

## Syphilitic tonsillitis in primary care:

### a case report

#### INTRODUCTION

Syphilis in the UK continues to be reported, with outbreaks occurring particularly among men who have sex with men. Secondary syphilis classically presents with cutaneous lesions affecting the skin and mucous membranes with or without genital involvement. This report describes a case of secondary syphilis in a patient who presented with tonsillitis and peri-oral rash and encourages GPs to explore risk factors and offer testing for sexually transmitted infections.

#### CASE REPORT

A 25-year old man who has sex with men and had a 2-week history of a sore throat as well as a facial and genital rash attended a genitourinary medicine (GUM) clinic. He was otherwise well, had no significant past medical history, and was not taking any medication. He had a regular male partner and had no other sexual partners in the 6 months prior to presentation. He had initially attended his GP after experiencing the triad of symptoms; he did not describe his genital symptoms to the GP as he was not questioned about them and did not feel they were important. He was given a 7-day course of amoxicillin for potential bacterial tonsillitis. As his sore throat did not improve and his genital symptoms worsened, he self-referred to a GUM clinic.

Examination revealed multiple superficial, tender, erythematous facial lesions under his mouth and on his upper neck (Figure 1), ulcerated papules on both tonsils (Figure 2), and multiple pus-filled lesions on the glans penis and frenulum. The history and presentation led to suspicion of secondary syphilis and/or primary HIV infection.

Syphilis serology demonstrated a positive treponemal Immunoglobulin (Ig) M/IgG antibody test, a positive treponemal particle agglutination test, and a venereal disease research laboratory test result of 1:256. HIV



Figure 1. Peri-oral rash.



Figure 2. Tonsillar lesions.

p24 antibody and antigen tests were negative.

The man was treated with benzathine penicillin (2.4 million units intramuscular) for secondary syphilis and asked to return for review and serological testing to assess for treatment response after 4 weeks. He was also asked to abstain from sex for 2 weeks, and until 2 weeks after his partner was tested and treated for syphilis. A health advisor discussed partner notification and safe sex.

#### DISCUSSION

Syphilis, a bacterial infection caused by *Treponema pallidum*, is an important infection causing morbidity and mortality; it is mainly transmitted sexually but can also be passed from mother to child during pregnancy.

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## Box 1. Learning points

- The number of cases of syphilis observed in the UK is increasing.
- Symptomatic presentations may include discrete localised signs and mimic other common diseases.
- Syphilis infection is an important facilitator of HIV.
- GPs are urged to explore risk factors, and test for, sexually transmitted infections, or refer patients to a GUM service.

In the UK, syphilis decreased dramatically from a peak during the Second World War because of the introduction of penicillin. There was a peak prior to the advent of HIV/AIDS, followed by a sharp decline in reported cases until the late 1990s, when case reporting again increased. Outbreaks in multiple UK cities — mainly, but not exclusively, in men who have sex with men — occurred between 1997 and 2004, and rates of infectious syphilis diagnoses in men increased by 1520%.<sup>1,2</sup>

Between 1999 and 2008, 13 175 diagnoses of infectious syphilis were observed, with 9590 (73%) occurring in men who have sex with men.<sup>2</sup> During the same period, 3375 diagnoses of infectious syphilis were observed in heterosexuals. Although previously driven by imported infections and commercial sex work, in 2008, a total of 68% of cases of heterosexually transmitted syphilis were acquired in the UK.<sup>2</sup>

Although there are classic descriptions of the stages and natural history of syphilis, it is worthy of its moniker of 'the great pretender' due to its wide variety of multisystem manifestations. The primary chancre is a painless ulcer with a rolled margin followed 4–8 weeks later by secondary syphilis, characterised by a maculopopular non-itchy rash on the trunk, palms, soles of the feet, arms, legs, face, mucous membranes, and genitalia. However, the stages can overlap, symptoms may be atypical, and infection can be asymptomatic; as such, the diagnosis may not be considered when only discrete, localised lesions are present.

The genital ulcerations associated with syphilis make it an important facilitator of HIV infection. Individuals diagnosed with syphilis should always be offered an HIV test, particularly as approximately one-third of all cases of infectious syphilis in men who have sex with men in the UK involve co-infection with HIV.<sup>2,3</sup>

Cases of syphilitic tonsillitis have been described both in secondary syphilis and in the late stages of syphilis.<sup>4–6</sup> Cases of tonsillar involvement in secondary syphilis have usually involved other cutaneous manifestations.<sup>4–6</sup> Other sexually

transmitted infections that may present with tonsillar involvement include primary HIV infection, orogenital herpes simplex, pharyngeal gonorrhoea, and chlamydia infection.

A seemingly straightforward case of a young man presenting with a sore throat has been presented; however, he did not inform his GP about his genital lesions, which were important. GUM clinics are reporting consistent numbers of syphilis cases; serological testing for syphilis, the cornerstone to diagnosis, is included in routine screening. GPs are urged to:

- continue to explore risk factors for STIs with their patients;
- consider syphilis in individuals (particularly men who have sex with men), who have atypical or aggressive cutaneous signs; and
- test for syphilis or refer patients to a GUM clinic (Box 1).

### Consent

The patient has provided written consent for this article to be published.

### Provenance

Freely submitted; externally peer reviewed.

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