CLINICAL PRACTICE
Clinical Images

Syphilis as Athlete's Foot: "The Great Imitator" Strikes Again

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A 51-year-old man with human immunodeficiency virus (HIV) infection presented with worsening bilateral foot pain and difficulty ambulating. Three weeks prior he was diagnosed with tinea pedis. Despite applying an antifungal cream to his feet, his symptoms progressed. Two weeks later he was prescribed an oral antifungal agent. His foot pain and rash continued to worsen until he was unable to bear weight. Examination showed flaking of the interdigital toe spaces with maceration of the soles (Fig. 1, star). Surrounding macules were noted (Fig. 1, arrows), prompting inspection of his palms, which showed similar lesions (Fig. 2, arrows). This raised suspicion for secondary syphilis. A rapid plasma reagin (RPR) test was positive at a titer of 1:256.

While studies have not shown an independent association between HIV infection and cutaneous dermatophyte infections[1], those with HIV infection may develop more severe infections that can be refractory to treatment[2]. Neither dermatophyte infections nor secondary syphilis typically cause pain. It was presumed that maceration from cutaneous breakdown was the source of this patient's pain. The presence of macular lesions on the soles and palms was an important clue in the diagnosis of syphilis in this patient.

Figure 2 Macular lesions (arrows) on palm

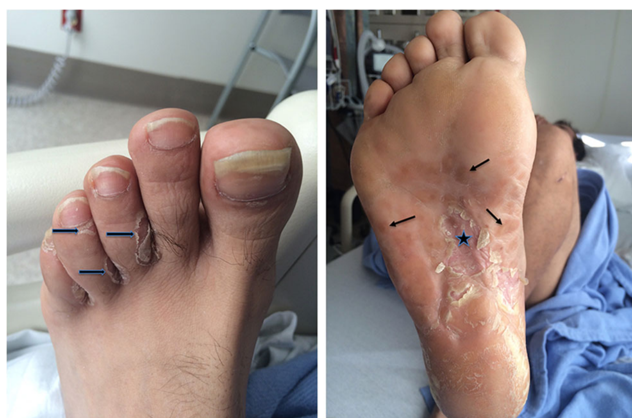

Figure 1 Maceration of sole (star) and macular lesions (arrows)

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Compliance with ethical standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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