Painful Anal Lesions in a Patient With HIV

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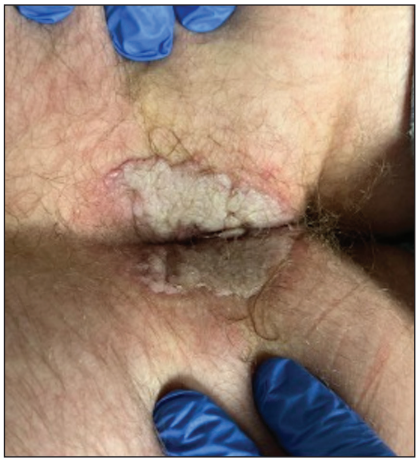

A 24-year-old man presented to the emergency department with rectal pain and lesions of 3 weeks' duration that were progressively worsening. He had a medical history of poorly controlled HIV, cerebral toxoplasmosis, and genital herpes, as well as a social history of sexual activity with other men.

He had been diagnosed with HIV 7 years prior and had been off therapy until 1 year prior to the current presentation, when he was hospitalized with encephalopathy (CD4 count, <50 cells/mm^3). A diagnosis of cerebral toxoplasmosis was made, and he began a treatment regimen of sulfadiazine, pyrimethamine, and leucovorin, as well as bictegravir, emtricitabine, and tenofovir alafenamide. Since then, the patient admitted to difficulty with medication adherence.

Rapid plasma reagin, gonorrhea, and chlamydia testing were negative during a routine workup 6 months prior to the current presentation. He initially presented to an urgent care clinic for evaluation of the rectal pain and lesions and was treated empirically with topical podofilox. He presented to the emergency department 1 week later (3 weeks after symptom onset) with anal warts and apparent vesicular lesions. Empiric treatment with oral valacyclovir was prescribed.

Despite these treatments, the rectal pain became severe—especially upon sitting, defecation, and physical exertion—prompting further evaluation. Physical examination revealed soft, flat-topped, moist-appearing, gray plaques with minimal surrounding erythema at the anus. Laboratory test results demonstrated a CD4 count of 161 cells/mm^3 and an HIV viral load of 137 copies/mL.

WHAT'S YOUR **DIAGNOSIS?**

a. anal squamous cell carcinoma
b. condyloma acuminatum
c. condyloma latum
d. molluscum contagiosum
e. psoriasis

PLEASE TURN TO PAGE E30 FOR THE DIAGNOSIS

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The authors report no conflict of interest.

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THE **DIAGNOSIS**
Condyloma Latum

Laboratory test results were notable for a rapid plasma reagin titer of 1:512, a positive *Treponema pallidum* particle agglutination test, negative rectal nucleic acid amplification tests for gonorrhea and chlamydia, and a negative herpes simplex virus polymerase chain reaction. A VDRL test of cerebrospinal fluid from a lumbar puncture was negative. Histopathology of the punch biopsy sample revealed marked verrucous epidermal hyperplasia without keratinocytic atypia and with mixed inflammation (Figure 1), while immunohistochemical staining showed numerus *T pallidum* organisms (Figure 2). A diagnosis of condyloma latum was made based on the laboratory, lumbar puncture, and punch biopsy results. Due to a penicillin allergy, the patient was treated with oral doxycycline for 14 days. On follow-up at day 12 of therapy, he reported cessation of rectal pain, and resolution of anal lesions was noted on physical examination.

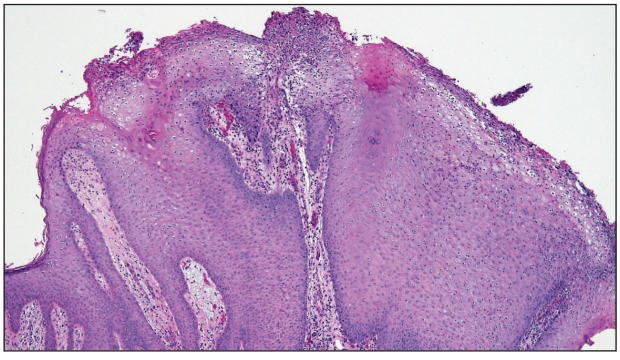

FIGURE 1. A punch biopsy revealed marked verrucous epidermal hyperplasia without keratinocytic atypia and with mixed inflammation, indicating a diagnosis of condyloma latum (H&E, original magnification ×40).

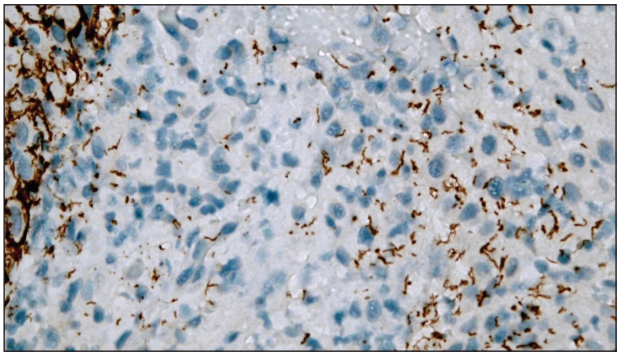

FIGURE 2. Immunohistochemical staining for *Treponema pallidum* generated a brown reaction; abundant small, rod-shaped, coiled organisms also were seen, indicating a diagnosis of condyloma latum (diaminobenzidine, original magnification ×400).

Condylomata lata are highly infectious cutaneous lesions that can manifest during secondary syphilis.[1] They typically are described as white or gray, raised, flat-appearing plaques and occur in moist areas or skin folds including the anus, scrotum, and vulva. However, these lesions also have been reported in the axillae, umbilicus, nasolabial folds, and other anatomic areas.[1,2] The lesions can be painful and often manifest in multiples, especially in patients living with HIV.[3]

Condylomata lata can have a verrucous appearance and may mimic other anogenital lesions, such as condylomata acuminata, genital herpes, and malignant tumors, leading to an initial misdiagnosis.[1,2] Condylomata lata should always be included in the differential when evaluating anogenital lesions. Other conditions in the differential diagnosis include psoriasis, typically manifesting as erythematous plaques with silver scale, and molluscum contagiosum, appearing as small umbilicated papules on physical examination.

Condylomata lata have been reported to occur in 6% to 23% of patients with secondary syphilis.[1] Although secondary syphilis more typically manifests with a diffuse maculopapular rash, condylomata lata may be the sole dermatologic manifestation.[4]

Histopathology of condylomata lata consists of epithelial hyperplasia as well as lymphocytic and plasma cell infiltrates. It is diagnosed by serologic testing as well as immunohistochemical staining or dark-field microscopy.

First-line treatment of secondary syphilis is a single dose of benzathine penicillin G administered intramuscularly.[5] However, a 14-day course of oral doxycycline can be used in patients with a penicillin allergy. When compliance and follow-up cannot be guaranteed, penicillin desensitization and treatment with benzathine penicillin G is recommended. Clinical evaluation and repeat serologic testing should be performed at 6 and 12 months follow-up, or more frequently if clinically indicated.[5]

REFERENCES

1. Pourang A, Fung MA, Tartar D, et al. Condyloma lata in secondary syphilis. *JAAD Case Rep*. 2021;10:18-21. doi:10.1016/j.jdcr.2021.01.025
2. Liu Z, Wang L, Zhang G, et al. Warty mucosal lesions: oral condyloma lata of secondary syphilis. *Indian J Dermatol Venereol Leprol*. 2017;83:277. doi:10.4103/0378-6323.191129
3. Rompalo AM, Joesoef MR, O'Donnell JA, et al; Syphilis and HIV Study Group. Clinical manifestations of early syphilis by HIV status and gender: results of the syphilis and HIV study. *Sex Transm Dis*. 2001;28:158-165.
4. Kumar P, Das A, Mondal A. Secondary syphilis: an unusual presentation. *Indian J Sex Transm Dis AIDS*. 2017;38:98-99. doi:10.4103/0253-7184.194318
5. Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep*. 2021;70:1-187. doi:10.15585/mmwr.rr7004a1