Letters to Editor

Nodular secondary syphilis with granulomatous inflammation

Sir,

Rather than the usual cutaneous manifestation of maculopapular rash, some cases of secondary syphilis continue to assume diverse/atypical morphological presentations.[4] Hence, a need exists to broaden its differential diagnosis in the appropriate clinical settings. Even the classical histopathological picture may rarely be supplanted by granulomatous inflammation.[5] Herein, we report a case of nodular secondary syphilis with sarcoid-like granulomas.

A 27-year-old male, married for 12 years, presented with a diffuse, asymptomatic rash, low-grade fever, and malaise for 2 weeks, without any preceding genital or extragenital ulcer. The patient denied any history of extramarital sexual intercourse over the past 6 months. Examination revealed multiple, well-defined, symmetric papules, plaques, and nodules over the upper extremities, trunk, neck, and forehead [Figure 1a and b]. Palms, soles, mucosae, hair, and nails were uninvolved. Lymph nodes (cervical, axillary, supratrochlear, and inguinal) were enlarged, shotty, mobile, and painless. Venereal disease research laboratory (VDRL) was nonreactive.

Histopathological examination of a nodule from the upper back revealed thinned out epidermis, dense upper dermal chronic infiltrate with scanty plasma cells, mid-dermal noncaseating uniform granulomas of plump epithelioid histiocytes with abundant eosinophilic cytoplasm, and...
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Indian Journal of Sexually Transmitted Diseases and AIDS Volume 43, Issue 1, January-June 2022

round-to-oval nuclei with small central nucleoli. The deep dermis revealed intense periadnexal and perineural inflammation [Figure 2a and b]. However, deep dermal tenderness (positive Buschke–Ollendorff sign) over some truncal lesions made us repeat VDRL quantitatively, which came back strongly reactive (1:256), as did Treponema pallidum hemagglutination assay (TPHA) (>1:640). The patient now revealed a history of unprotected sexual intercourse with a female sex worker 3 months ago. Serology for HIV, HBV, and HCV was nonreactive.

Diagnosed as having nodular secondary syphilis, the patient was administered benzathine penicillin G 1.2 million units in each buttock for 3 consecutive weeks (total 7.2 MU). All lesions flattened promptly [Figure 1c and d] and VDRL titer fell fourfold after 6 months.

Despite a steep decline, periodic outbreaks of this “great imitator” continue to be reported.[3] A papulonodular presentation sparing palms and soles with granulomatous inflammation has been described more commonly in tertiary syphilis.[4] A 2014 review of granulomatous secondary syphilis cases showed a significant correlation between the absence of palmoplantar involvement and the presence of nodular lesions; 17 out of 24 cases without palmoplantar involvement were diagnosed late and probably only with a heightened index of suspicion.[4] The duration of nodular eruptions in our patient at presentation was only 14 days, unlike the majority of previous cases, wherein it was ≥4 weeks.[4]

Only three previous cases of nodular secondary syphilis with granulomatous inflammation of ≤4-week duration have been described, with all three showing a clinical presentation akin to our patient, i.e., generalized papulonodular eruption, sparing of palms, soles, and mucosae.[4]

Histopathological analysis was not diagnostic because of the nonspecificity of sarcoid-like granulomata. The diagnosis of syphilis was therefore based on positive serology corroborated by a rapid clinical and eventual serological response to penicillin.

This case demonstrating an atypical clinical as well as histopathological presentation emphasizes the need for clinicians and pathologists to be aware of the diverse manifestations of secondary syphilis in order to make an early diagnosis.

Acknowledgment

The patient in this manuscript has given written informed consent to publication of his case details.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for images and other clinical information to be reported in the journal. The patient understands that name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Figure 1: Pretreatment symmetric papulonodular lesions over the (a) neck and back, (b) chest, abdomen, and upper extremities; posttreatment flattening of lesions over the (c) neck and back, (d) chest, abdomen, and upper extremities.

Figure 2: (a) Thinned out epidermis and dense chronic inflammation in the upper dermis and multiple granulomas in mid-dermis with periadnexal and perineural inflammation (hematoxylin & eosin, ×10). (b) High-power view showing perineural and periadnexal chronic inflammation (hematoxylin & eosin, ×40).
Vulvar syringoma – An uncommon presentation

Sir,

Syringomas are benign tumors of eccrine sweat gland origin that occur more frequently in women. Clinically, they appear as multiple, tiny, firm, skin-colored papules. The sites of predilection are the eyelids, malar regions, neck, and chest. Syringomas in the vulva are rare and asymptomatic and therefore overlooked.

A 32-year-old female presented to us with skin lesions over genitalia for 2 years, not associated with itching. There was a history of similar lesions near both eyes. There was no history of similar complaints in the family.

Examination of the vulva revealed the presence of multiple discrete dome-shaped skin-colored papules present over labia majora, measuring about 0.5–0.8 mm in diameter [Figure 1]. The lesions were nontender and symmetrically distributed. Similar lesions were present below both lower eyelids.

Punch biopsy was done from vulvar lesion and histopathological features were studied. Section showed epidermis with hyperkeratosis and increase in basal pigmentation [Figure 2]. Dermis showed multiple tubular ductal structures in dense collagenous stroma, lined by 2 layers of epithelial cells. Few ducts showed comma-like extensions, histological features consistent with syringoma [Figure 3].

Syringoma is a common benign tumor of eccrine sweat gland origin. It is more common in females. The characteristic presentations are multiple tiny skin-colored or yellowish papules over eyelids and may also involve neck, chest, axillae, and abdomen. Genital involvement is rare. Zalla and Perry in 1971 described syringomas confined to penis. Carnerio et al. were the first to report cases of vulval syringomas. [1] About 34 cases have been reported till 2015. [2] The incidence of vulvar syringoma is approximately 1:1100–1500 as evaluated in large gynecological collections. [3] Syringomas have been associated with Down syndrome, Marfan syndrome, and Ehlers–Danlos syndrome. Case of vulvar syringoma aggravated during pregnancy was reported by Bal et al. [4] Hormones may play a role in the development of syringomas. Wallace and Smoller demonstrated estrogen and progesterone receptor in syringomas. [5] Clinically vulvar syringomas should be differentiated from Fox–Fordyce disease, multiple small epidermal cysts.