

Images in Infectious Diseases

Oral cavity syphilides

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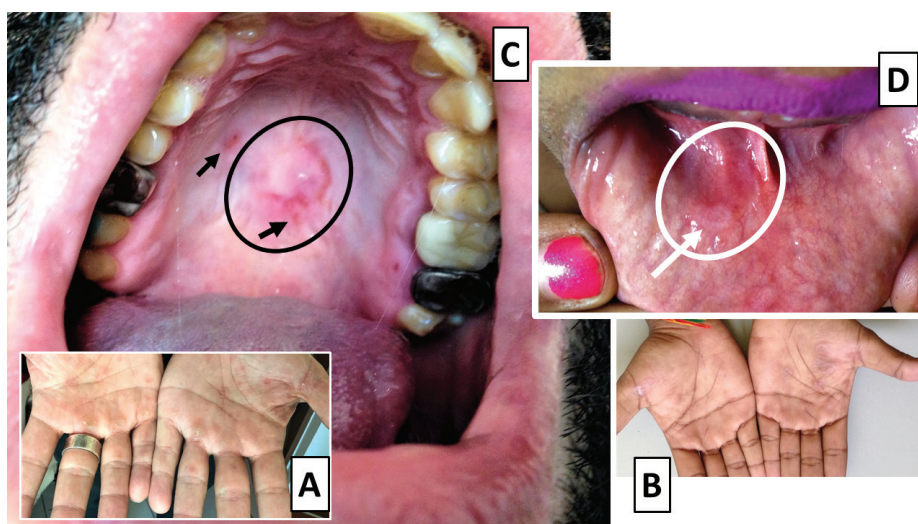


FIGURE 1: Clinical images of the patients. **A)** A papulosquamous rash over the palms of a 28-year old man who has sex with men (Patient 1); **B)** A papulosquamous rash over the palms of a 20-year-old trans woman who has sex with men (Patient 2); **C)** A faint rounded erythematous macule surrounded by a violaceous crescentic halo over the central hard palate of Patient 1 (black circle). A few satellite erythematous pinpoint macules can be seen (black arrows); **D)** A small, faint, oval, aphthous-like mucous-patch lesion covered by a whitish fibrinous pseudomembrane on the lower labial mucosa of Patient 2 (white arrow). An erythematous area extending to the vestibular fold and the labial frenulum is also seen (white circle).

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 underdiagnosed¹⁻³. They are classified into macular syphilides, papular syphilides (which are rare), and mucous patches². 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 all¹⁻³. Syphilis should be included as a differential diagnosis of all unexplained oral lesions³.

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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.

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