards sexual health education and safe sex practices requires a new approach.

Figures

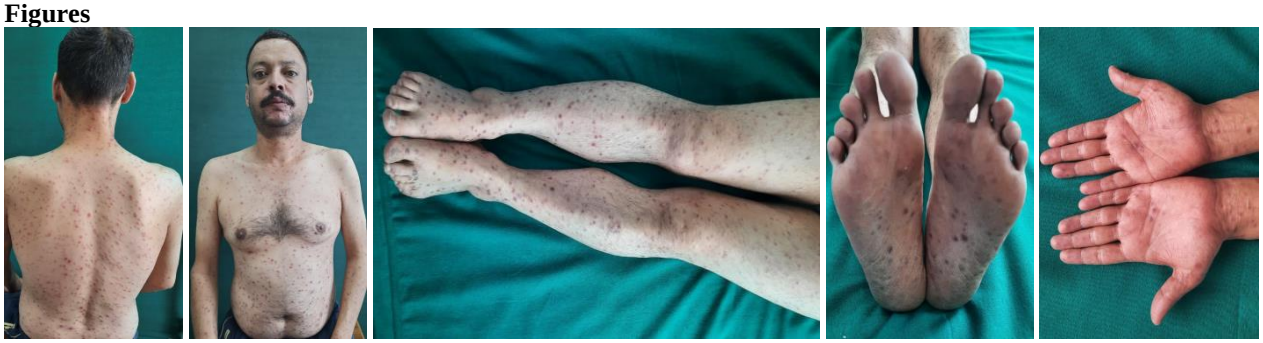

Figure 1-5: Clinical presentation of the patient with widespread maculo-papular rash as well as vasculitic lesions on hands and feet.

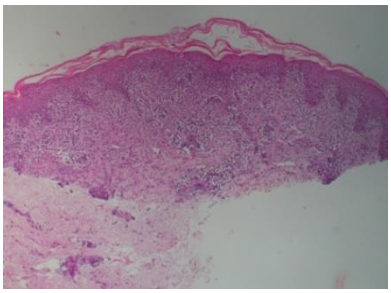

Figure 6: Histopathological examination: characteristic presence of dense superficial and mid perivascular lymphohistiocytic infiltrate with plasma cells in lichenoid pattern suggestive of secondary syphilis.

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