Missed Cases of Syphilis

Spregledani primeri sifilisa

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Izvleček

Izhodišča: V 80. letih prejšnjega stoletja je s pojavom HIV-a in s tem povezano vse večjo ozaveščenostjo pri uporabi zaščite med spolnimi donosi prišlo do postopnega upadanja števila okuženih s sifilisom.

Oktobra 1999 je število okuženih s sifilisom doseglo zgodovinsko nizko raven.

V zadnjih letih opažamo, da je število okužb s sifilisom spet v porastu, predvsem med homoseksualno populacijo. Še vedno pa velja zmotno prepričanje, da je sifilis izkoreninjen, zato zdravniki v ambulantah pogosto pozabljajo nanj.

V zadnjih dveh letih smo v naši proktološki ambulanti zabeležili sedem primerov primarne okužbe s sifilisom v 1.stadiju. Večinoma je šlo za moške, ki so prakticirali nezaščitene homoseksualne spolne odnose z nestalnimi partnerji.

Metode: Članek obravnava spregledane primere primarne okužbe sifilisa. V vseh primerih so bili bolniki pred prihodom v našo ambulanto pregledani pri vsaj enem specialistu zaradi težav, ki so bile posledica okužbe s sifilisom, a le-ta med obravnavo bolnika ni bila odkrita. V naših proktoloških ambulantah se držimo načela, da pri bolniku, ki je v preteklosti že imel diagnosticirano okužbo s SPO, napravimo `presejalni test` za najpogostejše SPO. Testiranje razkrije, ali je prišlo do morebitne okužbe z virusom hepatitisa B, virusom HIV, Treponemo pallidum, Neisserio gonorrhoeae, Chlamydio trachomatis in HPV. Presejalni test pa vključuje tudi analno citologijo.

Rezultati: Vsi bolniki, katerih primeri so opisani v članku, so imeli občasno analne spolne odnose. Pri kliničnem pregledu smo pri vseh priskovancih odkrili značilne spremembe na koži, okužbo s *Treponemo pallidum* pa so potrdili tudi laboratorijski testi. Rezultati so prikazani v Tabeli 1.

Zaključki: Incidenca sifilisa po svetu je v zadnjem desetletju v porastu, predvsem pri moških, ki imajo spolne odnose z moškimi. Razloge gre verjetno iskati pri vse manjši uporabi kontraceptivnih zaščitnih sredstev kot tudi v vse večjem številu tveganih spolnih odnosov. Vsi v članku opisani bolniki so imeli občasno analne spolne odnose.

V prihodnosti bo treba nameniti več pozornosti sledenju in ozaveščanju rizičnih skupin, zdravniki pa bodo morali v svojih ambulantah biti pozorni na značilne klinične simptome ter imeti diferencialnodiagnostično v mislih tudi možnost okužbe s sifilisom.

Z izkušnjami smo prišli do spoznanja, da smo

takrat, ko smo pri bolniku odkrili okužbo s SPO, s tem odkrili le vrh ledene gore, saj ob odkritju ene SPO običajno odkrijemo še več drugih SPO, kar je razvidno tudi iz primerov 1,2 in 3. Zato vsakič, ko odkrijemo okužbo s katero koli SPO, napravimo presejalni test za najpogostejše SPO. V to testiranje pa je danes zopet potrebno vključiti testiranje za okužbo s *Treponemo pallidum*.

Pri bolnikih, ki imajo težave z zadnjikom, je izredno pomembno vzeti spolno anamnezo in v skladu s tem iskati čankar na vstopnih mestih (nožnica, anus, usta), kar je razvidno tudi iz primerov 2 in 3. Tako bomo lahko še pravočasno odkrili okužbo s povzročiteljem sifilisa in pravilno ukrepali v smislu zdravljenja, s tem pa tudi preprečiIi širjenje te spolno prenosljive okužbe.

Abstract:
As syphilis incidence has been declining over the past few decades, a general belief is present that it has become practically eradicated. But since the 1990s reports about local outbreaks, mostly related to men who have sex with men (MSM), have been published.

In the past two years we have seen seven cases of syphilis in our proctology units that have been overlooked by other physicians. In this article a few interesting cases are presented.

Not only the risk groups, but physicians as well need to be informed about the increasing incidence of syphilis. When a patient is diagnosed with a sexually transmited infection (STI) or there is a clinical suspicion that he might have one, a screening test for the most common STIs should be performed which should also include testing for syphilis.

Introduction

The reported incidence of syphilis has been decreasing since the late 1970s. It significantly decreased after the appearance of AIDS in the 1980s and stayed stable at a low level throughout most of the 1990s. At the end of the 1980s the number of cases fell notably among men, probably as a result of changed behaviour in response to the emerging HIV/AIDS epidemic.[1]

After a period of declining syphilis incidence, reports about local outbreaks, mostly related to men who have sex with men (MSM), have been published since the end of the 1990s.[1,2,3,4] For the last five or more years, we have been noticing epidemics of syphilis emerging in more and more European cities and cities of the United States as well.

But there is still some general belief present, that this disease is practically eradicated. Therefore it is not uncommon to see the patients that have sought help, but have still been overlooked.

In the past two years we have seen seven such cases in our proctology units. In this article we will present a few interesting cases.

We would like to emphasize, that in our proctology units, if patients have already been diagnosed with a sexually transmited dissease, or there is the slightest clinical suspicion that they might have one, we tend to perform a screening test for the most common STIs.

The screening test includes the tests for hepatitis B, HIV, *Treponema pallidum*, *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, HPV and anal cytology.

Case 1

A 33 year-old MSM was referred to our proctology unit by his infectologist because of tumefaction in the rectum. The patient was tested HIV positive more than 8 years ago and had been taking therapy for approximately 5 years, which he then, self-willingly, stopped taking. He was seen by an infectiologist 10 days prior to his visit to our clinic with rectal problems, a skin rash and an abscess in the inguinal region.

He had a stable relationship with a HIV negative male partner and regular condom use during sex between them was reported. But he had also unprotected receptive anal sex with one-night partner during the holidays in Gran Canaria.

Case 2

A 35 year-old MSM presented with complaints of rectal pain, which had started about

a week earlier. Severe pain was present mainly at night and during defecation, during which he noticed some blood mixed with mucus. He felt pain in the entire spinal column. He got a pain-killer from his general practitioner who, consistently with the patient's history of spinal pain and the patient's failure to reveal his anorectal problems to his GP, thought the patient's main problem was ischialgia. The patient was affraid of disclosing his sexual orientation to his general practitioner as he doubted his confidentiallity and was affraid of his response.

Three days prior to his visit to our clinic, he noticed some skin rash that appeared on his torso, his back and his arms. Twice in that week he also had fever shivers.

He had no stable relationship at that moment. He often uses internet sex chat portals for seeking one-night male partners. Because he lives near the Slovenian south border he has contacts with Slovenian as well as with Croatian males. Inconsistant condom use during sex was reported.

Case 3

A 24 year-old MSM was concerned about a small errosion that he spotted on his lower gum, bordering on the lower lip. He also noticed a red-coloured rash that appeared all over his body. In the last 6 months, he was having diarrhoea which contained blood and mucus. He was having periodic coughs and was hoarse from time to time. He lost 5 kilograms in the last 6 months.

In the last year he had regular sex contacts with a boyfriend from Austria, but they broke up with each other 2 months prior to his visit to our clinic. He had a new partner for one month. Inconsistent condom use during sex was reported by both partners.

His new partner refused to be examined at our proctology unit as he is a military officer and is hiding his bi-sexual orientation. He was tested positive for gonorrhea and chlamydia two weeks later at the Dermatology department and hadn't been tested for syphilis and HIV at all. He denied having homosexual relationships while being examined by dermatovenereologist, and did not bring forward the fact that his partner had a syphilis infection.

Table 1: Findigs from physical and rectal examination, proctoscopy, anal citology and STI test results

	Physical & rectal examination	***proctoscopy***	***anal citology***	***STI test results***
Case 1	- skin rash - red, inflamed perianal skin - lichenised plaque 2x1 cm at the rectal entrance -enlarged and inflamed inguinal lymphatic glands	-inflamed mucosa -a few lichenised inflamed alterations in linea dentata region -deep ulcer 1x1 cm on right side of proximal anal canal	severe dysplasia	-*Treponema pallidum infection* -HPV 11, 39, 40, 42, 59, 82
Case 2	- skin rash on torso, back, arms - inflamed perianal skin - strengthened anal muscular tonus	-inflamed mucosa -ulcer in distal anal canal; 2 x 0.5 cm	mild dysplasia	-*Treponema pallidum infection* -HPV 11, 31, 40, 45, 52, 59, 66, 68, 70) -herpetic infection -rectal chlamydia
Case 3	-light redcolour rash over the entire upper body -whitecolour errosion on the lower gum 4x3 mm -enlarged submandibular lymphatic glands -thickness of mucosa in the reach of the finger	-inflamed edematous rectal mucosa covered with blood and mucus	no dysplasia	-*Treponema pallidum infection* - HPV 16, 58, 66 -rectal chlamydia -rectal gonorrhoea
Case 4	-aphthae-like changes on the upper and lower lips -red throat	-minor tear on the lower left side of the linea dentata	no dysplasia	-*Treponema pallidum infection*

Case 4

A 29 year-old married woman sought help at our clinic with complaints of having small wounds in mouth and on genitals. She noticed blood upon defecation and was concerned about the skin rash which had appeared a few months before.

She noticed small wounds in the mouth and on the penis of her occasional sexual partner who confessed having one-night sex with a female sex worker.

Before coming to our proctology unit she had also seen a general practitioner, gynecologist and two different infectologists with a complaint of having reccurent aphtae in her mouth. She also complained about having a reccurrent genital infections and numerous itchy spots all over her body (especially after showering). She was extremely concern about possible HIV infection.

Infectologists found few erythematous alterations on the body which measured approximately 1x3 cm and some ulcers on vestibular mucosa and under the patients tongue which measured about 3x3 mm. They did a smear test of the skin changes on fungus, HSV 1 and 2, and blood tests for HIV. All of the tests came out negative, and repetition of the tests was suggested in order to calm the patient. As repetition of the tests was also negative, psychical support was suggested by the last infectologist.

Findigs from physical and rectal examination, proctoscopy, anal cytology and STI test results are presented in Table 1.

Discussion

In the last decade the levels of unprotected anal intercourse have increased, which lead to increasing number of STIs reported in the literature.[3,4,5] Incidence of early-stage syphilis in the United States and Europe has increased significantly since 2000.[6] The same trend is also seen in our country. The risk of acquiring syphilis is higher in the population of MSM.[7] All of our patients listed in this article have occasionally practised unprotected receptive anal sex. One of them (Case 1) even practised unprotected sex, knowing that he is HIV positive.

STIs are nowadays transmited even more rapidly, not only inside one country or state, but internationaly as well. Interactions among MSM from neighbouring countries are not unusual as we can see in Cases 2 and 3. Low cost airlines enabled migrations on an even larger scale and gave swing to sexual tourism as seen in Case 1.

Risk groups need to be informed and educated that there are many other STIs beside HIV. Until now, the prevention in our country has mainly been focused on the anti-HIV campaigns.

By talking to HIV positive patients we realise that they need to be educated that strict condom use is very important for successful HIV treatment, as those who are already infected can be reinfected not only with a different sub-tipe of HIV, but with different STIs as well, which can seriously endanger their well being.

Experience has shown that when a patient is diagnosed with a sexualy transmited infection, that is usually just the tip of the iceberg. This is evident in Cases 1, 2 and 3 as well. Therefore, when a patient already has a STI or there is a clinical suspicion that he might have one, a screening test for the most common STIs should be performed. Nowadays testing for syphilis should be reintroduced, despite the fact that many physicians think that this disease no longer exists (Case 4).

Cases 2 and 3 show how extremely important is sexual history taking when a patient presents with rectal problems. Anal canal is often the site of entrance for different STIs.

But fear of discrimination and stigma keeps many in the community of gay, lesbian, bisexual and transgender people (GLBT) from seeking care for themselves or from disclosing relevant personal information once in care.[8]

It is not unusual, that patients will try to hide their actual sexual orientation, because of fear of being discriminated, which occured in Cases 2 and 3. It is highly important to apply non-judgemental history taking and to adapt it to each partner separately. The patient must understand, that we are not asking these questions because of the sheer curiosity, but in order to find the cause of the

patient's problems and try to come to the right diagnosis.

Although neutrality and empathy are considered vital in the doctor-patient relationship, homophobia clearly exists within the medical profession.[9,10] Therefore we must find ways to overcome it.

A survey of Arnold et al. revealed that medical students had a more negative attitude toward homosexuality than students of politics and veterinary medicine did. These findings suggest that educational and correcting interventions are required in medical training.[11] The recommendation is to integrate such teaching throughout the entire medical school curriculum.[12]

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