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Syphilitic Chancre Despite Use of Condoms: “Condom Chancre”

Sir,

The primary stage of syphilis is characterized by a chancre at the site of inoculation. In men, genital chancres are usually located on the coronal sulcus, the glans penis, the frenulum or the prepuce. Less common genital sites are the shaft of the penis and the pubic region (1). The use of condoms is generally considered to protect against sexually transmitted syphilis (2, 3). However, we report here on 2 male patients who were infected with syphilis by sexual contact with female prostitutes and subsequently developed penile chancres behind the area protected by a condom. We suggest the designation “condom chancre” to draw attention to the fact that condoms do not always provide sufficient protection against syphilis.

CASE REPORTS

Case 1

A 30-year-old heterosexual man consulted the clinic for sexually transmitted diseases with a solitary, indolent ulcer close to the radix penis. The ulcer had appeared 5 weeks after sexual contact with a foreign prostitute. A condom had been used and no defects had been observed. The ulcer was indurated, regularly edged, measuring 10 × 20 mm. Unilateral indolent inguinal lymph nodes were present. The clinical findings raised the suspicion of a syphilitic chancre and the diagnosis was confirmed by positive serology (WR 5, RPR 4, FTA-ABS IgM 0, IgG 4) and histological examination of a skin biopsy. No treponemes could be detected by dark-field microscopy. The patient was treated with procain penicillin at a dose of 600,000 units/day intramuscularly for 10 days.

Case 2

A 34-year-old heterosexual man presented with a penile lesion suspicious of a syphilitic chancre. The lesion developed 1–2 weeks after sexual intercourse with a foreign prostitute. A condom had been used during intercourse. The lesion was located near the radix of penis on an area not covered by the condom. It was a solitary, indolent, indurated ulcer with a regular edge and an oval shape, approximately 10 mm in diameter (Fig. 1). Regional adenopathy was present. A diagnosis of syphilis was established by dark-field microscopy, positive serology (WR 0, RPR 4, FTA-ABS IgM 2, IgG 3) and histology of a skin biopsy showing treponemes in the epidermis and the upper part of dermis (silver impregnation (Whartin Starry) and immunostaining with *Borrelia burgdorferi* polyclonal antibody (cat. number 1439-9406, Genesis)). The patient was treated with doxycycline at a dose of 100 mg orally every 12 h for 3 weeks.



Fig. 1. Penile chancre close to the radix penis, which is an area behind the protection of a condom.

DISCUSSION

The 2 cases were infected with *T. pallidum* in spite of the fact that condoms had been used during sexual activity. Syphilitic chancres developed proximally on the penis shaft close to the radix penis, which is an area outside the protection of a condom. The term “condom chancre” may therefore be appropriate (1). *T. pallidum* can probably penetrate intact skin and mucous membranes, but transmission is facilitated by defects in the skin barrier (1). Mechanical friction and stricture of a rubber condom may induce minor skin lesions and thereby facilitate the transmission of treponemes. Exposure to a high number of treponemes may be a prerequisite for developing such a chancre on otherwise intact skin.

Russian female prostitutes were regarded as the sources of infection in these 2 cases. Syphilis occurs worldwide, and the incidence varies with geographic location (4, 5). Of special concern is a large increase in the incidence of syphilis in the previous Soviet States (6). Here the incidence of syphilis has increased 15–60 times during the last 5–6 years, resulting in incidences of 200 and 280 cases per 100,000 inhabitants in 1997 in Russia and White Russia, respectively (6). For comparison, the number registered cases of syphilis in Denmark has remained below 59 per year since 1993, with

incidences of 1 per 100,000 inhabitants or less (6, 7). In 1998, 45 cases of syphilis were registered in Denmark (6). Thus, the rise of syphilis in Eastern Europe has not yet influenced the incidence of syphilis in Denmark.

In 1989 Mindel et al. described the location of 642 penile chancres and no cases were reported with a location close to the radix penis (8). However, these cases emphasize that a lesion located close to the radix penis may be a syphilitic chancre in a condom user. Condoms do not always provide protection against a sexually transmitted disease.

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Subungual Myiasis

Sir,

Subungual location of infestation by larvae is an unusual event that has not been sufficiently addressed in the literature (1).

CASE REPORT

A 90-year-old woman was seen in our dermatological clinic in 1999. She suffered from type-II diabetes mellitus, and had no previous history of other relevant diseases. She had noted bilateral leg swelling in the previous months, and intense pain on her right foot. She denied having intermittent claudication or symptoms of cardiac, renal or hepatic disease. On physical examination, she had bilateral pitting oedema, without varicosities. No distant pulses were felt, and she had bilateral femoral bruits. On her right first toe she had onycholysis, periungual erythema, and a distal erosion. Thoracic X-ray and laboratory test results, including blood cell count and blood chemistries, were within normal limits. Doppler ultrasound showed valvular incompetence of the veins. Only on a second visit did we realize that there were larvae under the nail (Fig. 1). We performed avulsion of the nail plate and cleaned the unguis bed. We found no signs of tissue necrosis. Larvae were identified as *Sarcophaga sp.* The patient's symptoms and oedema improved in the following days. We referred the patient to a vascular surgeon, who diagnosed non-critical lower-limb ischaemia.

DISCUSSION

This is an unusual, and hard to notice, location of myiasis. Previous reports of such infestation were induced by *Musca domestica* after trauma and subungual haematoma (1). *Sarcophaga* is a genus producing facultative myiasis, occasionally reported as infesting wounds. The presence of necrotic tissue, in a patient with diabetes mellitus and limb ischaemia, could have been a predisposing factor, but larvae are well

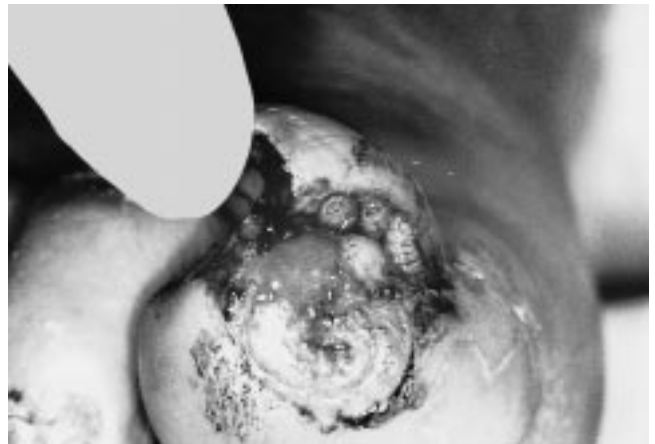


Fig. 1. On close inspection, larvae could be seen under the nail plate.

known to perform good debridement and may have avoided the detection of previous necrosis.

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