**Cutaneous and Visceral Syphilis: Unusual Presentation**

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**ABSTRACT**

Syphilis is the most commonly sexually transmitted disease in the world, showing a high incidence rate in our country. Its clinical course is well established and universally accepted, although there are cases in which the diversity of its signs and symptoms can make diagnosis a challenge. This is the reason why it is known as a “thousand faces” or a “great imitator” disease. Authors present a case report with hepatic involvement, which is rare when syphilis is concerned.

**Keywords:** syphilis, sexually transmitted diseases, treponematosis, STD.

**INTRODUCTION**

Syphilis is a disease with a very unusual clinical diversity, compromising skin and internal organs, and it is one of the most frequent sexually tract infections (STI) both around the world and in our country. In Brazil, in 2003, the estimate of the population between 15 and 49 years was of 843,300 syphilis cases. From 2005 to June, 2012, try. In Brazil, in 2003, the estimate of the population between 15 and sexually tract infections (STI) both around the world and in our country.

Secondary syphilis, a highly contagious stage, is the logical sequence of untreated primary syphilis, and it is characterised by an ulceration that appears from 1 to 6 months (usually 6 to 8 weeks) after the primary lesion has disappeared. It is an often erythematous ulceration that appears symmetrically on the trunk and limbs, and may reach the palmoplantar region. Although this description has already been established, other forms of manifestation can also be observed.

The most reported secondary syphilis general symptoms are the following: uneasiness (23-46%), headache (9-46%), fever (5-39%), pruritus (42%), hyporexia (25%). Other symptoms, less common, are: eye pain, bone pain, arthralgia, meningitis, iritis and hoarseness. More specific signs occur in the following frequencies: skin rash (88-100%), lymphadenopathy (85-89%), primary cancer (25-43%), flat condyloma (9-44%), hepatosplenomegaly (23%), mucous plaques (7-12%) and alopecia (3-11%). Rare manifestations include: acute meningitis, that occurs in approximately 2% of patients, hepatitis, renal disease, cardiac disease, gastritis, proctitis, ulcerative colitis, arthritis, periostitis, optic neuritis, iritis and uveitis.

This work demonstrates cutaneous and liver co-related aspects, of treponematosis etiology, in a HIV-seronegative patient.

**CASE REPORT**

An adult female patient sought several health professionals due to the eruption of disseminated lesions through her face. Patient made use of various topical treatments (sic) with no improvement. As conditions became worse, patient was sent to our Institution for evaluation. During our first consultation, apart from the cutaneous lesions, she complained about abdominal pain in the right upper quadrant. Patient received clinical care, and laboratory tests were requested. On physical examination, patient presented pain on palpation of the right hypochondrium and palpable liver 2 cm from the costal right edge; dermatological examination showed erythematous-violaceous papules, scattered over the centrofacial region and forehead (Figure 1). Some lesions, especially those located in the periorificial and nasal regions presented vegetant aspect. A lesion in the retroauricular region presented Biett’s collarette in its surface.

On palpation of ganglions a diffuse micropolypadenomegaly was noted. It was also observed conjunctive and icteric teguments. Our diagnosis impressions were as follows: histoplasmosis, paracoccidiomycosis, cryptococcosis, hepatitis, and syphilis. Tests required for diagnosis elucidation were the following: cutaneous biopsy, with material sent for histopathology and culture, VDRL, FTA-Abs and serology for fungi and bacteria, HIV and hepatitis types A, B and C. The results were as follows: VDRL: 1/256; TPH: positive; gamma-glutamyltransferase: 275; alkaline phosphatase: 162; alanine transaminase: 168; aspartate aminotransferase: 82; culture: showed no growth of fungus or bacteria; anti-HIV: negative; other serologies: negative; cutaneous biopsy with infiltrated limph-histio-plasmocitary around congestion vessels, surrounding but not invading the nervous filament (Figure 2).

Diagnosis of secondary syphilis was established, and the specific treatment based on the control manual of the Brazilian National Program of STD/AIDS was indicated. There was a favourable evolution of the symptoms, with the resolution of abdominal pain, normalisation of liver enzymes and resolution of icterus as well (Figure 3). The results of laboratory tests 30 days after the third dose of benzathine penicillin were the following: gamma-gluta-
myltransferase: 38; alkaline phosphatase: 82; alanine transaminase: 22; aspartate aminotransferase: 18.

**DISCUSSION**

It should be noted that syphilis dermatological manifestations are very clear, but the systemic involvement is still not so well established. It is possible that the association with other organs in earlier stages, besides skin, is more frequent than one can imagine. Specialized services have observed cutaneous stages overlay even in HIV-seronegative patients, apart from early onset of systemic symptoms in this same group. Syphilis classification in stages is only didactic, and as it is an infection,

![Figure 1](image1.png)

**Figure 1** – Erythematous-violaceous papules scattered over the centrofacial region and forehead.

![Figure 2](image2.png)

**Figure 2** - (a): Smallest increase (10x): thickened epidermis, with moderate exocytosis and dermis with dense mononuclear infiltrate forming a stripe in the superficial portion; (b): average increase (20x): infiltrated limph-histio-plasmocitary around congestion vessels, without invading the nervous filament; (c): largest increase (40x): detail of the inflammatory infiltrate with numerous plasmocytes, macrophages and lymphocytes with filaments without changes in the lower left corner.
CONCLUSION

Patient presented cutaneous lesions and hepatitis as a systemic involvement. We believe this condition was caused by treponematosi
since all other possible causes for the patient's hepatitis (viral hepatitis, alcoholism and drug use) were rejected, and patient also showed clinical and laboratory improvements due to syphilis treatment.

By presenting this case, we call the attention to the fact that internal organs may be concomitantly affected by syphilis cutaneous manifestation, and it shall be considered as a systemic disease from its beginning.

Conflict of interest

There was no conflict of interest.

REFERENCES


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