Zosteriform Late Cutaneous Syphilide

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Benign late syphilis—that is, cutaneous, mucocutaneous, and skeletal syphilis—occurs in about 10 to 15% of cases. Cutaneous late syphilis usually presents as nodules, ulcerative nodules, or gumma. The nodular syphilides usually occur as solitary or a few asymmetrical indurated papules the configuration of which, when multiple, is arciform or circinate. Much more rarely they occur in a zosteriform pattern. The following case report illustrates this rare pattern, which, however, has been described by Gaucher Bizard and Bralez (1915).

CASE REPORT

A man aged 36 was admitted to the Institute of Venereology, Madras, on 2 August 1961 with skin lesions on the left temple, scalp, and chin, and on the left side of the abdomen and groin (Figs. 1 and 2) of six to seven months' duration. He had also had a sore penis for two years.

He gave a history of having had bilateral bubo 21 years previously which was incised, and also of a white discharge with sore penis three years previously which had been treated with about 16 intra-

FIG. 1

muscular injections of penicillin (? procaine) and one intravenous injection of neoarsphenamine.

On examination multiple scars were seen on the dorsum of the prepuce, in the glans, and in the groins. A chronic sclerosing granulomatous ulcer in the coronal sulcus extending from 4 to 9 o'clock position, clinically suggestive of venereal granuloma, was present. The inguinal lymph nodes were just palpable, discrete, and painless. An ulcerated nodule was present on the medial side of the left groin. In addition, multiple thin atrophic non-contractile scars with an arciform configuration and a few indurated ulcers were found on the front and left side of the abdomen corresponding to the seventh to ninth dermatomes, with an ulcerated papule just to the right of the anterior midline. Similar ulcers and scars were seen on the temple and scalp on the left side, mainly in the distribution of the first division of the trigeminal nerve, and a few on the left side of the mandible.

Investigations.—Darkground illumination of smears from all ulcers was negative for *Treponema pallidum*. The blood V.D.R.L. slide test was reactive in 16 dilutions. Cerebrospinal fluid: four lymphocytes per cu. mm., total proteins 35 mg./100 ml., V.D.R.L. non-reactive. Non-capsulated forms of *Donovania granulomatis* were obtained from the penile lesion only.

Biopsy of the skin nodules from the scalp and abdominal wall was reported on by Professor A. S. Thambiah as follows: "Focal necrosis of the epidermis with foci of granulations in the dermis chiefly around the blood vessels consisting of epithelioid cells, lymphocytes, and histiocytes; vessels show endarteritis obliterans."

With P.A.M. (procaine penicillin in arachis oil with aluminium monostearate) 2 ml. intramuscularly daily for 10 days the lesions on the scalp, face, abdomen, and groin healed. Bisoxyl (bismuth oxychloride) 2 ml. intramuscularly once every five days was also given for a total of 10 injections. Subsequently streptomycin 1 g. intramuscularly twice daily for 10 days was given and the penile lesion healed.

COMMENT

This case simulated herpes zoster very closely. The absolutely painless onset and the occurrence of ulcerating nodules one after the other over the previous six to seven months; the arciform, polycyclic, or circinate configurations;

FIG. 2

and the characteristic thin atrophic non-contractile scars distinguishing it from herpes zoster strongly suggested late syphilis. There was no history of chicken-pox in the neighbourhood. The patient having had penicillin injections three years previously probably means either that it was not the oil-penicillin or that in spite of treatment the late cutaneous syphilide had occurred. The blood V.D.R.L. slide test, the healing of the lesions on the trunk, face, scalp, and groin, but not the penile sore, taken in conjunction with the biopsy report, are in favour of its being a late syphilide.

The presence of *Donovania granulomatis* from the penile sore, the failure to heal with P.A.M., and the prompt response to streptomycin therapy confirm that the patient also had venereal granuloma.

Unfortunately, virological or appropriate histopathological studies to prove or disprove the viral cause could not be done. The search of the available literature on this topic was fruitless. Stelwagon (1921) published a photograph with the following legend "Tubercular syphiloderm with decided ulceration showing a rare zosteriform distribution" and quoted Gaucher Bizard and Bralez (1915). The present case is the first to be reported in India.

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REFERENCES

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