



CONDYLOMA LATA IN A CHILD

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ABSTRACT

A 7-year old girl brought by her parents with two-week history of growth in the perianal region. On examination there was a greyish white fleshy plaque around the anal margin. A positive history of sexual abuse could not be elicited from the child or her parents. Dark-field examination of the lesion was positive for *Treponema pallidum*, rapid plasma reagin (RPR) was reactive in titre of 1:32 and *Treponema pallidum* haemagglutination assay (TPHA) was positive. A diagnosis of secondary syphilis with condyloma lata was made. The child was treated with appropriate dose of benzathine penicillin and the lesion resolved completely. RPR titre found decreasing during follow-up. Arriving at the diagnosis of condyloma lata was relatively simple but establishing the mode of transmission was difficult even though, exclusively child sexual abuse was suspected.

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INTRODUCTION

Acquired syphilis beyond early infancy raises concern for possible child sexual abuse. Clinical manifestations of syphilis in children are similar to those of adults. The diagnosis of syphilis, presenting with mucocutaneous manifestations like condyloma lata, is relatively simple but establishing the mode of transmission is difficult although, child sexual abuse is highly suspected. We report here a case of condyloma lata in a 7 year old female child.

Case Report

A 7 year old girl was brought by her parents for perianal lesions to our sexually transmitted infections (STI) clinic. She was apparently normal two weeks ago. Her mother noticed perianal lesions for which she visited the paediatric outpatient department from where she was referred to our STI clinic. The girl was born of a full term normal uncomplicated delivery. Her parents were daily waged workers. The child lived with her parents, brother and sister. The child went to school with group of boys who are their neighbours.

According to her parents the child did not exhibit any behavioural changes or concerns. The child and her parents were meticulously counselled by us and our social worker. A positive history suggestive of sexual exploitation and source of infection could not be elicited from the child and her parents even after repeated counselling. Physical examination revealed a malnourished child with inguinal lymph node enlargement.

Mucocutaneous examination revealed a greyish white round plaque of size 2.5cm diameter around the anal verge with moist surface and serous discharge [Figure 1].



Figure 1 Condyloma lata at presentation

There is no bleeding on touch or manipulation. Another greyish white moist papule of size 0.5cm present over the inner aspect of right labia majora. No other mucocutaneous features were seen. Systemic examination was normal. Dark-field examination of the lesions was positive for *Treponema pallidum*. Serology showed reactive rapid plasma reagin

(RPR) in 1:32 dilution, treponema pallidum haemagglutination assay (TPHA) was positive and HIV was negative. RPR of the mother and father were non-reactive. A diagnosis of condyloma lata was made based on the clinical, dark-field examination and serology. The child was admitted but child absconded with parents because of their ignorance. Next day our counsellor went to village where their parents are working and after repeated counselling and motivation the child was brought to our department. The child was again admitted and administered injection Benzathine penicillin 50000 IU/Kg single dose intra-muscular and she was discharged on next day because of their parent's request. She was advised to review after one week but child did not turn up. Again our counsellor went and after repeated persuasion child came for follow-up after one month. On examination the lesions subsided completely, her repeat RPR showed a decline in the titre from 1:32 to 1:16 and she is on follow up [Figure 2].

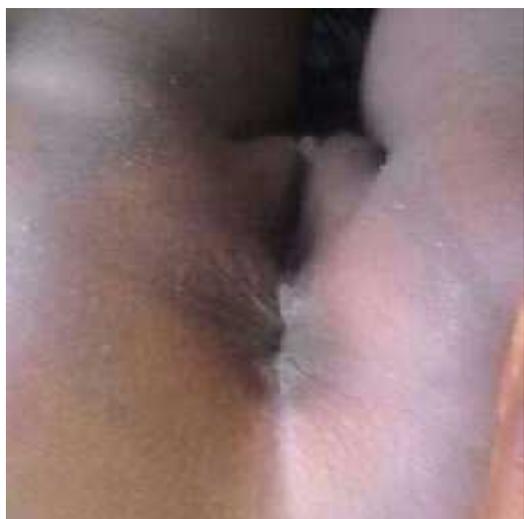


Figure 2 Condyloma lata cleared after one month of Benzathine penicillin

DISCUSSION

Sir William Osler called syphilis “the Great Imitator” in view of its protean clinical presentations. Syphilis caused by *Treponema pallidum* typically follows a progression of stages; primary (chancre), secondary, latent and late (benign tertiary, cardiovascular and neurosyphilis). Secondary syphilis is characterized by low grade fever, malaise, headache, sore throat, conjunctivitis and hepatosplenomegaly. Painless lymphadenopathy is present nearly 50-86% of patients and most commonly involves suboccipital, cervical, posterior auricular and epitrochlear nodes. Joint and bone involvement can be observed in approximately 12% and alopecia in 4.0 – 12.5% of patients.^{1,2} Cardiovascular, renal, neurological and ophthalmic manifestations may also occur.

Mucocutaneous manifestations of secondary syphilis seen in 75 to 100% of patients, span a wide spectrum and mimic those of other dermatoses. The most common presentation of secondary syphilis is a generalized, non-pruritic, papular or papulosquamous eruption that occurs bilaterally symmetrical over the trunk and extremities, including the palmar and plantar surfaces. Pustular, follicular, annular, lichenoid, corymbose and condyloma lata are varieties of papular syphilide.

Condyloma lata, a localized syphilid, an important

manifestation of secondary syphilis, is caused by the direct infiltration of *Treponema pallidum* characterised by smooth, flat, moist, greyish white or flesh-coloured, macerated papules, plaques or nodules, which are usually seen around the genital and anal areas, highly infective lesion. It occurs in 10 to 20% of secondary syphilis patients.¹ They also occur over the umbilicus, submammary area, axillae, nasolabial folds, angle of mouth, web spaces of toes and palms. Extensive forms rarely, can exist on neck, axillae, scrotum, inguinal folds and inner thighs.³

Syphilis although in children is considered to be an indicator of child sexual abuse, other non-sexual modes⁴ like kissing, breast feeding or handling also exist. In our patient a positive history of sexual abuse could not be obtained from the child or her parents. The identification of child sexual abuse usually relies on a clear history of sexual contact provided by the child. Although the finding of genital trauma or a sexually transmitted disease at times can be suggestive of sexual abuse, identifying the source of the abuse and protecting the child from additional molestation can prove difficult without a positive history of sexual abuse. The American Academy of Child and Adolescent Psychiatry and American Professional Society on the Abuse of Children have published practice guidelines for the psychosocial evaluation of suspected sexual abuse in young children.^{5,6} These guidelines recommend that a series of interviews to be conducted by experienced evaluators who have advanced training in child development and child sexual abuse. Although additional forensic interviewing may have revealed a history of abuse, lower rates of disclosure have been reported for children.

The efforts to identify the source of infection failed in our case. The possibility of acquired disease and sexual abuse was considered, but interviews by physician and social worker did not reveal the history of sexual abuse.

With the increase in syphilis seen in recent years,⁷ physicians are more likely to encounter children with syphilis. Our ability to document acquired infection and sexual abuse is hampered by the difficulties encountered in evaluation and follow-up and by limitations in interviewing young victims of sexual abuse, which may impair our ability to protect children from additional harm.

We are presenting this case to highlight the importance of creating awareness about child sexual abuse and sexually transmitted diseases, health and sex education to overcome the stigma associated with it and to improve the health seeking behaviour particularly in low socioeconomic groups who are highly ignorant.

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