Alopecia syphilitica diffusa

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Received: 17 February 2015 / Accepted: 21 April 2015 / Published online: 1 May 2015
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A 27-year-old HIV-positive man (CDC stadium A2) on stable antiretroviral therapy with tenofovir disoproxil fumarate/emtricitabine/rilpivirine (TDF/FTC/RPV) (CD4 cell count 960/μl, HIV RNA not detectable) presented with clinical findings of a progressive hair loss on his scalp within only a few weeks. On request, a painless ulceration on the palate 6 weeks prior to actual presentation after unprotected oral intercourse with another man has been reported. On physical examination, a 1 cm in diameter

large ulceration was observed on the mucosa of the hard palate, as well as cervical lymphadenopathy. Laboratory evaluation revealed a reactive *Treponema pallidum* particle agglutination assay (TPPA) and a Venereal Disease Research Laboratory (VDRL) test of 1:256 with known negative TPPA testing 5 months prior to actual presentation. Diagnosis of secondary syphilis with alopecia syphilitica diffusa, lymphadenopathy and persisting hard chancre was made. A treatment with a single gluteal, intramuscular injection of benzylpenicillin 2.4 million units [1] following 60 mg prednisolone per os as prophylaxis against Jarisch–Herxheimer reaction led to complete resolved symptoms. Alopecia syphilitica is a rare and rather uncommon manifestation of secondary syphilis occurring in only about 5 % of syphilis patients [2]. It can be the only clinical symptom of syphilis infection and mimic alopecia areata in clinical course or on histopathological findings [3]. Syphilitic hair loss, suggested to be caused by the direct infection of hair follicles by *Treponema pallidum* [4], is non-inflammatory and noncicatricial and typically presents in a diffuse or in a moth-eaten pattern with multiple patches of non-scarring alopecia, or in a combination of both [5, 6].

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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