Re-emergence of syphilis

Sir,

Syphilis, like tuberculosis, is making a comeback.

This comprehensive editorial by Michael Waugh is most timely (Vol 61(7), 2000, p. 454). Recently, several geographically dispersed outbreaks of infectious syphilis have occurred in the UK, most recently on the South coast. Both sexes have been affected in a wide age range with <5% of male cases and <25% of female cases occurring in teenagers. More worryingly, some have had human immunodeficiency virus (HIV) co-infection, which may potentially increase syphilis infectivity, modify its classical early manifestations, and also influence the serological response to infection.

This has occurred when increasing numbers of patients are presenting with sexually transmitted infections to genitourinary medicine clinics. The reasons for this are incompletely understood, although the lesser publicity given to HIV/AIDS, a result of the dramatic success of combination antiretroviral therapy in reducing disease progression and mortality, may have contributed to a general reduced adherence to safer sexual practices.

Importation of infection from other countries, related to increasing travel abroad, sex tourism and migration, may be another factor.

All doctors need heightened awareness of syphilis as a cause of genital ulceration and as part of the differential diagnosis in a wide array of other conditions. Early referral to genitourinary medicine clinics is advisable, especially for those patients with recent partner change or other risks revealed in their sexual and travel histories.

Many laboratories are introducing new screening tests for syphilis, which will be unfamiliar to most practitioners. Although injectable penicillin-based treatments remain effective, the imminent withdrawal of bicillin by the manufacturer will require modification of standard treatment regimens.

We should learn from the past experience in North America, where the large increase in the incidence of syphilis between 1986 and 1990 coincided with lowered clinician awareness and reduced serological screening for syphilis. Failure to diagnose early cases favours onward transmission. Moreover, so that the incidence of congenital syphilis remains at very low levels, it is essential that routine serological testing for syphilis, like HIV, be offered to all pregnant women.

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Sir,

This excellent editorial is a timely reminder that syphilis may present a range of problems and that early infectious syphilis is increasing in various parts of the world.

Arguably the epidemic in the former USSR is the greatest problem because of the increasing numbers of visitors to this region. As the editorial notes, early syphilis is increasing in the UK with widely scattered outbreaks. All clinicians, medical, nursing and others, must remember syphilis; with its protean clinical features cases may present in many settings.

The swift recognition of early infection remains crucial to control — rapid accurate diagnosis, effective treatment and speedy contact tracing minimize spread. As the editorial mentions, in genitourinary medicine clinics, diagnosis of primary (and secondary) syphilis can be confirmed by dark field or dark ground microscopy. This takes only a few minutes, and it is sensitive and specific in experienced hands.

Another arm of control is serological screening which must be maintained in antenatal clinics, the Blood Transfusion Service and when tissues are collected for donation. In addition screening must continue in genitourinary medicine clinics and when patients present in other settings with clinical features such as genital ulceration, rashes, mucosal ulceration and lymphadenopathy.

The principles of treatment as outlined are important; whenever possible daily intramuscular procaine penicillin is to be commended — tissue penetration is better than with other penicillins or different antimicrobials, and adherence is then documented.

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Neurological manifestations of malignant disease

Sir,

For the sake of completeness, the detailed list of paraneoplastic neurological stigmata given by Dr Rees (Vol 61(5), 2000, p. 319) ought also to include paraneoplastic involvement of the spinal cord, which may manifest itself as necrotizing myelopathy giving rise to acute, rapidly progressive and fatal paraplegia (Ojeda, 1984). Paraneoplastic involvement of the spinal cord can also give rise to a syndrome indistinguishable from motor neurone disease, followed by remission after resection of bronchial carcinoma (Mitchell and Olczak, 1979).

Paraneoplastic amyotrophic lateral sclerosis has recently been associated with the presence of anti-Hu antibodies (Forsyth et al, 1997), which seem to differentiate between tumour-associated *vs* non-tumour-associated amyotrophic lateral sclerosis (Kiernan and Hudson, 1993).

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Forsyth PA, Dalmau J, Graus F et al (1997) Motor neurone syndromes in cancer patients. *Ann Neurol* **41**: 722–30

Kiernan JA, Hudson AJ (1993) Anti-neurone antibodies are not characteristic of amyotrophic lateral sclerosis. *Neuroreport* **4:** 427–30

Mitchell DM, Olczak SA (1979) Remission of a syndrome indistinguishable from motor neurone disease after resection of bronchial carcinoma. *Br Med J* **ii**: 176–7

Ojeda VJ (1984) Necrotising myelopathy associated with malignancy: a clinicopathological study of two cases and literature review. *Cancer* **53**: 1115–23