Images in Infectious Diseases

Oral cavity syphilides


Two epidemiologically unrelated human immunodeficiency virus (HIV)-infected patients (a 28-year-old man who engaged in sexual intercourse with men and a 20-year-old transwoman who engaged in sexual intercourse with men) presented with generalized papulosquamous rashes highly suggestive of secondary syphilis (Figure 1A and Figure 1B). Thorough clinical examinations revealed asymptomatic oral lesions. Patient 1 exhibited a rounded erythematous macule surrounded by a violaceous crescentic halo over the hard palate (Figure 1C). Patient 2 had an oval mucous patch covered by a whitish pseudomembrane on the lower labial mucosa (Figure 1D). Syphilis serologies (which previously tested negative) yielded positive results. All tegumentary and mucosal lesions regressed after appropriate penicillin treatment. Diagnoses of secondary syphilis with mucosal syphilides were made.

Oral lesions of secondary syphilis may vary in presentation and are probably underdiagnosed[1-3]. They are classified into macular syphilides, papular syphilides (which are rare), and mucous patches[2]. Macular syphilides tend to arise in the hard palate, as in patient 1[1,2]. Mucous patches are considered fundamental lesions of secondary syphilis. They present as painful or asymptomatic, oval or crescentic, slightly raised or shallow erosions, or whitish plaques that may coalesce and form serpiginous lesions. The most frequently recorded sites are the soft palate, pillars, tongue, and vestibular and labial mucosa, as in patient 2. Lesions rapidly regress after treatment. Reasonable precautions, such as wearing gloves, should be taken when handling such lesions since they are reported to be the most infectious of all[1,3]. Syphilis should be included as a differential diagnosis of all unexplained oral lesions[1].
Conflict of interest

The authors declare that there is no conflict of interest.

Informed consent

Informed consent of the patients was obtained for publication of the cases.

REFERENCES

