Multiple primary penile chancre: A re-emphasize

Sir,
The incidence of primary syphilis is on a decline because of excellent responses to penicillin and increase in awareness of sexually transmitted diseases (STD) among youths and sexual workers. Syphilis is a STD caused by the spirochete Treponema pallidum. Primary syphilis most often manifests as a solitary, painless chancre that develops at the site of infection within an average of 3 weeks after exposure to T. pallidum. Primary syphilis is most often associated with a single, painless chancre, although it can manifest in other ways (i.e., multiple chancre, painful papules or ulcers, or no lesions). Solitary lesions are often thought to be typical, but multiple lesions frequently occur.

A 20-year-old promiscuous male presented with asymptomatic lesions over the penis since
3 days. There was no history of pain, dysuria or discharge per urethra. On examination, there were four small discrete ulcers; one ulcer situated over distal shaft was discrete, indurated and non-tender. Other three ulcers developed after 3 days of the initial lesion and were superficially situated with regular border and with mild tenderness [Figure 1]. Inguinal examination revealed bilateral inguinal lymphadenopathy with firm discrete shotty lymph nodes with mild tenderness of the right inguinal nodes. The rest of the physical examination was unremarkable.

Gram stain of the tissue scraping from the base of ulcer was negative for *Haemophilus ducreyi* and *Neisseria gonorrhoea*. Dark ground microscopic examination revealed refractile *T. pallidum* only from newer lesion. Venereal Disease Research Laboratory titer was reactive up to 1:32 dilution. Bacterial culture of the tissue sample was negative. A diagnosis of multiple primary chancre was done and the patient was treated with a single intramuscular injection of benzathine penicillin 2.4 million units. On follow-up visit at day 7, lesions were healing reconfirming the diagnosis [Figure 2].

Various studies have shown a rise in the prevalence of syphilis in recent years in India. Most of the studies showing a constant or a rising prevalence of syphilis have shown an actual increase in the secondary stage of presentation. Solitary lesions are often thought to be typical, but multiple lesions frequently occur. Atypical clinical features like multiple non-indurated tender chancre and ulcers with irregular and slightly undermined margins, and unilateral lymphadenitis are also seen. Our patient presented with multiple chancre with atypical morphology, among them one was indurated and others were non-indurated. Furthermore seen was unilateral lymphadenitis.

According to Koranne et al., out of 36 untreated primary chancre case four patients with primary syphilis had multiple chancre; two with two ulcers, one with three ulcers and one had four ulcers, three cases had only unilateral lymphadenitis. Lesions that can be confused with the chancre of primary syphilis include herpes simplex virus infection, chancroid, fixed drug eruption, lymphogranuloma venereum, granuloma inguinale (donovanosis), traumatic ulcer, furuncle (boil), and aphthous ulcer. In conclusion, multiple primary chancre with atypical manifestation as in our case appears to be rare we have to reconsider every case of multiple genital lesion to rule out syphilis.

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Dermatological manifestations of human immunodeficiency virus/acquired immunodeficiency syndrome in era of highly active antiretroviral therapy

Sir,

Dermatological manifestations are seen at every stage of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), and are often earliest and the only sign of HIV/AIDS. The advent of highly active antiretroviral therapy (HAART) has been largely beneficial to patients with HIV associated skin disease, but novel side effects of these drugs have emerged.[1,2] Thus, we had conducted cross sectional observational study to know the epidemiological profile of cutaneous manifestations of HIV in patients who were on HAART.

This study was conducted in Dermatology Outpatient Department of SMIMER, Surat, from April 2010 to January 2011, with prior permission from institutional ethical committee. 150 HIV positive patients who were referred from antiretroviral therapy (ART) center and were on HAART were included in the study. Children below age of 18 years, pregnant women and patients with transient nevirapine induced rash were excluded from the study. Detailed history of selected patients was recorded in a predesigned proforma. Cases were thoroughly examined and investigated.

Out of 150 cases, 107 (71.33%) were males and 43 (28.66%) were females. Majority of the patients were from age group of 31–40 years comprising 76 (50.66%) cases, followed by 41 (27.33%) in age group of 18–30 years, 25 (16.66%) in 41–50 years, and 8 (5.33%) cases were above the age of 51 years. Maximum number of cases observed were of adverse cutaneous drug eruption (ACDE) comprising 31 cases (20.66%), followed by herpes zoster (HZ) 22 (14.66%), dermatophytosis 19 (12.66%), papular and pruritic eruption (PPE) of HIV 18 (12.00%), herpes genitalis 15 (10%), pyoderma 12 (8%) and variable prevalence of other dermatosis.

Broadly out of total patients, nearly 63.34% of patients were of infectious etiology, 20.66% were of drug reactions and 16.66% were of inflammatory conditions. This finding is corroborated with study done by Calista et al.[1]

ACDE was the most common findings [Table 1] (20.66%) and was consistent with study done by Calista et al.[1] Their study also had reported 20% prevalence of ACDE in patients who were on HAART. Sharma et al. in their study have reported 44.4% ACDE in patients on HAART.[3] Out of 31; 29 patients had maculopapular rash, one patient had fixed drug reaction and one patient had Stevens–Johnson syndrome. In our study, 94 patients who were on nevirapine, 20 patients (21.27%) had experienced exanthematous rash. This finding was consistent with study done by Ward et al.[2] Sharma et al. reported nevirapine rash to the tune of 11.8%. [4] Second most common presentation was HZ (14.66%). This finding is corroborated with study done by Hengge et al.[5] Two patients had 2nd attack of HZ; two had multidermatomal HZ [Figure 1], three had HZ ophathalmicus (HZO). CD4+ count in two patients with 2nd attack of HZ was 226 cells/µm and 436 cells/µm. On other hand in patients with HZO median CD4+ count was 90 cells/µm, suggesting advanced degree of immunosuppression.

Dermatophytosis was next manifestation that had accounted for 12.66%, and is comparable to study done by Hengge et al.[5] Median CD4 count was

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