

## CASE REPORT

### EXUBERANT ULCERATED LESIONS OF SECONDARY SYPHILIS ON THE PALMS - AN UNUSUAL PRESENTATION

**Nasser Rashid Dar, Sadia Masood\*, Naeem Raza\*\***

Department of Dermatology, Combined Military Hospital, Bahawalpur, \*Naval Hospital, PNS Shifa, Karachi and \*\*Combined Military Hospital, Abbottabad

Ulcerated lesions in secondary syphilis are rare. Exuberant tissue is seen in condylomas of syphilis, which occur in flexural and occluded areas of the body and not in open areas such as palms. We report a case of secondary syphilis that presented with ulcerated exuberant lesions on palms, which on initial examination gave an impression of lesions of Orf and Milker's Nodule.

**Key words:** Secondary Syphilis, Exuberant, Ulcerated lesions, Palms

## INTRODUCTION

Secondary syphilis is known in Dermatology as a great mimicker of skin disease, just as in Neurology Multiple Sclerosis is famous for mimicking any neurological sign. Secondary syphilis can present with a myriad of skin lesions including macules, papules, psoriasiform lesions, lichenoid lesions, condylomas, oral ulcers, alopecia and rarely ulcerated, nodular<sup>1</sup>, pustular and varioliform lesions. Exuberant tissue is seen in condylomas of syphilis which occur in flexural and occluded areas of the body and not in open areas such as palms. We report a case of secondary syphilis who presented with ulcerated lesions of the palms showing exuberant tissue. These lesions on initial examination resembled the lesions of Orf / Milker's nodule which are viral infections presenting as one or more ulcerated nodules commonly located on dorsal and palmar aspect of hands.

## CASE REPORT

A 28 years old soldier presented with non healing, painless ulcers over palms of two months duration. Examination revealed two ulcers, one on the left palm and the other on right index finger near the crease lines, measuring about 1 to 2 cm (Fig.1). The ulcers had a firm base with shiny dome shaped granulating surface and a mild central crust. The axillary and epitrochlear lymph nodes were enlarged, firm and non tender. Initially the patient was suspected of having Orf / Milker's nodules. However there was no history of contact with cows or sheep. On further inquiring the patient gave history of ulcer over the penis, which was noticed four months back and was treated as fixed drug eruption and healed without any specific treatment.

Few days later erythematous macular lesions were also noticed over both soles measuring about 1 to 2 cm with small central crusting. Genital examination showed firm, erythematous papules over glans penis. A faint macular rash of generalized

distribution was noted over the trunk. General and systemic examination was within normal limits.

Haemogram, urinalysis, serum biochemistry, hepatic and renal function tests were within normal limits. VDRL (Venereal Diseases Reference Laboratory) test was positive in 1:16 dilution and Treponema pallidum haemagglutination test was also positive. He tested negative for HIV (Human Immunodeficiency Virus) antibodies by latex agglutination method. Skin biopsy on histopathology from the lesion over the palm revealed an ulcerated epidermis. There was morbid infiltrate of lymphocytes, histiocytes and plasma cells in diffuse as well as perivascular and peri-appendigeal distribution. Blood vessels showed endothelial proliferation but no thrombosis and necrosis. Examination of CSF was not done (In military setting lumbar puncture is not done in the absence of clinical evidence of CNS involvement and these patients are treated with benzyl penicillin, which can cover any asymptomatic neurological infection). His spouse was not available for examination because she was living in another city.

The patient was treated with intramuscular injections of benzyl penicillin 1 million units 6 hourly for 15 days. The lesions started improving in 5 days and healed with mild scarring by the end of treatment period. His VDRL was reactive in 1:8 dilutions after 3 months.

**Figure-1 : Raised ulcerated exuberant lesions on palms along with typical papular lesions on the glans penis**

## DISCUSSION

In the light of history of a preceding genital ulcer, subsequent development of multiple papular and macular lesions over glans and soles respectively, lymphadenopathy, positive serology, suggestive histopathology and prompt response to penicillin, our patient was having secondary syphilis with ulcerated/exuberant lesions of the palms.

Ulcerated lesions in secondary syphilis are rare. Such lesions may occur in the settings of leu maligna,<sup>2</sup> which is characterized by fever, headache and muscle pain associated with sharply marginated ulcer. The histology is that of obliterative vasculitis. Our patient did not have any of these findings.

Ulcerated secondary syphilis may also occur as a result of pustular and varioliform syphilides<sup>3</sup> or may be confused with precocious tertiary syphilis in HIV.<sup>4</sup> Our patient had neither of these lesions and was HIV negative.

Ulcerated secondary syphilis has very occasionally been described in syphilis occurring in normal individuals. Vinod et al<sup>5</sup> described a 30 years old, HIV negative, ex- army man with secondary syphilis who had firm papular lesions over genitalia and ulcerated lesions on wrist and hand.

Exuberant tissue is seen in condylomas of syphilis which occur in flexural and occluded areas of the body and not in open areas such as palms as was seen in our patient. The lesions were situated near crease lines of joints where frequent movements

could have been responsible for the formation of such lesions.

The clinical morphology of the lesions on palms with ulceration and elevated exuberant tissue in our patient deserve to be mentioned because these are unusual. On initial examination these resembled the lesions of Orf / Milker's nodule which are viral infections presenting as ulcerated nodules commonly on dorsal and palmer aspect of hands. It is recommended that such lesions may be included in the differential diagnosis of secondary syphilis in appropriate settings.

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### Address For Correspondence:

**Dr Naeem Raza**, Department of Dermatology, Combined Military Hospital, Abbottabad. Tel:3516154

**Email:** naeemraza561@hotmail.com