

Syphilitic Proctitis with Human HIV Mimicking Ulcerative Colitis: A Case Report

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1. Abstract

Syphilis is a chronic bacterial infection caused by *Treponema pallidum*. Syphilitic lesions may coexist with other sexually transmitted diseases, and their endoscopic features often overlap with those of inflammatory bowel disease, other infection types, and non-steroidal anti-inflammatory drug enteropathy.

Syphilitic proctitis is rarely reported but is being recognized more frequently because of the increased incidence of syphilis. The objective of our study is to alarm clinicians to consider the possibility of syphilitic proctitis in high-risk patients. Here, we report a case of syphilitic proctitis in 36-year-old women that presented with diffuse rectal ulceration mimicking ulcerative colitis. The patient was treated with intramuscular penicillin G benzathine, 2.4 million units per week for 3 weeks and the results were spectacular after a few weeks of treatment.

The diagnosis of syphilitic proctitis is then an entity difficult to diagnose and therefore to take care of correctly as soon as possible, hence the interest of a reminder of the treatment with review of the literature to improve the care of these patients

2. Introduction

Syphilis which is caused by *Treponema pallidum* infections, it affects a multiple variety of organs. Infections involving the skin, genitals, retina, and central nervous system are commonly described; rarely, unusual manifestations, of the gastrointestinal tract can also occur [1].

Syphilitic proctitis is a rare entity. It usually presents as proctitis, ulcer or neoplasm but lacks pathognomonic clinical symptoms. It is, therefore, difficult to diagnosis and is often treated inappropriately. Here, <https://jgastrohepto.org/>

we report a case of syphilitic proctitis in a 36-year-old woman that presented with diffuse rectal ulceration mimicking ulcerative colitis [2].

3. Material and Methods

A 36-year-old women presented with a 6 months' history of diarrhea and occasional anal bleeding the patient had no particular pathological history other than unprotected sex with multiple partners [3-5].

4. Results

On clinical examination, the patient was conscious, hemodynamically and respiratory stable with a mucocutaneous palor; on rectal examination, the finger cot came back soiled with blood. On the cutaneous level, the patient presented a specific syphilitic chancre at the level of the labia major without other associated clinic manifestations.

In the biological assessment: a microcytic hypochromic anemia was found with a hemoglobin level of 9.2 g / dl with a positive syphilitic serology and negative HIV serology. At colonoscopy: the rectum presented deep well ulcerations with diffuse petechial lesions suggesting ulcerative colitis and multiple biopsies were taken [6-9].

The pathological results of the biopsy showed an abundant lymphocyte infiltrate with plasma cells and neutrophils with formation of lymphoid follicles and ulcerations, without heterotypic cells or signs of malignancy. The patient was treated with IM penicillin G benzathine, 2.4 M. U per week for 3 weeks. One month after de diagnosis, the patient was asymptomatic and a repeat colonoscopy showed the previous ulcers completely cleared [10].

5. Discussion

The signs and symptoms of proctitis may include rectal bleeding, rectal pain with or without bowel movements passing of mucus through

the rectum, or a feeling of rectal fullness. However, symptoms vary depending on the underlying etiology, but can be similar to lesions in inflammatory bowel disease. Radiation proctitis usually starts during radiation therapy and can last for months to years after treatment ends. Colitis with *Clostridium difficile*, whether or not secondary to antibiotic therapy, can also present in the form of rectal ulcerations, most often with deposition of pseudomembranes. Eosinophilic proctitis occurs when eosinophils accumulate in the rectal lining, typically affecting only children that syphilis infections of the stratified squamous epithelium are commonly seen in the perianal area and at the anal verge; however, our patient did not have these features. Dark field examinations and tests for *T. pallidum* in secretions or lesion tissues are definitive methods of detecting syphilis. However, the low availability of Dark field microscopes and the expertise to use them limits the identification of the Treponeme. Alternatives for the direct detection of *T. pallidum* are fluorescence microscopy and nucleic acid amplification. Nevertheless, syphilis remains a difficult diagnosis to demonstrate by histological examinations by staining with hematoxylin and eosin or by staining of Warthin-Starry. Thus, serological testing remains the most common method for syphilis screening, diagnosis, and treatment determination. Specific immunohistochemical staining for *T. pallidum* is a more sensitive and specific method than the standard Warthin-Starry staining method for the detection of spirochetes. Hoang et al. reported a 71% sensitivity for IHC, compared with 41% for silver staining; false positives were also absent among the control specimens. The use of specific *T. pallidum* antibodies, as used in the present case, also drastically reduces background interference. In our case, intra- and extracellular spiral and threadlike microorganisms were identified under a direct microscope, thus making the diagnosis of syphilitic proctitis. Thus, the combination of colonoscopy and IHC was essential for the definitive diagnosis of the patient. Syphilitic proctitis remains rare in the general population but is becoming increasingly common due to the increasing incidence of syphilis in subjects with risky sexual behavior. Patients may complain of hematochezia, urgency, diarrhea, or constipation. The endoscopic appearance of the rectal area may include diffuse edema, erythema, multiple friable erosions, or ulceration. These features are similar to those of lesions due to inflammatory bowel disease, other infection types, and non-steroidal anti-inflammatory drug enteropathy. Regardless, clinicians should consider the possibility of syphilitic proctitis, especially in high-risk patients. Penicillin has long been the drug of choice for syphilis treatment; at present, long-acting benzylpenicillin is the most commonly recommended therapy and was effective in the present case for a period of 3 weeks.

6. Conclusion

Syphilitic proctitis should be suspected in the event of any isolated proctitis progressing in a patient with risky sexual behavior. Histopathology remains non-pathognomonic, and specific serology and staining are essential to make the diagnosis. Thus, the diagnosis may

be delayed, leading to potentially fatal consequences. Simple treatment with benzatin penicillus G is sufficient to treat syphilitic proctitis once diagnosed.

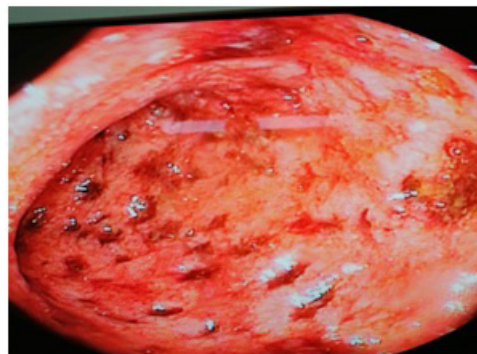


Figure 1: fragile erythematous mucosa with deep ulcers on colonoscopy

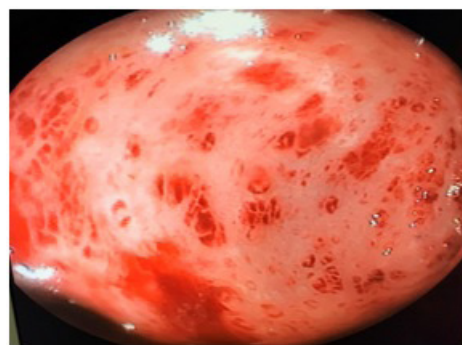


Figure 2: colonoscopic images of diffuse petechial lesions in the rectum

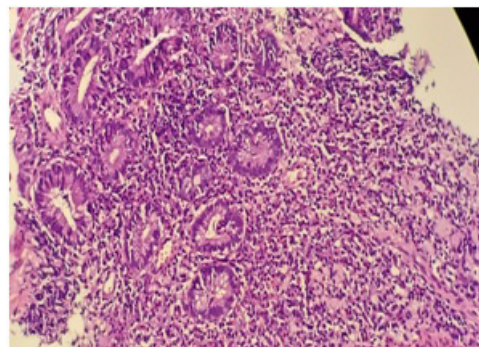


Figure 3: lymphocytic infiltrate with modification of the glandular architecture, non-specific appearance

References

1. Lamb CA, Lamb EI, Mansfield JC, Sankar KN. Sexually transmitted infections manifesting as proctitis. *Frontline Gastroenterol.* 2013; 4: 32–40.
2. Faris MR, Perry JJ, Westermeier TG, Redmond J 3rd. Rectal syphilis mimicking histiocytic lymphoma. *Am J Clin Pathol.* 1983; 80: 719–721.
3. Song SH, Jang I, Kim BS, Kim ET, Woo SH, Park MJ et al. A case of primary syphilis in the rectum. *J Korean Med Sci.* 2005; 20: 886–887.
4. Ghanem KG. Management of adult syphilis: key questions to inform the 2015 Centers for Disease Control and Prevention sexually transmitted diseases treatment guidelines. *Clin Infect Dis.* 2015; 61(Suppl 8): S818–S836.

5. Bassi O, Cosa G, Colavolpe A, Argentieri R. Primary syphilis of the rectum--endoscopic and clinical features. Report of a case. *Dis Colon Rectum*. 1991; 34: 1024-6.
6. Adachi E, Koibuchi T, Okame M. Case of secondary syphilis presenting with unusual complications: Syphilitic proctitis, gastritis, and hepatitis. *J Clin Microbiol*. 2011; 49: 4394-6.
7. Hoentjen F, Rubin DT. Infectious proctitis: When to suspect it is not inflammatory bowel disease. *Dig Dis Sci*. 2012; 57: 269– 273.
8. Hamlyn E, Taylor C. Sexually transmitted proctitis. *Postgrad Med J*. 2006; 82: 733-6.
9. Gianfaldoni S, Tchernev G, Wollina U. Syphilis such as the other sexually transmitted diseases are a cultural background of dermatologist. *Open Access Maced J Med Sci*. 2017; 5: 551-3.
10. Akdamar K, Martin RJ, Ichinose H. Syphilitic proctitis. *Am J Dig Dis*. 1977; 22: 701–704.
11. Gallegos M, Bradley D, Jakate S, Keshavarzian A. Lymphogranuloma venereum proctosigmoiditis is a mimicker of inflammatory bowel disease. *World J Gastroenterol*. 2012; 18: 3317-21.
12. Quinn TC, Lukehart SA, Goodell S, Mkrtychian E, Schuffler MD, Holmes KK et al. Rectal mass caused by *Treponema pallidum*: confirmation by immunofluorescent staining. *Gastroenterology*. 1982; 82: 135-1398.