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Leprosy and syphilis: a case report

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This is a report on a leprosy patient who was referred from a provincial leprosy clinic to a leprosy hospital because of skin lesions that could not be diagnosed at the clinic. The patient was found to be suffering from secondary syphilis as well as leprosy. Comments are made on the findings that could be common to both leprosy and secondary syphilis.

A 22-year-old unmarried man was referred to All Africa Leprosy and Rehabilitation Training Centre (ALERT), Addis Ababa, because of skin lesions on the scrotum (Figure 1). At the referring clinic, a diagnosis of leprosy and a classification of 'lepromatous' had been made. The patient was on DDS and had received treatment for 3 months.

History taken at ALERT revealed that the patient had noticed skin patches of leprosy for 1 year. Three months prior to coming to us he had observed lesions on the scrotum. His parents were dead and he was living with his uncle. There was no history of contact with leprosy. He admitted to sexual intercourse before developing the scrotal lesions.

On examination the patient was found to have a thickened right ear and papulo-squamous lesions around the nose and between the lower lip and the chin (Figure 2). There were ill-defined hypopigmented macular lesions on the face, on the upper arms and on the buttocks. Sensation was intact in these lesions. Erythematous lesions were seen on the palms. The cervical and inguinal lymph nodes were enlarged. Of the nerves, the great auricular, the ulnar and the radial cutaneous were bilaterally enlarged and they were not tender.

On the scrotum and in the anal area foul-smelling lesions of condylomata lata were observed. Sensory testing revealed anaesthesia of the hands and feet.

Laboratory investigation: the bacillary index (BI) was 3.0 (3+, 2+, 2+, 5+, 3+, 2+), morphological index (MI) was 0, and VDRL reaction ++++ (the

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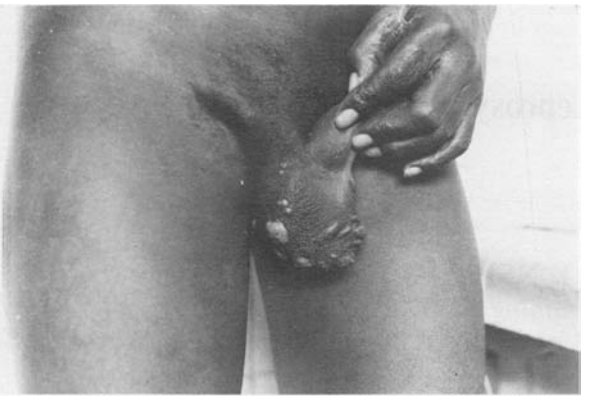

Figure 1

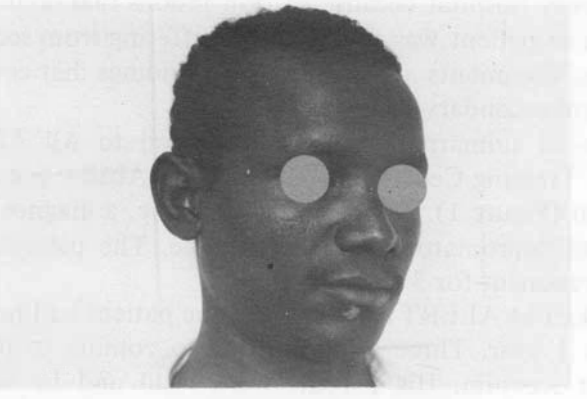

Figure 2

strongest recorded in our laboratory). Dark ground illumination examination and other serological tests for syphilis could not be done at our hospital.

A diagnosis of BL leprosy and secondary syphilis was made.

Treatment included a course of procaine penicillin and DDS and later a course of Rifampicin with DDS.

The patient showed very remarkable improvement on penicillin, all syphilitic lesions disappearing after about 3 weeks.

Comments

Syphilis, and secondary syphilis in particular, has been known to be a great imitator of other diseases. The following manifestations can be found in secondary syphilis:

(a) *Leucoderma*, i.e. hypopigmentation of the skin. This could be confused with hypopigmentation in tuberculoid, borderline or lepromatous leprosy.
(b) *Annular lesions* could be confused with similar lesions in tuberculoid or borderline leprosy.
(c) *Papular lesions* can look like papules of lepromatous leprosy or BL.
(d) *Joint pains with fever and malaise.* These are also common manifestations in leprosy patients especially during reactions.
(e) *Uveitis.* Occurs in lepromatous leprosy as well.
(f) *Hoarseness of the voice.* Also found in cases of lepromatous leprosy.
(g) *Lymph node enlargement.* Is a common finding in leprosy especially during reaction.
(h) *Positive reagin serological tests for syphilis.* Lepromatous leprosy is one of the causes of biological false positive tests for syphilis.

Leprosy patients may be exposed to syphilis just like other people in any community and we should be alert to the possibility of confusing syphilitic manifestations with those of leprosy.

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