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Secondary Syphilis in Pregnancy with Papulosquamous Cutaneous Syphilides

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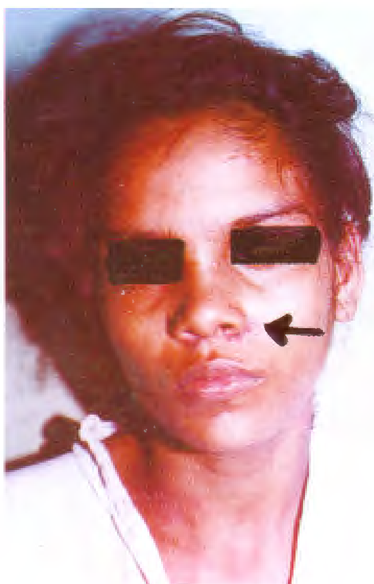
Mrs. R.S. a 24 year old, Muslim, primigravida from a low socio-economic strata presented at L.T.M.G. Hospital, with 38 weeks amenorrhoea in labour on 22.7.1999. She was divorced from her first husband following marital discord and physical abuse. He was a chronic alcoholic and had exposure to multiple sex partners.

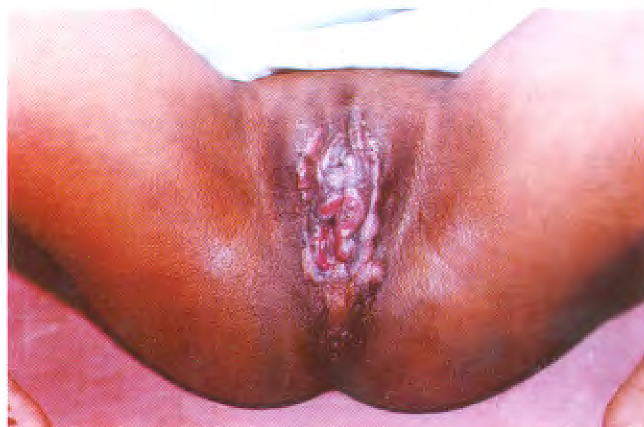
The patient was referred from a peripheral maternity centre with h/o 9 months amenorrhoea and vulval lesions since the past 3-4 weeks. There was h/o low grade fever, cough with expectoration and burning micturition since a week prior. The patient had two antenatal visits and had received two doses of tetanus toxoid. She had no major medical or surgical illness in the past.



Photograph I

On general examination she was averagely built and nourished. She was febrile(99°F) and had mild tachycardia. Her blood pressure was normal. She had cervical lymphadenopathy, superficial mucous patches near the nostrils (Photograph I). On RS examination, air entry was bilaterally equal and there were coarse crepts in the Rt. lung. CVS examination was WNL. Per abdominally, there was a single live fetus in cephalic presentation, LOA with FHR 146 bpm and regular.

On local examination there were bilaterally symmetrical pale reddish pink papulosquamous lesions on the labia majora and minora extending towards the mons pubis. (Photograph II) Bilaterally, inguinal lymphnodes were enlarged, but not tender.



Photograph II

On per vaginal examination, she was in active labour. The cervix was 6 cms. Dilated, 80% effaced. The membranes were absent and liquor clear. The presenting part was vertex and station at 0. The patient delivered

vaginally within two hours of admission, a 2.1 kg male baby. Apgar score at 1 min and 5 min was 8/10. The placenta was expelled completely and appeared grossly normal. The 3rd stage of labour was normal.

Her haematological investigations showed Hb. 9gm%, WBC 12100/cc with lymphocytosis. Sr. VDRL 1:64 positive; Urine pus cells 6-8/HPF; FBS WNL; Liver and renal function tests were WNL; Sputum for AFB –ve; X-ray chest showed prominent bronchovascular markings.

In view of history of exposure from her first husband, a positive Sr. VDRL and cutaneous manifestations, a dermatological reference was taken. A diagnosis of papulosquamous secondary syphilides was confirmed.

There was grossly no hyperplacentosis and no endarteritic changes on histopathological examination of the placenta. The baby did not have any immediate gross affections of congenital syphilis.

The patient was given Inj. Benzathine penicillin 2.4 mega units IM ATD and the baby was given 50000 IU/kg Inj. Benzathine penicillin ATD prophylactically. She was counseled and discharged 10 days later and advised regular follow-up at the post natal outpatient department.

Though the manifestations of secondary syphilis are protean, mucous patches and papulosquamous syphilides seen in this case are classical lesions. They represent progressive endarteritis obliterans and ischaemia leading to superficial scaling of papules. Central necrosis of these lesions may eventually lead to pustular syphilides. Our patient fortunately did not develop Jarisch Herxheimer reaction following treatment, which is seen in almost 90% cases of secondary syphilis.