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Letter to the Editor

Syphilitic hepatitis: Look for raised alkaline phosphatase level

Dear Editor,

Syphilis, a sexually transmitted disease, is capable of involving practically every organ in the body. Hepatic involvement in syphilis may be seen at any stage of the disease.¹ Syphilitic hepatitis in primary syphilis with concomitant secondary syphilis is quite rare. We report a case of primary syphilis with concomitant secondary syphilis, along with syphilitic hepatitis, which dramatically responded to penicillin.

A 40-year-old male patient presented with sore penis and inguinal swelling since two weeks and generalised non-itchy skin rash with low-grade fever since one week. There was history of unprotected, penovaginal sexual exposure with an acquaintance, two weeks prior to onset of sore penis. General examination revealed no icterus. There was generalised non-tender lymphadenopathy involving cervical, occipital and epitrochlear lymph nodes. Systemic examination was normal with no hepatomegaly. Dermatological examination revealed a generalised, faint, erythematous to hyperpigmented macular and papular rash with mild scaling involving the trunk. Buschke-Ollendorff sign was negative (Fig. 1). The prepuce was swollen with a healing ulcer and button-like induration at four O' clock position and impossible to retract. There was no visible discharge. One left inguinal lymph node was enlarged, firm, non-tender, mobile and non-fluctuant (Fig. 2). Palms and soles, hair, nails and oral mucosa were normal. He was provisionally diagnosed as a case of secondary syphilis with possible persisting primary chancre. Sub-preputial smear and culture, and dark-ground examination for treponema were negative. Haematological investigation revealed mild leucocytosis (11,400 cells/cu mm) with neutrophilia (88%). Urine routine examination was unremarkable and bile salts and bile pigments were absent. Liver function tests (LFT) showed mildly raised serum bilirubin (1.8 mg %) with positive direct Van den Berg reaction. Serum glutamic oxaloacetate transaminase (93 IU/L) and serum glutamic pyruvate transaminase (60 IU/L) were marginally raised. Serum alkaline phosphatase (1260 U/L) was markedly raised. Serology showed a highly reactive VDRL (1:128) and Treponema Pallidum Haemagglutination Assay (TPHA) was positive. Tests for HIV, chlamydiae,

HBSAg and HCV were negative. Ultrasound scan of the liver revealed mild hepatomegaly with normal echotexture. Patient was unwilling for liver biopsy. He was diagnosed as a case of secondary syphilis with persisting syphilitic chancre and probable syphilitic hepatitis. He was prescribed one injection of benzathine penicillin 2.4 mega units I.M. The patient showed excellent clinical response to treatment with complete healing of skin lesions and regression of lymphadenopathy. All the liver enzymes rapidly returned to normal after treatment, confirming syphilitic hepatitis.

Though the incidence of syphilitic hepatitis is currently unknown, it was found to be 9.7% in an earlier study on syphilis published in the Lancet in 1975. A more recent retrospective study showed 2.7% of early syphilis patients had syphilitic hepatitis.² The most consistent abnormality in case of syphilitic hepatitis is disproportionately raised serum alkaline phosphatase levels.³ This case highlights the importance of looking for disproportionate increase in serum alkaline phosphatase levels in suspected syphilitic hepatitis and the rare occurrence of syphilitic hepatitis in secondary syphilis with concomitant primary syphilis.

Fig. 1 – Faint hyperpigmented maculo-papular rash seen on the abdomen and thighs with enlarged left inguinal lymph node.

Fig. 2 – Swollen prepuce with a healing ulcer and button-like induration at four O' clock position. Enlarged left inguinal lymph node seen.

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Letter to the Editor

Rectus palsy and dengue

Dear Editor,

I read with great interest the case report titled “Lateral rectus palsy in a case of dengue fever” by Mishra et al published in *Med J Armed Forces India* 2015; 71 (July Supplement issue): S101–103.¹

Indeed, dengue is a common tropical infection with several uncommon clinical presentations.² Focusing on cranial nerve palsy as a complication of dengue, it is extremely rare. Considering cranial nerve controlling ocular movement, there is a recent report by Shivanthan et al. on abducens nerve palsy.³ Shivanthan et al. noted that “dengue related abducens neuropathy may be considered as a differential diagnosis in cases of acquired lateral rectus palsy after dengue fever”.³ It is no doubt that rectal palsy can be seen in dengue, however, the myth is on the pathophysiology. Indeed, mononeuropathy can be seen after dengue and the immunopathological process is usually mentioned.^{4,5} In addition to immunopathological process, the direct involvement of nerve by local internal bleeding might be another possible explanation for the palsy. Nevertheless, the palsy might be an accidental concurrent finding. This has to be verified and Mishra et al. did not mention for this aspect.

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