Leucomelanoderma in early syphilis

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Leucomelanoderma, a well-recognized late feature of treponematoses (Willcox, 1964), is now encountered infrequently. The rarity of syphilitic leucomelanoderma occurring in the early stage of disease prompts us to report the case of a patient with palmoplantar leucomelanoderma as a manifestation of early syphilis.

Case Report

A 40-year-old priest presented with asymptomatic depigmented and hyperpigmented areas on the palms and the soles of 2½ years' duration. The depigmented lesions on the palms had developed first and a month later hyperpigmented lesions appeared nearby. New lesions gradually involved the skin of the backs and sides of the hands and the flexor surface of the wrists. Similar lesions appeared on the insteps of both feet 6 months later. The patient was unmarried and gave a history of multiple sexual exposures over the past 3 years. He denied having had any previous skin rash or sore on the genitalia.

Examination

Bilateral symmetrical areas of depigmentation interspersed with hyperpigmented macules were seen on the palms (Figure), extending on to the flexor aspects of the wrists and the sides and backs of the fingers, and also on

FIGURE Hypo- and hyperpigmented macular lesions symmetrically distributed on the palms and the flexor aspect of the wrists

the instep on both feet. There were no other lesions on the skin or the mucous membranes. Bilateral posterior cervical, axillary, epitrochlear, and inguinal lymph nodes were enlarged, discrete, firm, non-tender, and freely mobile. Systemic examination did not reveal any abnormality.

Routine investigations of blood, urine, and stools were normal. The erythrocyte sedimentation rate was 24 mm. 1st hr (Westergren). The serum Venereal Diseases Reference Laboratory (VDRL) test was positive at a dilution of 1:64 on three occasions. Dark-ground examination of serum from two skin lesions and material obtained by lymph node puncture failed to reveal any treponemes. The cerebrospinal fluid chemistry and cell count was normal and the VDRL test was negative. A chest radiograph was normal and a biopsy from the skin lesions showed non-specific changes.

Treatment

Ten injections of 600,000 i.u. procaine penicillin G in oil with monostearate (PAM) were given over 3 weeks. A few hours after the first injection, a moderate fever with marked constitutional symptoms developed and lasted for about 12 hours.

Result

The lymph nodes regressed and the VDRL titre fell to 1:16 on completion of the treatment.

Comment

The clinical features of leucomelanoderma of the palms and soles and generalized lymphadenopathy in the presence of a positive serum VDRL test in high dilution suggested a diagnosis of early acquired syphilis. The therapeutic response, namely fever after the first injection of PAM, regression of the lymph nodes, and a considerable fall in the VDRL titre further supported the diagnosis of early syphilis. Leucomelanoderma is generally believed to be a manifestation of late syphilis (Willcox, 1964; King and Nicol, 1969; Bedi and Arunthathi, 1972), but in the present case it was seen at an early stage.

References

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