

SHORT COMMUNICATION

Psoriasiform Eruption in an Immunocompromised Neurosyphilis Patient

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INTRODUCTION

The rash of syphilis may take on a number of different morphologies, especially in the immunocompromised. Here we present an immunocompromised man with tertiary syphilis and a psoriatic eruption of his palms and soles.

CASE REPORT

A 38-year-old male presented with a five-week history of a mildly pruritic, diffuse papulosquamous rash on his chest, back, and arms (**Figure 1**), and a thick scaling rash with fissures on his palms and soles (**Figure 2**). He additionally had a ten-day history of progressive painful bilateral vision loss and headache. He had a history of untreated HIV with a CD4 count of 599 cells/mm³ and tested positive for hepatitis B surface antigen during his admission. A positive serum RPR and a positive CSF VDRL confirmed the diagnosis of neurosyphilis, and he was started on a 10-day course of IV penicillin G. He was initially diagnosed with presumptive CMV retinitis due to his history of immunosuppression, so oral valganciclovir and intravitreal ganciclovir and foscarnet were begun. However, anterior compartment eye biopsies were negative for CMV, and he was diagnosed with ocular

syphilis. Over the course of his 10-day admission his vision slowly improved and was almost completely regained by the time of his discharge. The rash on his palms and soles was painful, and the fissures bled when he walked. Topical emollients provided mild relief. The lesions on his face, head, chest, back, and arms slowly improved with treatment, but the rash on his palms and soles remained severe even at discharge. Fortunately, this patient had a phenomenal outcome. One week after his discharge he was feeling very well and was seeing gradual improvement of his palms and soles. He was scheduled to follow up for outpatient HIV and hepatitis treatment.



Figure 1. Diffuse papulosquamous rash on the upper back and shoulders



Figure 2. Thick, scaling, psoriasiform rash on the palms (a) and soles (b). Fissures present on bilateral feet.

DISCUSSION

The spirochete *Treponema Pallidum* may cause a range of cutaneous manifestations so broad, that syphilis has been called “the great imitator”. The early rash of secondary

syphilis classically presents as localized or diffuse macules or papules. They may vary in color, but are most often pale pink on lighter skin or violaceous on darker skin.¹ Later in the disease course the rash is primarily papulosquamous and may affect the extremities, trunk, palms, and soles.² However, up to 12 distinct lesion classifications have been reported among the cutaneous manifestations of syphilis.^{1,2}

With so many clinical presentations, syphilis is often mistaken for any number of the more common diagnoses it resembles, including pityriasis rosea and lichen planus. Atypical presentations of the rash have been reported most frequently in patients with simultaneous HIV infection.² If this patient had presented without neurologic or systemic symptoms, he could have easily been misdiagnosed with palmoplantar psoriasis. The psoriasiform presentation of syphilis was first reported in the literature in 1885 when Guibout christened it *syphilide psoriasiforme*. In 1906, Fournier then described the predilection for the medial aspect of the sole, as well as the fissuring, associated with this variant.³ Today, there are a few case reports of this presentation. However, we believe that the patient presented here is unique among the reports due to the striking extent of fissuring and thick scale present across the entire plantar and palmar surfaces.

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