Symptomatic congenital syphilis: still a reality

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DESCRIPTION

We describe the case of a newborn, first daughter of young parents, both unemployed, with no history of bisexual behaviour, sex work, drug use, social marginalisation, prison, domestic violence or any other known social risk factor. The pregnancy was unplanned and poorly monitored. The ultrasounds, performed at 14th and 22th weeks of gestation, were normal. Both the Venereal Disease Research Laboratory (VDRL) test (1/8) and the Treponema pallidum haemagglutination test were reactive (1/1280) in the third trimester, HIV was negative. However, she missed her appointment and consequently was not medicated. At 34 weeks of gestation, due to placental abruption, emergency caesarean delivery was performed. The newborn needed reanimation with invasive mechanical ventilation and was transferred to an intensive neonatal care unit. At birth, it was evident a widely disseminated and bullous rash (pemphigus syphiliticus), hepatomegaly, anaemia (haemoglobin 111 g/L), hypoglycaemia (14 g/dL) and jaundice (10.4 mg/dL). VDRL titre was more than fourfold the corresponding maternal titre (1/128). Cerebrospinal fluid VDRL was non-reactive and cerebral ultrasound, hearing test and eye examination were normal. A chest radiograph showed bilateral perihilar infiltrate, suggestive of pneumonitis and the long-bone radiographs periostitis and osteochondritis of the lower limbs ([figure 1](#)). The diagnosis of congenital syphilis was made and she was treated with intravenous aqueous penicillin G (50 000 U/kg per dose every 12 hours during the first 7 days and every 8 hours for a total of 10 days). Both parents were

Figure 1 Skeletal radiography: diaphyseal periostitis and osteochondritis in long bones (tibia and femur).

Figure 2 Skeletal radiography (12 months): no signs of periostitis or osteochondritis of the long bones.

treated with intramuscular benzathine penicillin G and cases duly notified.

At 4 months VDRL was negative and at 12 months she was asymptomatic, without neurodevelopmental problems or evident osseous lesions ([figure 2](#)).

Although it is preventable and traceable, with an easy and cheap treatment, syphilis has a high prevalence worldwide (about 19 million people infected), and its incidence has been rising in recent years, which is likely to be associated with an increase in underprivileged and high-risk populations.¹ In Portugal, 451 cases of syphilis were reported between 2013 and 2017, of which 23 were of congenital syphilis.²

We are reporting a case of symptomatic congenital syphilis, with multisystemic involvement,

Learning points

- ▶ Congenital syphilis is still a major public health issue, including in developed countries.
- ▶ Repeated serology during pregnancy is recommended, especially if risk factors are present.
- ▶ The diagnosis of congenital syphilis should be considered in any infant with suspicious clinical findings, despite maternal serological status, in order to establish early diagnosis and institute appropriate treatment, avoiding the high morbidity and mortality associated with the disease.

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manifested by prematurity, anaemia, jaundice, hypoglycaemic and cutaneous, bone and pulmonary lesions. In this case, institution of appropriate therapy was delayed because of incomplete follow-up, not only due to several missed appointments by the mother, as well as lack of communication between health services and the patient. We spot the fact that it is fundamental to comply with the pregnancy follow-up, once all the appointments are free of charge and of easy access. We also point the need to design collaboration protocols between laboratories, general practitioner and patient, especially in high-risk groups for sexually transmitted diseases. The diagnosis of the infection in the mother and its adequate treatment is essential in order to prevent its high mortality and morbidity in the newborn.^{3 4}

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