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CASE REPORT

What if skin eruption is not caused by allergic reaction to drugs?

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Abstract: In this case report authors have described a case of a 39 years old Caucasian single man who was unsuccessfully treated for an allergic reaction to drugs by multiple dermatologists, due to two etiologically different diseases. It was a classical second stage syphilitic infection and positive serologic tests for HIV infection, proved by screening and confirmatory tests. Syphilitic infection was treated and followed up by dermatologist and for the treatment of HIV infection, the patient was referred to the Centre for treatment HIV/AIDS in Kosice *(Fig. 4, Ref. 3)*. Full Text (Free, PDF) *www.bmj.sk.*
Key words: secondary syphilis, papulous recidivans form, positive tests for HIV.

Syphilis is a chronic, systemic infectious disease, which affects all parts of body, without treatment could persist for years, and leads to severe damage of the central nervous system and blood vessels or even death. The infection is caused by Treponema pallidum. In the acquired infection, the entrance site is skin and mucous membranes, but transmission of infection can by caused also by blood transfusion, where spiral bacteria are present, also called decapitated syphilis. Nowadays it almost never happens. When administering an inadequate dose of antibiotic treatment during the incubation period, it could postpone the appearance of the primary chancre, or eventually mask symptoms of primary or secondary syphilis, but the blood tests are positive, which is called a masked syphilis (1).

The masked course of infection was observed also in our case, where the first stage of infection and early secondary stage was covered with oral antibiotic, which was not specifically applied for this infection. The primary chancre was not observed. Chancre can occur not only in the genital area, but also in the extra genital areas like lips, tongue or even breast nipple. It mainly depends where spiral bacteria enter the body. Our patient was bisexually oriented and also reported a wide use of illegal drugs. In our case, the infection was diagnosed in the secondary stage. General somatic symptoms could be in the secondary stage completely absent or are very inconsiderable (2). Patient reports he had not observed any symptoms, until admitting to our hospital, he had been working and was treated by multiple dermatologists as an outpatient for the skin rash.

Case

Patient was a 39 year old Caucasian single man; his past medical history was noncontributory. He had just ordinary childhood diseases. His vaccinations was up to date, he did not been hospitalized. In the epidemiologic history he admitted sexual activities with men and women. He has reported multiple unknown sexual partners on his business trips (Canada, EU), and had experiences also with illicit drugs (heroin, cocaine, marihuana, LSD, amphetamines). He came to our clinic for an unsuccessfully treated recurrent palm and soles eruptions. The rash interfered with his business and social life and caused a social handicap. He was unsuccessfully treated by three dermatologists. He was treated as an outpatient from summer 2008 as a recurrent allergic reaction to drugs, using antihistaminic, local steroids and moisturizes creams, in three different occasions. He used antibiotic each time for 7 days. After the antibiotic treatment, the patient reported a temporary relief of his symptoms on hands and soles. After a while the patient reported that he had noticed exacerbations and disseminations of skin rashes. He states that when he noticed a rash in his face, he had looked up for medical help in different cities. In our clinic, biologic samples were taken for screening tests (RPR, TPHA, and HIV 1, 2) and also a complete blood count and lipid panel. Patient was admitted to the hospital on 15th January 2009 with the diagnosis of secondary syphilis. Within less than 24 hours the microbiologic labs has proved the diagnosis of syphilitic infection. We have begun the antibiotic therapy.

Local dermatologic finding

On the chest (Fig. 3) and extremities, with the maximal presentation on palms and soles (Figs 1 and 2) the light red and pink papules were present, extended over the level of skin, marginal zones had inaccurate level with skin on surface with pealing collar on margins of the rash. On the back, columbiform eruptions were present (Fig. 4), typical for the recurrent syphilitic infection. Mucous membranes in the mouth, foreskin and glans of penis were also affected. Dark brown discolorations without evident subjective symptoms were present.

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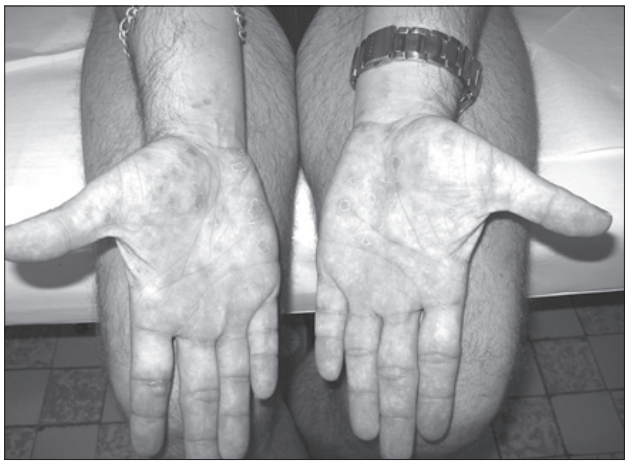

Fig. 1. Maculo-papulotic syphilis rash on palms.

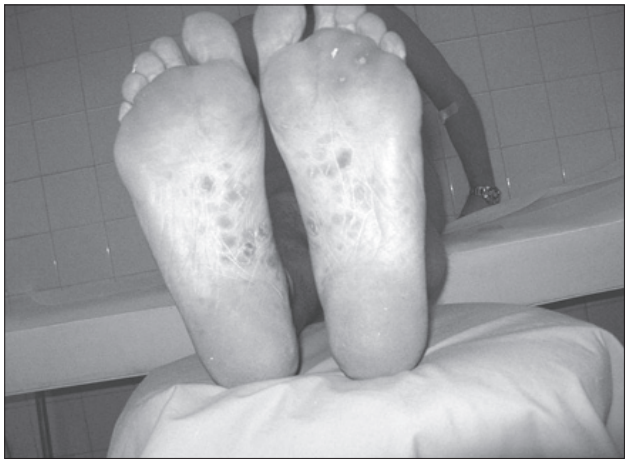

Fig. 2. Papulotic nodular syphilitic rash on soles.

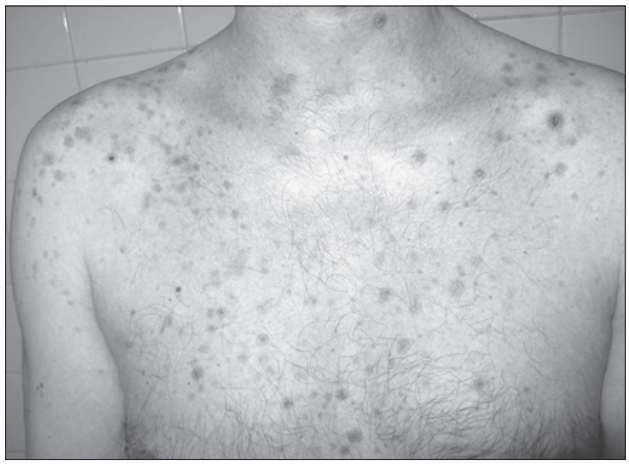

Fig. 3. Papulotic and papulosquamous syphilitic rash on trunk.

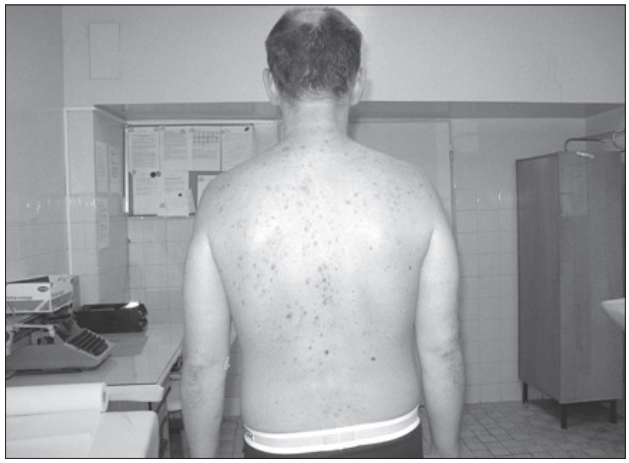

Fig. 4. Papulotic rash with columbiform structures on back.

On the central part of the face, hair, and the front part of chest, macular lesion with scales on the surface were present. Lesions had not accurate margins with yellowish obscure scale on the top.

Patient also stated that during longer and intense stay on the sun, he was photophobic.

The inguinal lymphatic nodes were bilaterally enlarged of size approx. 0.5 cm, hard consistency, not painful. In the armpit we have palpated enlarged lymphatic nodes of size approx. 1 cm, hard and painless. Rest lymphatic nodes were not enlarged.

Laboratory findings

A complete blood count was within normal limits, ESR was ^ 32/68. He had elevated GMT, TAG, cholesterol, ASLO and C reactive protein. He had a positive finding of IgA antibody to H. pylori, but negative for IgG H. pylori and HBsAg.

Blood test for STDs: RPR+, VDRL quantitative positive + 1:64, FTA Abs IgG 1:5+++, FTA Abs IgM 1:10+, VDRL qualitative +, ELISA recomb.+, ELISA IgG+, ELISA IgM+, TPHA 1.80, 1:160 non specific.

Summary: The present of specific and non specific antibodies to treponema pallidum had proved the diagnosis of syphilis (National centre for syphilis, Kosice).

Cultivation from urethra: neisseria gonorrhoe negative, mycoplasma hominis negative, ureaplasma urealiticum, trichomonas vaginalis, Candida albicans positive, E.coli positive.

HIV 1, 2 test positive (ELISA), HIV blot: anti HIV 1 positive, ULTRA HIV Ag/Ab positive.

Summary confirmatory test from the National centre for HIV/AIDS Bratislava: anti HIV 1 positive.

Therapy

Patient reported that he had allergy for penicillin (skin rash), so therapy began with tetracycline antibiotics for 28 days and as a prevention to Jarish Herxheimer reaction he was administered prednisone and antihistaminic. For the positive finding from urethra, he used the antimycotic therapy (ketoconazol), proton pump inhibitors, and anxiolitic.

Diagnosis

Secondary syphilis recurrent papulotic form

HIV positivity
Dermatitis seborrhoica-exacerbated in HIV positivity
Persistent generalized lymphadenopathy syndrome

Discussion

From the sexual history detailed to the probability of infections (whether HIV or syphilitic), we assume that patient was infected between March – April 2008 when he was traveling for business trips to Czech Republic, Nederland and Canada. The sources of infections were not identified, because it was a group of sexual contact with unknown partners. We cannot say if the source of infections was one or multiple, and which infection was acquired earlier. Even a goal directed to investigation on glans penis, sulcus coronarius and foreskin we can not see a scar after the primary chancre, so we assumed that infection was acquired in a different way. We also considered that symptoms of both infections had been altered by using a non effective antibiotic therapy, which was a cause of multiple clinical presentations. Local dermatologic findings after 28 days of therapy were healed; there were just small persistent discolorated lesions. Clinical presentations of seborrhoic dermatitis were completely resolved. We consulted and referred the patient to the Centre for treatment of HIV/AIDS. After the velvet revolution, Slovak became opened to Europe. Migration plays an important role in both directions for work, tourism, and knowledge. Since that period we have observed a changed sexual behavior of peoples, spreading promiscuity and prostitution. Mentioned social-political evolution has showed an increased incidence of classical sexually transmitted diseases. Health services in Slovakia is also undergoing transformation, a lot of Dermatovenerologic departments are closed. By the liquidation of inpatient Dermatovenerolgic departments in some regions, the continuity of reporting STDs, early diagnostics and therapy was disrupted. In most of the cases, it was imported infections. Our practical experience showed that people did not have finance for the treatment abroad, so they come back home. In some regions there is no nursing staff responsible for the epidemiology of STDs. Health legislations has also changed. Prevention and control are now the responsibility of the epidemiologic section of the national health centers. That massive change has a negative effect on the underreporting of STDs. In cosmopolitan traveling and migration of people, the primary dermatologist should think also on this cause of skin eruptions in case of an unclear presentation.

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