

ANSWER TO PHOTO QUIZ (FROM PAGE 362)
A PATIENT WITH SKIN AND BONE LESIONS - G. VERVOORT

Because of the inflammatory lesions in both the bone (especially clavulae) and skin, the diagnosis of SAPHO syndrome (synovitis, acne, pustulosis, hyperostosis and osteitis) was made. Three subtypes of SAPHO are distinguished with the following common features: sternoclavicular hyperostosis and sterile inflammatory bone lesions, and skin eruptions. SAPHO syndrome groups together sternocostoclavicular hyperostosis, chronic recurring multifocal osteomyelitis, and pustular arthro-osteitis. Aetiology and pathogenesis of SAPHO are unknown. The syndrome often runs a protracted course, with relapses and remissions but without resulting in serious disability. Treatment is symptomatic using non-steroidal anti-inflammatory drugs.

The patient was treated with topical corticosteroids and the skin lesions disappeared in just a few weeks. Bone scintigraphy four months after admission revealed no progression of the lesions; X-ray of the left clavicle no longer showed any radiographic abnormalities.

A year later she volunteered as a blood donor in our hospital. Unexpectedly, routine screening showed positive syphilis serology: Venereal Disease Research Laboratory (VDRL) test 1:128; *T. pallidum* haemagglutination assay (TPHA) 1:40960; fluorescent treponemal antibody absorption (FTA-abs) positive. HIV serology was repeatedly negative. There was no history of drug abuse or sexual promiscuity. However, her husband was treated with antibiotics by the general practitioner because of an ulcerative lesion on the penis.

Histopathological revision showed spirochetes in both clavicle and the uterus (figure 3 and 4). The patient was now diagnosed as having late syphilis with skin lesions and gummas of the bone. She was treated with penicillin G 2 million units six times daily intravenously for three weeks. After treatment the VDRL titre decreased. One year after treatment, bone scintigraphy revealed no abnormalities.

Syphilis is a chronic infection caused by *Treponema pallidum*. Late syphilis is defined as the stages of syphilis that occur after early or latent syphilis, typically involving the central nervous system, cardiovascular system or the skin, viscera and bones. The hallmark of late syphilis of the skin or viscera is gummas, granulomatous lesions that can easily be mistaken for sarcoidosis and tuberculosis. Skeletal gummas most frequently involve the long bones of the legs. Presenting symptoms usually include tenderness and pain and less frequently swelling; trauma may predispose a specific site to involvement. Radiographic abnormalities include periostitis and destructing or sclerosing osteitis.

Treatment of late syphilis requires prolonged courses of penicillin G. For late syphilis without central nervous system involvement a two-week course of intramuscular penicillin G. would be adequate. In our patient lumbar puncture failed, so the patient was treated as having neurosyphilis with a three-week course of intravenous penicillin G.

The response to treatment is monitored by the VDRL titre. In our patient, the VDRL titre dropped rapidly to 1:16 and has remained so for >6 years, but never became negative. She remained asymptomatic.

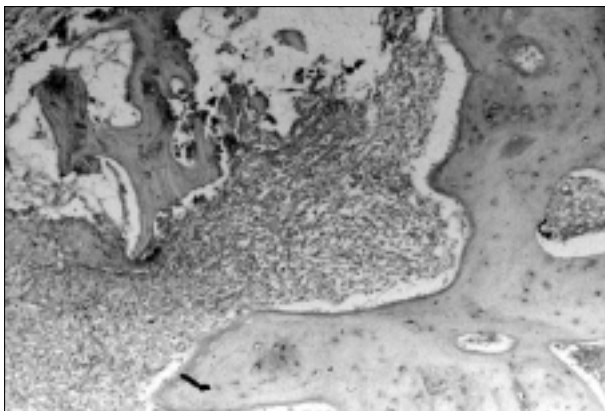


Figure 3

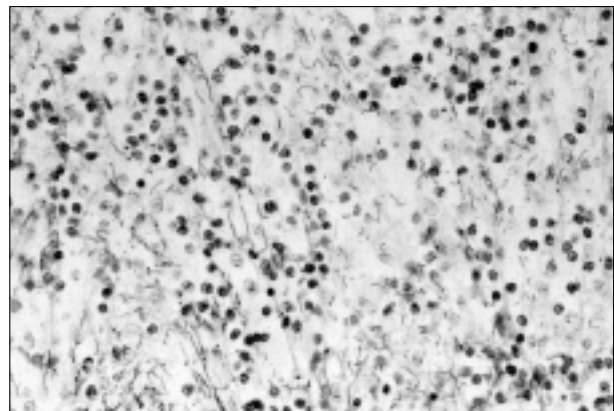


Figure 4