

of the symptoms following reduction of drug dosage confirmed the suspected diagnosis and agreed with the findings published by other authors.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Nodular Secondary Syphilis

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To the Editor:

The reduction in the number of cases of syphilis since the advent of antibiotics has diminished knowledge

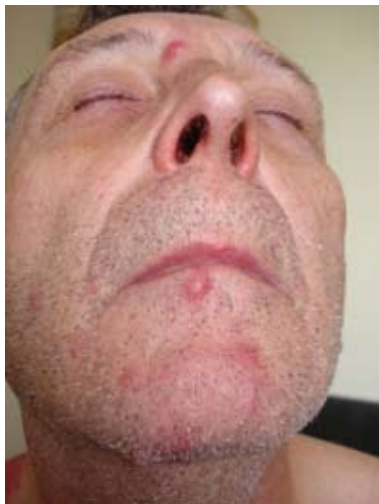
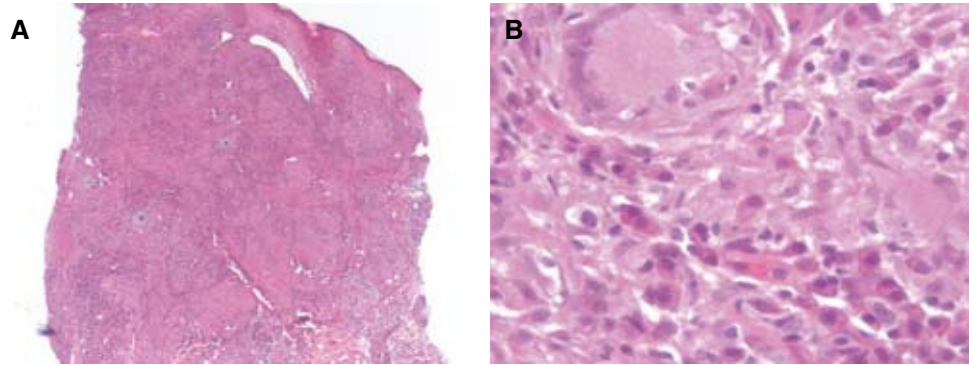


Figure 1.
Asymptomatic nodular lesions on the face

of the disease. However, “the great simulator” is still amongst us and we must maintain a high degree of diagnostic suspicion.¹ Common forms of clinical presentation are complemented by extremely rare cutaneous manifestations that complicate diagnosis, as in the case presented here.

A 58 year-old white man, with no relevant medical history, attended for an asymptomatic rash on the face and chest with onset 4 weeks previously (Figure 1). He reported no asthenia, fever, weight loss, night sweats, or other symptoms. On physical examination, the man had a healthy appearance, with multiple painless nodules of an intense pink color and firm consistency measuring approximately 1 cm in diameter located on the face and chest. There was no ulceration of the lesions. The palms, soles of the feet, and mucous membranes were unaffected. The hair and nails showed no abnormalities. There were multiple painless symmetrical adenopathies in the cervical and axillary regions, but with no sign of hepatosplenomegaly.

Figure 2. A, Diffuse granulomatous dermatitis occupying the mid and deep dermis (hematoxylin-eosin, $\times 25$). B, Detail of the granulomatous dermal infiltrate, showing the presence of numerous epithelioid histiocytes, multinucleated giant cells and plasma cells (hematoxylin-eosin $\times 400$).



Histological findings in one of the lesions showed a preserved epidermis with a dense, granulomatous nodular dermal infiltrate that contained epithelioid histiocytes and multiple multinucleated giant cells of the Langerhans type, accompanied by a dense predominantly plasma cell infiltrate. The infiltrate presented a marked perivascular distribution, and small capillary vessels with edematous walls were present (Figure 2).

Nontreponemal tests with a titer of 1:32 were positive for *Treponema pallidum*-specific immunoglobulin G, and treponemal tests (hemoagglutination) were also positive. The patient was seronegative for HIV in 2 tests. He was diagnosed with secondary nodular syphilis and treated with penicillin G benzathine 2.4 million units per week for 3 weeks by intramuscular injection. The clinical course was favorable, with no adverse effects and with complete resolution of the lesions.

The lesions of secondary syphilis correspond to the phase of infection characterized by the widespread dissemination of spirochetes; the clinical manifestations may be varied. The generalized nonpruriginous papular and scaly rash (roseola syphilitica) is the most common cutaneous symptom; it may be accompanied by fever, arthromyalgia, weight loss, and enlarged lymph nodes. Serology (reagin or treponemal) always gives positive results in patients with secondary syphilis.²

The nodular presentation of secondary syphilis is extremely uncommon, and although it was first described more than 20 years ago only a few cases have been published in the literature.³ Clinically, the lesions present as partially infiltrated plaques or nodules of a red-to-violaceous color,² sometimes simulating pseudolymphoma or even panniculitis.^{4,5} The nodular eruption can be localized, with predilection for the face, mucous membranes, palms, and soles of the feet.⁶ The presence of ulceration or nodules tends to correspond to a late secondary stage and can indicate progression toward the third stage of the disease, with its potential associated

morbidity and mortality.⁷ Histological findings can show a granulomatous inflammation.² The histological differential diagnosis must include various entities such as atypical mycobacteriosis, deep fungal infections, leprosy, tuberculosis, leishmaniasis, sarcoidosis, lymphoma, foreign body granuloma, and drug eruptions, among others.⁸

Various hypotheses have been proposed to explain the formation of granulomatous nodular lesions in secondary syphilis. The most widely accepted hypotheses include a specific hypersensitivity reaction related to treponemal infection, or a long period of infection with progression towards the third stage.^{9,10}

In our patient there was a marked presence of diffuse nodules on the face and chest, with no sign of the palmar, plantar, or mucosal lesions typical of secondary syphilis. The diagnosis of secondary nodular syphilis allowing for early treatment of these cases relies on a thorough compilation of the patient's medical records—full medical history with details of sexual activity, physical examination, and serological and histological findings—and a good response to treatment.⁸

Unlike Sir William Ostler, as quoted by Sánchez,¹¹ we do not believe that syphilis is the only disease a doctor needs to be familiar with in order to become an expert dermatologist. However, the fact that syphilis can simulate so many other illnesses means we must be cautious and remain alert to this diagnosis even when it presents with rare clinical manifestations.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Localized Trichorrhhexis Nodosa

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To the Editor:

Trichorrhhexis nodosa (TN), also known as trichonodosis, was first described by Wilks in 1852.¹ It is the most common of hair dysplasias associated with increased hair fragility. It is considered an anomalous response of the hair shaft to external trauma and is clinically characterized by dry, dull, and brittle hairs of different lengths with varying numbers of small grayish-white or yellowish nodules distributed irregularly along the shaft.² These nodular formations are transverse



Figure 1. Lock of abnormal hair, with shafts of different lengths, a dry appearance, and the presence of multiple whitish-gray nodules.

fissures through which the hair can break off completely. If the nodules are located on the proximal portions of the hair, fracture of the shafts near the scalp will result in bald spots. If, on the other hand, they are located on the distal portion, the hairs will be fragile and of different lengths, and will show distal speckling and trichoptilosis, but no bald patches.²

TN can be a congenital disorder, presenting as an isolated autosomal dominant defect, or it may be associated with ectodermal dysplasias, ichthyosis, or other syndromes. Acquired TN, however, is much more frequent and is classified into 3 major groups³: proximal (predominantly among blacks) or distal (the most common in Spain) according to the area of the hair shaft in which the nodules appear, and localized. Very few cases of localized TN have been reported in the literature.⁴⁻¹⁰ Its main clinical characteristic is that it is limited to well defined hairy areas—generally the scalp, but also the beard, moustache, pubic hair, etc. We present the case of a 24-year-old man, with no relevant history, who said that for about the last 3 years he had had a lock of hair on the frontotemporal hairline that was different from the rest. The hairs were dry, brittle, and of varying lengths, with small nodules along the shafts (Figure 1). On examination, except for Hamilton class I male pattern baldness, no underlying cutaneous abnormality was found. The patient denied using topical hair products, but did mention that when studying he used a reading light that shone directly on the lock of anomalous hair and that he had a certain tendency