RAPID PROGRESSION TO GUMMATOUS TERTIARY SYPHILIS IN AN HIV PATIENT.

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Background: We present a case of a 25 year old ATSI male with a five year history of untreated Human Immunodeficiency Virus (HIV) infection and injecting drug use, referred to our facility from a local Mental Health service with acute psychosis in April 2017. Two deep ulcerating skin lesions, mid-back and right forearm were noted on examination. A penile chancre which was PCR positive for syphilis, was partially treated 2 years earlier prior to loss to follow up.

Analysis: During this admission, he was diagnosed with tertiary syphilis with biopsy-proven gummatous skin disease, showing granuloma formation, plasmacytic infiltration, and a high density of spirochetes. His serum HIV viral load (VL) was 122,762 copies/mL, CD4 was 210 mm^{-3} and rapid plasma reagin (RPR) was 128. Magnetic resonance imaging of the brain demonstrated right-sided mastoiditis. The cerebrospinal fluid (CSF) was acellular, protein 0.26g/dl and glucose 3.0 mmol/L. CSF syphilis studies were discordant, with a negative venereal disease research laboratory test (VDRL), but positive fluorescent treponemal antibody (FTA). Treponemal CSF PCR was negative, and the CSF HIV-1 VL 14,780 copies/mL, without notable blood contamination.

Outcome: CSF test interpretation debate centred around the sensitivity and specificity of FTA and VDRL in CSF for neurosyphilis. The patient was treated for neurosyphilis, which would also treat gummatous disease. He commenced dolutegravir, abacavir and lamivudine together with olanzepine and received 10 days of intravenous benzyl-penicillin prior to absconding from the ward.

Conclusions: Rapid progression to tertiary syphilis is more likely in the context of HIV immunosuppression. This case highlights the importance of early HIV and syphilis treatment and close follow up from a public health perspective. Mental health and cultural issues may further complicate management. Interpretation of the discordant CSF syphilis results, gummatous pathology and inconsistency between Australian, US and British guidelines for the management of tertiary syphilis will be discussed.

Disclosure of Interest Statement
All authors declare no conflict of interest.