Correspondence

The Clinical Appearance of Pinta Mimics Secondary Syphilis: Another Trap of Treponematosis?

Sir—We read with interest the report by Kim et al. [1] that described a 23-year-old pregnant Latino woman with secondary syphilis. The authors diagnosed secondary syphilis on the basis of the characteristics of the clinical lesions: 2 round, painful ulcers (one on the plantar region of the left foot and the other on the cutaneous surface of the homolateral ankle); a shallow, painless ulcer on the hard palate; a circumscribed, hypopigmented, macular rash on the back; and the presence of spirochetes in a silver-stained biopsy specimen from the ulcer on the ankle. The authors report that the diagnosis was supported by reactivity to a rapid plasma reagent test (titer, 1:32) and reactivity to a microhemagglutination test for antibodies against Treponema pallidum. We agree that the presence of spirochetes in the biopsy specimen seems to confirm that the causative agent of the infection was a species of Treponema; however, on the basis of our experience, the reported findings do not seem to meet the criteria for the diagnosis of secondary syphilis.

First of all, reactivity to rapid plasma reagent and microhemagglutination tests is not sufficient for distinguishing a new infection from a previous one. Only the presence of IgM class antibodies against T. pallidum is a serological marker of early syphilis, particularly in the secondary stage [2], yet the authors did not test for this subclass of antibodies. Second, silver-staining of a biopsy specimen is not commonly used for the diagnosis of syphilis because of its low sensitivity (~40%) [3] and because it does not allow for the definitive identification of the 3 types of movement typical of T. pallidum (“spin pace,” pendular movement, and undulatory movement), which generally can only be recognized by means of dark-ground microscopy [2].

Moreover, the woman had hypopigmented lesions on her back; the skin rash caused by secondary syphilis, which in most cases is clearly red, particularly among nonblack persons [4], is rarely limited to the back, and is almost always present also on the sides of the trunk. Furthermore, the patient had shallow ulcers on the hard palate, whereas secondary-syphilis lesions in the oral cavity are usually flat plaques. Secondary syphilis is generally associated with plaques on the palms of the hand and the soles of the feet, yet the patient only had a single large ulcer on the sole of her left foot. In addition, ulcers are generally associated with primary syphilis, and their occurrence on nongenital and nonoral tissue has only been described in anecdotal reports.

For all of the above reasons, we believe that the woman may have had another treponematosis and not syphilis. In fact, the findings described by Kim et al. [1] seem to be consistent with the clinical, serological, and histological characteristics of infection with Treponema carateum, also known as “pinta” and “carate.” Moreover, the pregnant woman was from a rural area of Mexico where this nonvenereal treponematoses has been described as endemic [5]. The diagnosis of pinta seems to be in accordance with the following findings, in particular: (1) the presence of hypopigmented lesions on the woman’s back, (2) the simultaneous presence of lesions characteristic of different stages of disease, (3) the lack of mother-to-child transmission of the infection, and (4) the cross-reaction to serological tests for syphilis, such as a rapid plasma reagent test and a T. pallidum hemagglutination assay. Although the diagnosis of pinta is generally clinically based, the authors could confirm this hypothesis with a home-made PCR test to detect DNA sequences specific to T. carateum (to be performed on the silver-stained tissue specimen from the patient’s ankle).

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Massimo Giuliani, Alessandra Latini, Guido Palamara, Antonio Maini, and Aldo Di Carlo
Division of Dermatological Infectious Diseases, STI/HIV Unit, Istituto Dermatologico San Gallicano (IRCCS), Rome, Italy

References


Reply to Giuliani et al.

Sir—I appreciate the comment from Giuliani et al. [1] in reference to our report of