Skin rash is the most common characteristic of secondary syphilis and can take any form except vesicular lesions. Our patient had the classical distribution of symmetric, macular, or papular eruptions involving the trunk and extremities, including the palms and soles. Although the patient denied having had sexual activity for the prior 2 years, these lesions typically present weeks to months postexposure.

Uveitis is the most common ocular manifestation of secondary and tertiary syphilis in both HIV-positive and HIV-negative patients, occurring in 2.5 to 5% of the untreated patients that progress to this stage. The diagnosis should prompt an analysis of the cerebrospinal fluid to exclude neurosyphilis, which was diagnosed in our patient.

The diagnostic criteria for syphilitic hepatitis are abnormal liver enzymes indicating hepatic involvement, serologic evidence of syphilis in conjunction with acute clinical presentation consistent with primary or secondary syphilis, and exclusion of alternative causes of hepatic damage with prompt liver function recovery after antimicrobial therapy (1, 2). This case met all the aforementioned criteria. In addition, the histological features of inflammation with polymorphonuclear cells, hepatocellular necrosis, mild hepatocellular cholestasis, and cholangitis were also consistent with the diagnosis.

The clinical manifestations of syphilitic hepatitis are likely to be subsequent to the dissemination of the treponema to the liver (2–4). However, demonstration of spirochetes in liver biopsy specimens has been inconsistent. The failure to demonstrate spirochetes in liver biopsy samples may be due to technical factors during storage and staining specimens or may be the result of effective phagocytosis by Kupfer cells (2). In this case, the Warthin-Starry stain did not demonstrate spirochetes, but spirochetes were visibly stained by a specific immunohistochemical stain highly specific for *Treponema pallidum* (Biocare Medical, LLC, Concord, CA).

REFERENCES

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