TERTIARY SYPHILIS AS TRIGGERING FACTOR FOR POSTERIOR UVEITIS: A CASE REPOR

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ABSTRACT

The syphilis eye disease is rare, affecting 2.5% to 5% of patients with tertiary disease. The eye affections are generally related to immunosuppression. In our case report, a patient (VF, 37, male), presented progressive blindness complaint, burning, itching, algia eye movement and scotoma. Laboratory tests: HIV, nonreactive; VDRL reagent; FTA-ABS IgG positive. The ophthalmologic exam posterior uveitis with cystoid macular edema, optic disc edema and epithelial defect in the mid-periphery. Implemented treatment with benzathine penicillin for three weeks and due to non-adherence, chose crystalline penicillin for 15 days, when he said resolution of symptoms.

KEYWORDS: Syphilis, tertiary syphilis, uveitis.

1. INTRODUCTION

In recent decades, despite improvements in the public health field in Brazil still has a high incidence of sexually transmitted diseases. Place in the world more than 12 million cases per year, of these, 900 000 cases in Brazil[1].

T. pallidum is acquired through direct contact with the wound, either through vaginal intercourse, anal or oral. Pregnant women with syphilis can pass it to the baby, being called congenital syphilis. The other form of transmission is rare, it is by indirect means, blood transfusion[2].

Thus, the primary syphilis is manifested by adenitis in the range of three to four weeks and disappear without leaving scars. Occurs in the exposed point initially to treponema, often at the ends of the penis, rectum, mouth or tongue. In men it is more common to diagnose it in balanopreputial fold, prepuce, urethral meatus, or rarely intraurethral[2]. In females, injuries can occur inside the genital tract or the labia minora, however are difficult to diagnosed[3].

In the secondary phase is the beginning between four and eight weeks after the primary lesion. General symptoms of secondary phase are: malaise, headache, eye pain, bone pain, arthralgia, meningism, arthritis and hoarseness, rash on the body and face[4].

While tertiary syphilis are developed lesions with great potential to evolve and affect all organs, including the skin, mucous membranes, bone, cardiovascular and nervous. Syphilis in the nervous system is asymptomatic or symptomatic, with the following forms: meningovascular, acute meningitis, brain or spinal cord gum, neurosyphilis, psychosis, paralysis and atrophy of the optic nerve, stroke[5].

Therefore, the diagnosis is based on clinical, epidemiological and laboratory criteria. The dark field microscopy is the fastest and most effective way for the observation of treponema, procedure with about 70% to 80% of sensibility[2].

The serological diagnosis is based on non-treponemic or cardiolipínicas and treponemic reactions reactions. The routine test is the VDRL reaction because the property of being capable of titration. To confirm the diagnosis we use a treponemal test as FTA-ABS, which has high sensitivity and specificity, and the first to be positive for the infection. But the involvement of the nervous system is proven in CSF analysis[6,(7,(8.

Therefore, the treatment consists in:

- Primary syphilis: Benzathine penicillin 2.400.000UI (IM), single dose.
- Secondary syphilis: Benzathine penicillin 4.800.000UI (IM) in two weekly doses of 2.400.000UI.
- Tertiary syphilis: Benzathine penicillin 7.200.000UI (IM) in three weekly doses of 2.400.000UI.

In neurosyphilis selected medication is penicillin G,

the dose ranges from 3 to 4,000,000 IU and administered intravenously for four hours that corresponds the total of 18 to 24,000,000 IU daily for 10 to 14 days[6,7].

Despite the neurosyphilis be related to the tertiary or late stage of infection, the invasion of the central or peripheral nervous system can occur at any time during the course of the disease syphilitic[9].

The syphilis who eye disease is rare, affecting about 2.5% to 5% of patients with tertiary disease. Ocular manifestations are diverse, with previous descriptions of focal retinitis, papillitis, iritis, endothelial precipitates, periflebitis, vitreitis and serous retina[10].

These authors described a case of ocular syphilis, with multifocal retinitis and placoid lesions, associated with intense intraocular inflammation. The clinical picture was initially related to some type of immunosuppression, such as HIV or the use of corticosteroids. Recent reports, however, showed that this clinical condition may also affect immunocompetent patients as one of several forms of presentation of ocular syphilis instead of an atypical related immunodepression. Which includes the case in our study addressed.

2. CASE REPORT

VF, 37, male, single, with the complaint vision loss. Refers partial amaurosis progressive starting 4 months ago in the left eye, the lateral field, with episodes of improvement during the day and worse in low light and bright light. After 10 days started the affection of the right eye in a similar evolution.

Reports stinging, itching and character algia predominantly moderate eye movement. Mentions the presence of concomitant scotoma partial blindness, eye when he sought medical assistance was encouraged to make use of steroids and eye drops for two weeks. However, reported worsening symptoms then seeking another specialist, who referred him to a rheumatologist and these together with infectious diseases requested some tests to elucidate a diagnosis.

Laboratory tests were performed presenting: HIV serology, nonreactive; serology for syphilis - positive VDRL (title 1/16); IgG positive FTA-ABS (7.4 IU / ml); blood count, white blood cell count and urinalysis unchanged. Ophthalmologic examination showed the right eye posterior uveitis with cystoid macular edema, optic disc edema and epithelial defect in the mid-periphery leading to diagnosis suggestive of neurosyphilis, then being inferred the diagnosis of posterior uveitis by tertiary syphilis.

To that end, we implemented treatment with benzathine penicillin 7200000UI divided into three doses of 240,000 IU for three weeks. There was improvement of blindness by 40%, however not to have occurred membership effectively, was established new treatment with crystalline penicillin 4,000,000 IU of 4 in 4 hours for 15 days, when he said resolution of pruritus and pain symptoms, but no significant changes in partial blindness.

3. DISCUSSION

As aforesaid by Santos and ANGELS, 2009, STDs such as syphilis remain high prevalence which was corroborated by the case presented diagnosed with posterior uveitis by tertiary syphilis.

This pathology has as main route of transmission through sexual contact, however, in the case presented was not possible to make a retrospective study to establish the route of transmission, however, not history was mentioned sexual activity with a primary partner, but without the use of condoms.

Because it is a rare disease and to present similar symptoms to various eye diseases and their diagnosis difficult and often is not contemplated the possibility of uveitis by syphilis. After evaluation of three medical professionals of different specialties (rheumatology, infectious disease and ophthalmologist) was elucidated the possibility of tertiary syphilis, and for that, the empirical therapy was performed in order to reduce possible complications.

In the studied literature, as aforesaid, the treatment of tertiary syphilis is: benzathine penicillin as first choice, but when there is no adequate response infers the use of crystalline penicillin. What was duly carried to the patient in question, however, some authors suggest the need to evaluate the cerebrospinal fluid to confirm the diagnosis and therapeutic approach.

4. CONCLUSION

Thus, after appropriate therapy was partial resolution of symptoms presented, corroborating other authors regarding the early diagnosis and treatment aimed at reducing the morbidity and even mortality of affected by syphilis.

REFERENCES

[1] Santos VC, Anjos KF. Sífilis: uma realidade prevenível. Sua erradicação, um desafio atual. Revista Saúde e Pesquisa. 2009; 2(2):257-63.

[2] Avelleira JCR, Bottino G. Sífilis: diagnóstico, tratamento e controle. An Bras Dermatol. 2006; 81(2):111-26.

[3] Saraceni V. Sífilis, a gravidez e a Sífilis Congênita. ENSP – FIOCRUZ. 2005; 03-11.

[4] Oliveira EVL. *et al.* Sífilis secundária com acometimento pulmonar. An Brás Dermatol. 2007; 82(2):163-7.

[5] Brasil. Sífilis: Estratégias para Diagnóstico no Brasil. Brasília: Ministério da Saúde, Coordenação de Doenças Sexualmente Transmissíveis e Aids. 2010; 01-100.
[6] Brasil. Diretrizes para controle da sífilis congênita: manual de bolso. 2. ed. Brasília : Ministério da Saúde. 2006; 24;15-27.
[7] WHO. Guidelines for the management of sexually transmitted infections. 2010; 39-46.
[8] Sato NS, *et al.* Reatividade do anticorpo IgM anti-*Treponema pallidum* na soroconversão e na resposta sorológica ao tratamento de sífilis. J Bras Patol Med Lab 2012; 48(6): 409-414.
[9] Barra LAC. *et al.* Neurossífilis apresentação como polirradiculopatia lombar: relato de caso. DST. J Bras Doenças Sex Transm. 2001; 13(4):52-4.
[10] Zambon F. *et al.* Syphilitic retinitis and panuveitis simulating acute retinal necrosis: case report. Arq Bras Oftalmol. 2010;73(3):288-90.