



Ocular Syphilis: The uncommon presentation of Syphilis

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Introduction

Syphilis, a bacterial infection caused by the organism *Treponema Pallidum*, results in a wide array of clinical manifestations, and its prevalence has been increasing in the US.

We present a case highlighting the importance of obtaining a detailed history along with the various workup entailed in making the diagnosis of an unconventional presentation of secondary and neurosyphilis manifesting as loss of vision.

Case

A 72-year-old male with a history of cerebrovascular accidents along with atrial fibrillation presents to the hospital for diminished vision in his right eye. An MRI of the brain and CTA of the head and neck were negative. On day 2 of hospitalization, he started to complain of postauricular temporal headaches. His inflammatory markers, in particular his CRP was elevated at 40.94 mg/L. He was started on intravenous 1gm Methylprednisolone and a temporal artery biopsy was obtained with a suspicion for GCA.

The biopsy was negative and he was discharged with a tapering dose of oral steroids.

Less than one month later, he developed a diffuse maculopapular rash for which he was seen by a dermatologist for skin biopsy with a concern for drug induced rash.

Case

He also developed blindness of his right eye, arthralgia, and partial bilateral hearing loss. The skin biopsy results revealed a positive RPR. Further history obtained was notable for an unprotected sexual encounter with a male sex worker prior to his initial presentation. Given the clinical course and a positive syphilis screen, he was started on IV Penicillin 3.4 million Units every 4 hours. A lumbar puncture was performed with additional treponemal serologies sent. His CSF was reactive for VDRL and showed 77 WBCs with 46% lymphocytes and 44% monocytes and 10% neutrophils, along with protein level 45mg/dl and glucose 46mg/dl, consistent with neurosyphilis. HIV antibody testing was negative. He completed a 14-day course of IV penicillin; subsequent titres of RPR had decreased and patient noted mild improvement of his hearing loss and his rash.

Discussion

Ocular syphilis is an uncommon presentation with manifestations including uveitis most commonly and less so keratitis and retinitis. This presentation can occur throughout any stage, more commonly in the latent stage than the primary stage. In immunocompetent patients, it can present as the initial complaints in elderly patients due to decreased immunity and due to other underlying comorbidities.

Discussion

Whereas in younger patients it can present as the initial presentation if they have co infections with HIV. Throughout the case, he had no complaints of genital or perianal sores, and no penile discharge. As with our patient, symptoms of optic syphilis can worsen with the use of topical/systemic steroids.

Ocular syphilis was once one of the predominant cause of blindness in the mid 20th century. With the advent of penicillin, the incidence of blindness has dropped from 15% to 0.6%.

With increasing cases being reported, a high index of suspicion should remain for serological testing as a delay in the diagnosis can lead to relapse of the same intraocular complaints, complications from visual changes such as glaucoma, or it can lead to progressive and irreversible vision loss.

Conclusion

With incidence of syphilis rising, clinicians must keep in mind the diagnosis of syphilis as early dissemination of disease can present as a wide variety of symptoms.

Our case details the multidisciplinary approach to the diagnosis and treatment of uncommon presentations of syphilis.

References

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