

SECONDARY SYPHILIS MASQUERADING AS PSORIASIS VULGARIS- A RARE CASE REPORT**Keerthana Bhaskar P.¹, Sruthy S.R.², Jayakar Thomas*³, Deepthi Ravi⁴, Manoharan D.⁵ and Manohara K.⁶**^{1,2}Junior Resident, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.³HOD & Professor, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.⁴Senior Resident, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.^{5,6}Professors, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.***Corresponding Author: Jayakar Thomas**

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ABSTRACT

Secondary syphilis is a generalized infection which is sexually transmitted and psoriasis is an immunologically mediated disease. Syphilis can highly mimic psoriasis due to its varied disease presentations. Here we present a case who came with lesions over the palms, soles, trunk and genital area giving a psoriasiform picture. We first thought it to be psoriasis vulgaris but because of the atypical presentation, genital lesions and history of contact, the patient was evaluated for syphilis. RPR was positive and HIV ELISA was positive. The patient was then diagnosed as secondary syphilis and treated with benzathine penicillin.

KEYWORDS: secondary syphilis, psoriasiform picture, treatment.**INTRODUCTION**

Syphilis is a sexually transmitted common infection worldwide developing due to a spirochete *Treponema pallidum* in a range of 1-6 months. It is more common among the people who are at risk for HIV which is also sexually transmitted but the exact etiology is still unclear. This infects palms and soles, genital area, anus, lips, oral cavity of both men and women. Syphilis is transmitted from sexual contact with someone who already has it. Apart from that it can also pass from mother to baby during pregnancy. Secondary syphilitic lesions may resemble other disease lesions as in psoriasis, Lichen planus, Rubella, Measles, pityriasis rosea. Serological tests are essential to confirm the diagnosis. Treatment modality is the same though associated with other conditions.

CASE REPORT

A 28 year old unmarried male walked into our OPD with complaints of asymptomatic red to brown coloured rashes from one month initially started over penis later progressed to both palms and soles and other parts of the body. The rash was painless and non itchy. There was a history of unprotected paid sexual contact with a female

3 months ago and three times of similar sexual contact from the past one year. No history of trauma, ulceration, burning or painful micturition, weight loss or appetite or bowel abnormalities. No similar complaints in the family. Patient has no other comorbidities and gives a history of alcoholism and smoking from the past 10 years. General condition was normal. Systemic examination and ophthalmic examination was normal. Dermatological examination revealed diffuse, symmetrical erythematous to pigmented scaly papules and nodules with few vesicles present over [Figure 1] bilateral palms and soles, trunk, both the lower limbs and genitalia. These lesions were 0.5 to 1cm diameter with peripheral collarette scaling over palms and soles. Scalp, lips, oral mucosa and nails were normal. A clinical diagnosis of secondary syphilis was made. Patient showed Reactive HIV antibodies, increased CRP, TPHA showed positive 1:160 dilution indicating Syphilis. Neutrophils and white blood cells were high indicating active infection. A punch biopsy has been taken from left palmar scaly nodule showed Psoriasiform picture with end arteritis obliterans and plenty of plasma cells [Figure 2] thus confirming the diagnosis of secondary syphilis along with psoriasis.

Legends and Figures



Figure 1: Clinical photograph showing erythematous maculopapular rash bilaterally symmetrical over palms and soles with few lesions over trunk.

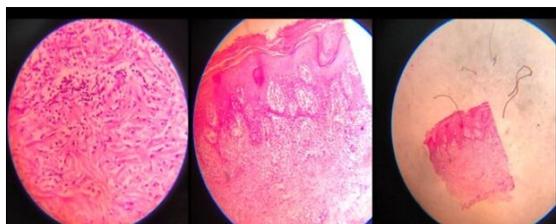


Figure 2: Photomicrograph showing A) End arteritis obliterans and plasma cells at high power B) Hyperkeratosis, parakeratosis and acanthosis with sub epidermal edema and inflammatory cell infiltration at low power and C) hyperkeratosis and dermal infiltration on scanning view.

DISCUSSION

Our patient reported with skin lesions suggestive of secondary syphilis which had psoriasiform presentation. Syphilis is caused by *Treponema pallidum* which is common among IV drug abusers, homosexuals, multiple partners and HIV patients. It occurs in primary, secondary, latent and tertiary forms. Primary syphilis is characterized by chancre whereas secondary syphilis has several presentations which includes fever, headache, weight loss, sore throat, anorexia and myalgia.

Cutaneous lesions of syphilis is variable where skin rash and lymphadenopathy being the most common of about 67%-92% and 63%-100% respectively. Skin rash may be macular, papular, maculopapular, papulosquamous, psoriasiform, annular, pustular or follicular characterized by generalized, bilaterally symmetrical, more on upper extremities with mucous membrane, palms and soles involvement also. The classical lesions are described as “raw-ham” or copper coloured. Cutaneous manifestations can not only involve any other organ but can mimic various other skin conditions like Rubella, measles, Drug rash, glandular fever, HIV sero

conversion illness, papulo squamous rash of psoriasis, Lichen planus, Pityriasis rosea and warts. It is known as the “great imitator”. The skin lesions are non-pruritic except for Follicular variant of secondary syphilis. The pathognomonic sign of secondary syphilis is Buschke Ollendorf sign and resolving lesion showing necklace of venus (Leucoderma Syphiliticum). Nodular presentation is rare where there are 20 cases only in literature. Apart from this secondary syphilis may present with moth-eaten Alopecia, Nail changes like pitting, onycholysis, Beau’s lines, onychodystrophy. When it is associated with HIV, CSF changes are significantly high. Lues maligna is a widespread form of secondary syphilis which gives papulopustular eruption. Usually, silver staining (Warthin Starry or Levaditi stains) is the method to detect spirochetes in tissue sections where the histology may resemble lichen planus or psoriasis. Epidermis shows spongiosis, parakeratosis and acanthosis. Blood vessels show dilatation, mural edema and endothelial swelling. Perivascular infiltration with plasma cells is common. Treponemas can be identified in lesions by dark field microscopy. Serological tests for screening are TPHA and RPR. The standard treatment for secondary syphilis is Benzathine penicillin 2.4 mega units intramuscularly as a single dose or aqueous procaine penicillin 600,000 units IM per day for 10 days. After injection, at times, Jarisch-Herxheimer reaction is seen. Other alternatives are Doxycycline, tetracycline, Azithromycin. Relapse of secondary syphilis is seen in 20%-25% cases if untreated. Prevention and control of syphilis can be achieved by enhanced surveillance, screening and partner notification. Targeted mass treatment is required in high prevalence of syphilis. Recent developments in identification of *T. pallidum* immunogens help in vaccine development.