

Early congenital syphilis

Since the publication of our recent public health article about early congenital syphilis,¹ we have been able to obtain patient consent for publication of photographs and details pertaining to 2 pregnant women who delivered babies with congenital syphilis. Both cases provide important educational messages.

Figure 1 is a photograph taken immediately after cesarean section that shows multiple painless genital ulcers that were mistaken for genital herpes. The absence of pain is more suggestive of a diagnosis of syphilis, although syphilitic ulceration can also be painful. The findings of a direct test (culture for herpes simplex virus) from the genital ulcers were negative, whereas the results of a fluorescent antibody test for *Treponema pallidum* were positive, together with the findings of reactive rapid plasma reagin (128 dilutions) and *T. pallidum* particle agglutination tests. In another similar case, the patient underwent emergent cesarean section, because the lesions, which subsequently tested negative for herpes simplex virus, were presumed to be active genital herpes.

In the second case (Figure 2), multiple condyloma lata may be seen on the external genitalia; these secondary syphilitic lesions are typically



Figure 1: Multiple painless genital ulcers that were mistaken for genital herpes.

flesh-coloured, smooth-topped and classically painless and may be mistaken for the more common condyloma acuminata caused by human papillomavirus. This patient was reported to have no symptoms and thus her condition would have been “staged” as an early latent stage of syphilis had careful physical examination not been performed, which revealed these genital lesions, as well as posterior cervical lymphadenopathy, thus staging her condition as a case of secondary syphilis. The lesions resolved completely within a few weeks of treatment. This difficulty with accurately staging syphilis has led some experts to recommend treating all pregnant women with infectious syphilis (primary, secondary and early latent syphilis) with benzathine penicillin G, 2.4 million units by intramuscular injection for 2 weekly doses, even though published data only support this recommendation for secondary syphilis.² A high index of suspicion is required of clinicians to consider the diagnosis of syphilis and to stage this infection accurately in pregnant women.

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Figure 2: Multiple condyloma lata may be seen on the external genitalia.

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In memoriam Ursus

As I listened to U2's *Beautiful Day* on my iPod while jogging on a beautiful day, I mourned the loss of my comrade in the trenches of family medicine, Ursus.¹ Who else relishes the freedom of singing along to an uplifting song on the commute to work? Who else berates himself for missing Guillain-Barré syndrome in a patient with vague symptoms? Who else speaks frankly of his personal challenges with mental illness?

Query has been the highlight of each *CMAJ* issue for me since Ursus' introduction. Ursus always seemed to eloquently verbalize the internal struggles I also grapple with as a rural family physician. Difficulties with colleagues and patients and the challenges of trying to maintain a work-life balance are common to all physicians, but simply knowing that we are not alone in our struggles makes it easier to continue plodding forward.

Ursus, whoever you are, I salute you. I will think of you (and sing in your honour) the next time I hear *Beautiful Day* on my car radio.

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