INTRODUCTION
Syphilis is caused by Treponema pallidum, and spread during sexual contact, transplacental transmission and exposure to infected lesions. Post antibiotic era decreased its incidence with active interventions. Syphilis is a STI (sexually transmitted infection) which consists of primary, secondary, latent, and tertiary stages. Primary syphilis causes one or more sores in or around the anus, genitals or mouth. Progression will lead to the second stage, if not treated called as secondary syphilis. This stage of syphilis is medically curable with treatment. If it progresses to latent ant tertiary stages which are not curable damage to organs, or dementia, paralysis and death may occur. Syphilis has high correlation to HIV and can be transmitted through syphilitic sores. Primary syphilis usually seen as a single sore appears three weeks after the initial infection. This single sore is called a chancre, which is small, painless, firm and round. It appears usually at the mouth, anus, or genitals. If symptoms are not treated at this stage this bacterium will spread through bloodstream causing secondary syphilis. The symptoms of secondary syphilis symptoms are seen in two to eight weeks if primary syphilis is not treated.

The secondary syphilis presents as a non-itchy rash which may spread to several parts of the body. rough, reddish-brown dots on the palms of your hands and feet bottoms. This is often misdiagnosed to some other disease. Other symptoms of secondary syphilis include swollen lymph glands, headaches, hair loss, weight loss, sore throat, fever, fatigue, muscle aches, loss of appetite, joint pain, enlarged lymph nodes, wart-like patches around skin folds or genitals and changes in vision. In more recent years syphilis has re-emerged particularly among the homosexual population and those with human immunodeficiency virus (HIV) infection. We report 12 cases of secondary syphilis from April 13 to July 14 attending our tertiary care centre. In order to study the pattern of clinical presentation of secondary syphilis and its association with HIV infection, the present study was conducted. In continuation of our earlier work [1-3] in dermatology we are herewith presenting the findings of this study.

MATERIAL AND METHODS
All the patients attending DVL OPD are examined including those referred from ART clinic, ICTC for any evidence STI. All those presenting with features of secondary syphilis were examined in detail, investigated and followed up. Out of 73,646 patients who attended DVL OPD; 6708 patients attended STI clinic. Of them, 12 cases were diagnosed as having secondary syphilis. They were tested with RPR and TPHA and screened for HIV. Skin
RESULTS AND DISCUSSION

Out of 12 cases of secondary syphilis studied, 9 were males, 3 were females. The male to female ratio of 3:1 was seen. Age range of the patients was between 21 – 55 yrs with average age of presentation was 29 yrs. Duration of presenting complaints ranged from 10 days to 2 months. Eight patients were HIV positive and four patients were HIV negative. Of the eight RVD patients, 6 were newly diagnosed as having HIV infection after they presented with secondary syphilis. Past history of primary chancre was present in 5 cases (41%). Of them one RVD patient had persisting primary chancre when presented with secondary syphilis. All the patients presented with generalized bilaterally symmetrical skin rash with generalized lymphadenopathy. Oral lesions were seen in 3 patients while Genital lesions were seen in 5 patients. Perianal lesions were found in 2 patients. Conjunctival congestion was seen in only one patient.

Of the three female patients, husband & wife presenting with secondary syphilis simultaneously. One patient was 38 wks pregnant. One patient was non RVD. RPR and TPHA were reactive in all patients. RPR titres ranged from 1:8 to 1:64 dilutions. TPHA - highest titre of 1:1280 was observed. CSF, VDRL & CSF analysis was also done in HIV patients, which were normal in all. Abnormal LFT with elevated liver enzymes was observed in 2 patients. In our study, of 12 cases of secondary syphilis, 9 (75%) were males, with mean age of presentation was 29 yrs. 76% patients were male, and the median age was 32 years [4]. 66% patients had HIV infection with CD4 count range of 8-478 cells/cu mm. 30% patients had human immunodeficiency virus (HIV) infection [4]. Clinical manifestations of secondary syphilis noted were mucocutaneous manifestations, associated with generalized lymphadenopathy. Skin rash & gen. lymphadenopathy were seen in all patients. Maculopapular rash was noticed in 8 patients (66%). Psoriasiform lesions was observed in 4 patients (33%). Ecthymiform lesions (2 patients), Rupioid lesions (1 pt), Split papules (3 patients) and Palmoplantar lesions (6 patients) were also observed. Mucosal lesions were seen in seven patients (58%). Oral lesions were seen in three patients and genital lesions were found in five patients. Persisting primary chancre was observed in one RVD patient [5]. Associated symptoms like fever, headache, malaise, anorexia were observed in 8 patients. Arthralgias were seen in 3 patients. No other systemic manifestations were observed except for abnormal LFT in 2 pts & hepatomegaly in 1 patient. In our study, all 8 RVD patients showed reactive RPR and TPHA like in the study of Wahab et al. (2013) [5]. In all RVD cases CSF analysis was normal. No evidence of neurosyphilis was found clinically. After treatment RPR was used as follow up laboratory test after the treatment. Decreasing titres were observed during follow up, even in HIV patients also. Secondary syphilis is commonly present in association with HIV. This should alert treating physicians to look for HIV, whenever they come across secondary syphilis & all HIV patients to be screened for STI. Secondary syphilis with HIV co-infection can present with florid clinical manifestations. So they should be treated aggressively and followed up for prolonged periods. Response to the standard treatment was good with clinical and serological improvement. Even term pregnant women should be screened for syphilis if they are not screened earlier to achieve Goal of Elimination of Congenital syphilis by 2015.

REFERENCES:

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