

Rupoid syphilis in a HIV patient

Sir,

Syphilis, “The Great Imitator” is among the most fascinating skin diseases. Syphilis, in the presence of human immunodeficiency virus (HIV) infection, has varied clinical manifestations, often presenting in secondary stage.^[1] Hyperkeratotic, crusted limpet-like and discolored lesions called “rupia” are uncommon and are usually seen in relapsing secondary syphilis. In pustular syphilis, as a result of endarteritis obliterans and diminution of blood supply, the papules and pustules undergo central necrosis, which extend deep and they present with a central core of necrotic tissue giving rise to “limpet-like” crusts resembling an “oyster shell,” which may be discolored with altered blood. Face is the common site. Progression is rapid and may be associated with toxicity, fever, arthralgia and occasionally hepatitis. This rapidly evolving course of secondary syphilis is called as Lues Maligna.^[2] With the spread of the HIV epidemic, atypical mucocutaneous manifestations of secondary syphilis may be seen more frequently than before and may pose problems in the diagnosis.^[3] Here, we report a case of rupoid syphilis.

A 48-year-old married man, HIV positive since 4 years, not on antiretroviral treatment (ART), presented with multiple asymptomatic crusted lesions over the face, extremities, genitalia and trunk of 3 months duration.

Initially, the eruptions started as papules, which evolved into pustules and then crusted lesions. There was no history of fever, arthralgia or abdominal pain. The patient had not taken any medications for any other illness for at least 3 months before the onset of these skin eruptions. He had not suffered from any major medical or surgical illness in the past. There was no history of similar episode in the past. However, he gave history of multiple heterosexual, unprotected exposures with commercial sex workers in the past, which were not followed by urethral discharge or genital sores.

The emaciated individual had inguinal and axillary lymph adenopathy (discrete, mobile, firm and non-tender nodes). Systemic examination was unremarkable. Cutaneous examination revealed multiple crusted lesions covered with dirty-looking, adherent and heaped-up crusts distributed mainly on the face and limbs [Figures 1 and 2]. Multiple non-tender ulcers were seen on the palate, while small scattered similar lesions were noted on the trunk and genitalia.



Figure 1: Rupoid lesions over the face



Figure 2: Rupoid lesions over the leg

On investigation, routine blood, urine examination and biochemical parameters were normal. Erythrocyte sedimentation rate (ESR) was 50 mm at first hour. Blood VDRL test was reactive (1:64). Cerebro spinal fluid VDRL test was non-reactive. CD4 cell count was 271 cells/mm³. Other investigations were normal. Skin biopsy and histopathology revealed endarteritis obliterans and few granulomas. Because dark ground illumination (DGI) microscopy and Treponema pallidum haemagglutination test (TPHA) or Microhaemagglutination-Treponema pallidum test (MHATP) were not available at our institute, these were not performed. The patient was treated with injection Benzathine penicillin, 24 lac units, deep intramuscular, once a week for 3 weeks. Within 1 month, the skin lesions completely healed with post-inflammatory hyperpigmentation and the blood VDRL titer came down to 1:16 at the end of 3 months.

Now a days, syphilis is a milder disease compared with the ulcerating epidemics of the sixteenth century. Rupioid syphilis is a rare form of malignant syphilis with extensive indolent tissue necrosis. It is more commonly seen in undernourished patients or those with other debilitating diseases such as diabetes or chronic nephritis. It is more common as a recurrence than as a part of original secondary eruptions. In a report, among 21 malignant syphilis cases, five patients had rupioid crusts, two among them were HIV positive with CD4 counts of 140 and 556 cells/mm³, respectively.^[3] In another report, there were 21 cases of pustular syphilis and among them, three patients had rupial syphilide. These cases of pustular syphilis were reported before the HIV era.^[4] In yet another report, a case of rupial syphilide was reported in a single male from India but the patient was HIV negative.^[5] In another case report, hyperkeratotic syphilide lesions disappeared in 1 month after 24 lac units of Benzathine penicillin.^[6] In our case, the patient had typical heaped-up crusts without toxemia and lesions were afresh and were not consequences of recurrences. The histopathological features were typical of secondary syphilis. In addition to the classical histopathological features of secondary syphilis, granulomas, a rare feature, were observed. A high index of suspicion for HIV is required whenever we see such atypical skin lesions of secondary syphilis in any patient.

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