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Letter

Tonsillar chancre as unusual manifestation of primary syphilis

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Abstract

Primary syphilis with oropharyngeal manifestations should be kept in mind, though. Lips and tongue ulcers are the most frequently reported lesions and tonsillar ulcers are much more rare. We report the case of a 24-year-old woman with a syphilitic ulcer localized in her left tonsil.

Keywords: primary syphilis, tonsil, pharynx, chancre

Case synopsis

A 24-year-old woman presented to the emergency room complaining of a painless lump on the left side of her tonsil, which started a week before. She was allergic to penicillin and had no relevant medical history. On examination there was a hypertrophic left tonsil with a red-dull aspect and an ulcerated and erosive surface that was deviating the anterior tonsillar pillar (Figure 1). She also presented with two enlarged left submandibular lymph nodes. She noted that she had sexual intercourse with oral sex with her regular partner who had suffered an injury to his genitals some weeks prior. An ultrasound showed enlarged left cervical lymph nodes with

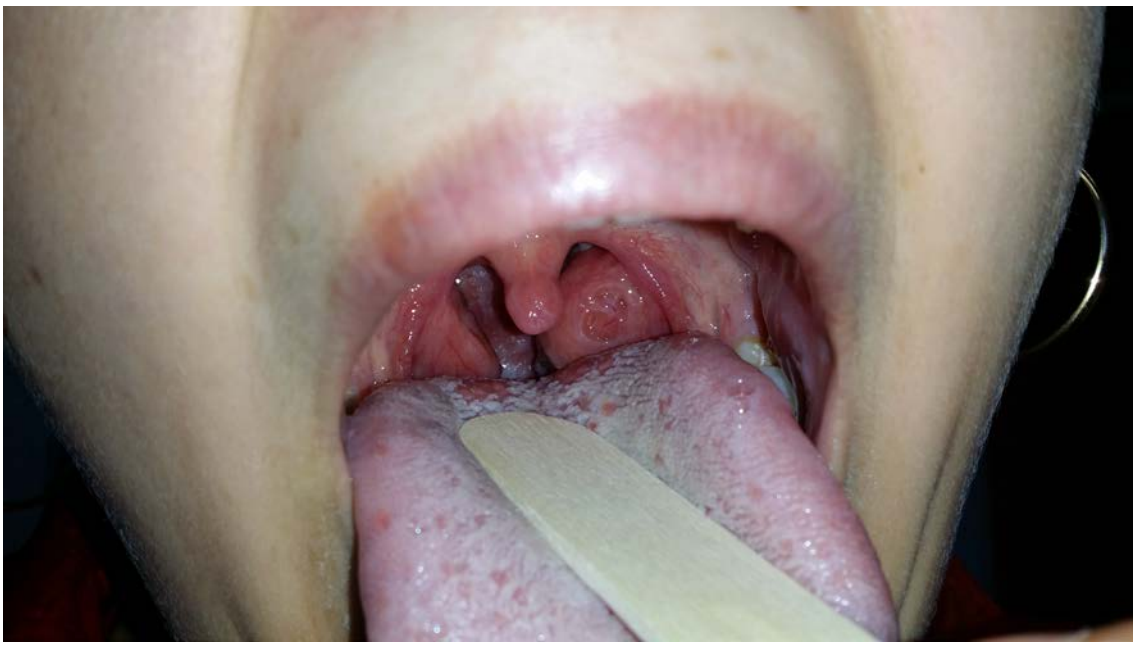

Figure 1. Chancre on left tonsil with ulcerated surface.

no alterations on the right side. Laboratory tests revealed a positive RPR of 1:2 dilution and a positive TPHA. HIV serology was negative. A diagnosis of primary syphilis was made and she went on a regimen of doxycycline 100 mg twice a day for 14 days. Six months later at a follow up visit, the ulcer had healed and RPR titles decreased; TPHA remained positive.

After the decrease in the middle of the 20th century related to the introduction of penicillin, syphilis has re-emerged since the 1990s. In addition, oro-genital sex practices have led to an increase in sexually transmitted infections of the oral cavity. In 2013, the rate of reported primary and secondary syphilis in the United States was 5.3 cases per 100,000 population, more than double the lowest rate of 2.1 in 2000. During 2005-2013, primary and secondary syphilis rates increased among men of all ages and races/ethnicities, with the largest increases occurring among men who have sex with men (MSM). Among women, rates increased during 2005-2008 and decreased during 2009-2013 [1].

Lesions of primary syphilis develop between 10 and 45 days after infection as an indolent papule, followed by surface necrosis and the typical well-circumscribed ulceration that is firm to palpation and better known as a chancre. This can be accompanied by enlarged regional lymph nodes. Untreated lesions heal within a few weeks. Because chancres are usually non tender and asymptomatic, they can go unrecognized in less visible locations, such as the cervical, anal, perianal, rectal, or oropharyngeal areas.

Chancres appear at the site of infection, mostly on the genital area, but they can be present anywhere on the skin. Chancres are usually found on the genitals (85%) or the anus (10%). Syphilitic lesions of the oral cavity and pharynx may appear during any of the stages of the infection. The oropharynx is affected in only 4% of cases of primary syphilis. In the oral cavity, lips are the most common site of chancres. In males they tend to be located on the upper lip and in females in the lower lip [2]. Next in frequency is the tongue and the tonsillar area, where chancres are rare. Soft palate, hard palate, pharynx, larynx, epiglottis, and aryepiglottic folds can also be affected. In the tonsil, lesions appear as edema and redness with an ulcerated or eroded surface. The uvula may be pushed over to the uninvolved side and the anterior tonsillar pillar appears red, swollen, and anteriorly displaced. In all the documented cases of tonsillar syphilis, the left tonsil appears to be more affected than the right one [3], but no hypothesis has been established relating to this observation [4]. There are also cases of bilateral tonsillitis.

Up to 22 per cent of secondary syphilis patients have oral involvement, usually as part of a systemic illness. Mucous patches and painful serpinginous ulcers that can extend onto the surface of the tonsils are the main lesions at this stage. Ablanedo-Terrazas et al. reported 9 HIV patients with secondary syphilis and oropharyngeal lesions with the most affected sites being the anterior tonsillar pillars in 5 cases, the tongue in 3 cases, the soft palate in 3 cases, the oral mucosa in 3 cases, and the tonsils in 1 case [5]. Contrary to what could be expected, no lesions of primary syphilis were found. However, these findings have also been reported in non-HIV infected patients [6] and there are records of bilateral secondary syphilis of the tonsil [7]. Syphilis facilitates the spread of HIV, so early detection and treatment of syphilis may play an important role in preventing the transmission of HIV.

The differential diagnosis includes infectious diseases such as herpesviruses (HSV, EBV, CMV), streptococci, actinomycetes, Mycobacterium tuberculosis, non-tuberculous mycobacteria, and protozoa such as Toxoplasma gondii. Neoplasms such as lymphoma and squamous cell carcinoma must be considered [8, 9].

The diagnosis of syphilis continues to be challenging owing to the variability of the clinical features. In particular, cases of extragenital manifestations are frequently misinterpreted and usually go unrecognized. This is the main reason why syphilis should become part of the differential diagnosis of oral lesions and the presence of HIV should be assessed [10].

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