A Case Report of Condylomata Lata, an Unsual Manifestation of Syphilis in The Western World

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ABSTRACT: A 62-year-old caucasian male with an intellectual disability was referred due to two exophytic, pediculated, non-infiltrated perianal lesions of reddish-pink colour, surrounded by ten hyperpigmented brown macules in the gluteal area (figure 1). No relevant prior history was available. Histology showed marked acanthosis with surface erosion and exuberant neutrophil exocytosis; a dense plasmocytic inflammatory infiltrate was present (figure 2). Serological testing showed increased anti-treponemic IgG and IgM titers and RPR title of 1:128.
Condylomata lata is a rare clinical manifestation of secondary syphilis consisting of pinkish or hypopigmented papules or plaques in the anogenital area. They are extremely infectious, and their recognition enables prompt diagnosis and effective therapy, with excellent prognosis.

KEY WORDS: syphilis, condylomata lata, western world

INTRODUCTION

Condylomata lata is a clinical manifestation of secondary syphilis characterized by flesh coloured or hypopigmented papules or plaques in the anogenital area (1). It is an infrequent diagnosis in the developed world, especially when compared with the typical presentations of secondary syphilis (2). However, the importance of recognising this manifestation is paramount, as these flat condylomas are extremely infectious and their recognition will enable prompt diagnosis and therapy.

This report presents a rare atypical case of condylomata lata as the main manifestations of secondary syphilis.

CLINICAL CASE

We present the case of a 62-year-old caucasian male with no relevant prior history apart from congenital deafness and intellectual disability, referred to the dermatology clinic due to two perianal lesions. These lesions, localized at 3 and 9 o'clock positions, were exophytic, pediculated, with a non-infiltrated base, and had a diameter of 1 and 3 centimetres. They presented reddish-pink colour, with a moist and vaguely papillomatous surface (Fig 1a).

Additionally, there were about ten hyperpigmented brown macules nearing one centimetre in diameter, dispersed, localized mainly in the right gluteal area (Fig 1b). No other cutaneous findings were present. The patient was not aware of how long the lesions had been present, and history of sexual risk behaviour or other relevant data was not feasible.

The right perianal lesion was biopsied, and histological examination showed marked acanthosis with surface erosion and exuberant neutrophil exocytosis. In the underlying dermis, a moderately dense infiltrate was present with plasmocytic predominance.

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Serological testing showed increased anti-treponemic IgG and IgM titers and RPR title of 1:128.

These findings allowed the diagnosis of secondary syphilis to be established. The patient was medicated with one injection of intramuscular benzathine penicillin G 2.4 million UI, with complete resolution of all lesions two months after treatment and RPR 1:16 after four months. The patient was discharged after one year of follow-up, with no recurrences.

DISCUSSION

Secondary syphilis, the haematogenous spread of spirochete in the sexually or vertically transmitted infection caused by Treponema pallidum, is increasingly frequent in developed countries (3). It presents diagnostic and epidemiological challenges, with many cases being asymptomatic and others presenting with unusual or unspecific clinical characteristics (3,4). The most common presentation of secondary syphilis is a red-to-brownish generalized maculopapular rash (80%–95% of cases), which may be accompanied by lymphadenopathy, other lesions such as mucous patches and condylomata lata, and unspecific systemic symptoms such as sore throat, malaise, fever, headache and weight loss (4).

Condylomata lata are pinkish or hypopigmented, painless papules or plaques covered in a pale grey, mucoid exudate, found most frequently in intertriginous areas of the anogenital skin or mucosa. Typically, they are smaller and flatter than condyloma acuminata, but less commonly can be larger, up to several centimetres in size, exophytic and pedunculate (5). These characteristics, in addition to a frequent absence of reported risk factors for sexually transmitted disease, leads to frequent misdiagnoses as condyloma acuminata, malignancies or lymphogranuloma venereum (2). Diagnosis is further hampered if other clinical manifestations of syphilis are absent.

Histological examination is frequently performed to exclude malignancy. Superficially, it can reveal long and broad rete ridges or overt acanthosis. An underlying dense lichenoid lymphoplasmacytic inflammatory infiltrate with marked neutrophil exocytosis and exuberant vascular proliferation and dilatation is also typical (1). Condylomata lata are also characterized by their high concentrations of spirochete in the lesions, making them the most infectious of syphilis lesions; indeed, the lesions are thought to be able to spread by direct contact, explaining their clustering in a specific body area (6).

Once diagnosis has been established, treatment is similar to that of other presentations of secondary syphilis and should be promptly initiated. One injection of Intramuscular benzathine penicillin G is the first line of therapy for cases of secondary syphilis (7). In case of penicillin allergy, oral doxycycline should be prescribed. Sexual partners should be traced and treated to avoid spread and subsequent disease (7).

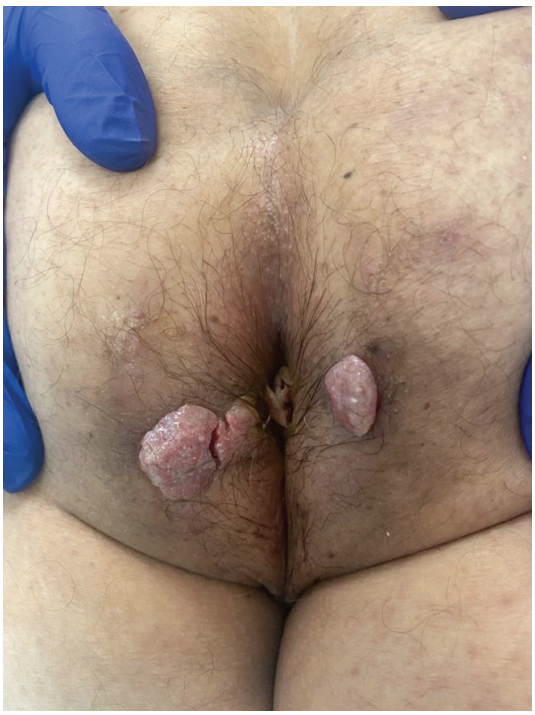

Figure 1a

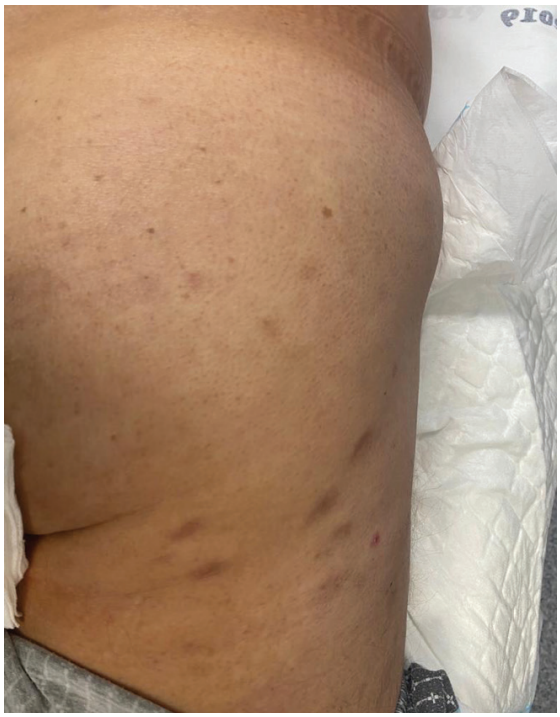

Figure 1b

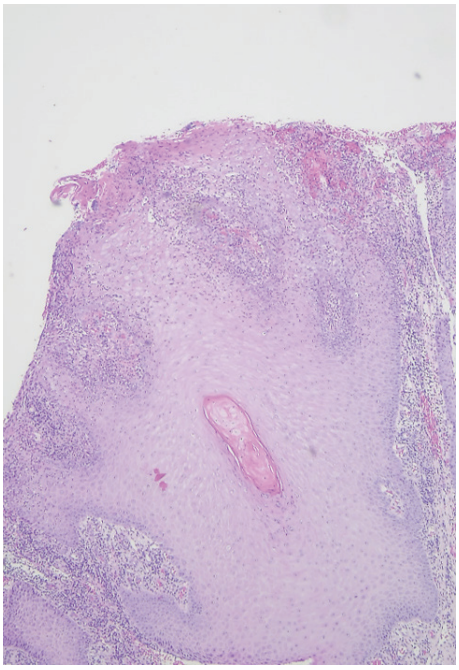

Figure 2a

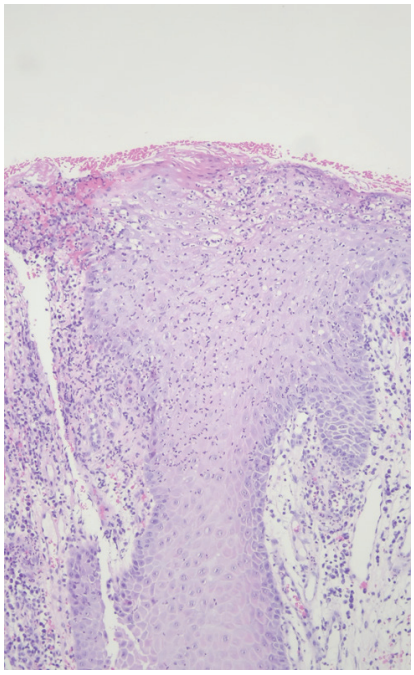

Figure 2b

Screening for other sexually transmitted diseases in affected patients is also recommended. Prognosis is very favourable upon treatment, with an adequate response being documented by clinical resolution and RPR titer reduction of four-fold or more. However, re-infection is frequent.

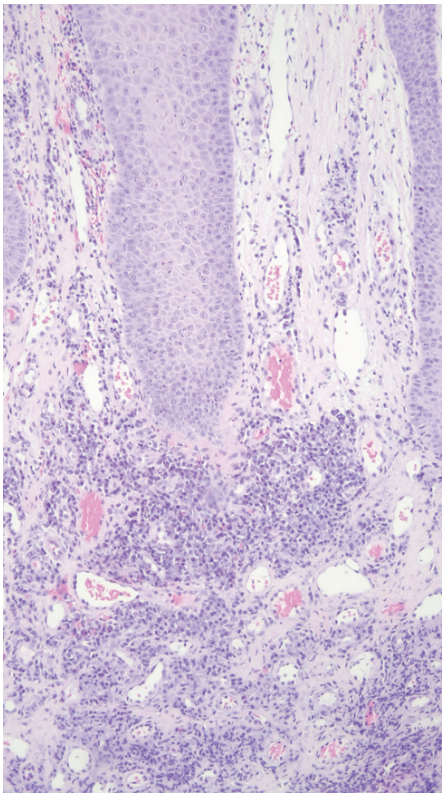

Figure 2c

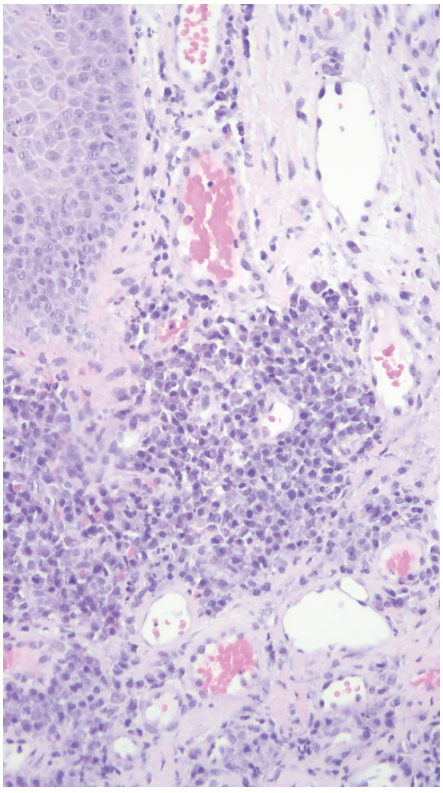

Figure 2d

Figs 2a-2d. Acantholysis with surface erosion and exuberant neutrophil exocytois. In the dermis a moderately dense infiltrate with palsomocytic predominance. H&E.

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