ANSWER TO PHOTO QUIZ (ON PAGE 82)

PERIANAL ULCER AND RASH

The diagnosis was primary syphilis, followed by secondary syphilis. This was confirmed with repeated serological testing, showing a TPHA titre of 1:2560, VDRL titre of 1:64 and a positive FTA.

Primary syphilis is characterised by a painless, indurated, clear-based ulcer, accompanied by locoregional lymph node swelling. Establishing the diagnosis solely on the clinical picture is difficult, because the sensitivity and specificity for a characteristic syphilitic ulcer are 31 and 98%, respectively. Other diagnoses to be considered are genital herpes, chancroid and lymphogranuloma venereum.
The typical presentation of secondary syphilis is a symmetric papular rash on the entire trunk and extremities, including the palms and soles. The latter localisation is highly suggestive of secondary syphilis. Other possible symptoms include malaise, weight loss, fever, hair loss and generalised lymphadenopathy.
The clinical picture of syphilis in HIV-infected patients can differ from HIV-negative patients. HIV-infected patients with early syphilis appear to be more likely to present with secondary syphilis and those with secondary syphilis are more likely to have persistent chancres.

Although the diagnosis can be made by darkfield microscopy on direct preparations or PCR techniques on tissue biopsies, serology is usually used to establish the diagnosis. HIV-infected individuals more often have falsely reactive non-treponemal tests (VDRL). In advanced HIV infection, abnormal B cell function may lead to false-negative serological responses. In case of high spirochaetal load a false-negative result can occur due to the 'prozone' reaction, caused by a mismatch between concentrations of antigen and antibody. Many other non-HIV-related conditions can cause falsely reactive or non-reactive treponemal and non-treponemal tests. Moreover, in primary syphilis, serum samples for serology may be obtained before seroconversion has occurred. In general, FTA becomes positive first, followed by TPHA and finally VDRL. Therefore, repetitive testing is necessary to differentiate between early and late latent syphilis as was done in our patient.

After the diagnosis was established, treatment was started with benzathine penicillin G, 2.4 million units intramuscularly He developed a Jarish-Herxheimer reaction, which was treated in the emergency room. During follow-up, all symptoms vanished and VDRL became negative.

DIAGNOSIS

Secondary syphilis.