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ECHO: NOT YOUR USUAL STI CASES

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[video transcript]

00:08
So today we're going to do some cases, but not your usual STI cases. And objectives for today will be to discuss the differential diagnosis for various Ulcerative STI presentations, and identify STI tests indicated for conditions that present with cutaneous or mucosal ulcers. So here's the first case, this is a 37 year old female who has a medical history significant for chronic lung disease, but is otherwise healthy. And she presented with fever, cough, some abdominal pain on the left side and my elders that had been going on for about 10 days. And she initially presented to her primary care physician, notably about two weeks before that she had been diagnosed which with what was thought to be a bilateral ear infection after having some ear pain. This was for this, she was given a course of amoxicillin. And she did develop some additional symptoms after starting the amoxicillin which included some vaginal discharge, some pruritis and rash in the groin area as well. And when she described the history, and in talking with her providers at that time, she had also noted a new male sexual partner whom she had met online. She did not have other partners though this part, this male partner did have multiple other partners who were all reported to be female. And the last time she had sex with this person was about three weeks prior to the onset of her symptoms. And they did have about a one month one and a half month of sexual relationship. The she did have oral sex, vaginal sex and anal sex with no condom use. So as I as I start there any thoughts from the group from Dr. Irvin there are the group at large here?

02:11
Well, so to to sort of focus of our so she has sort of nonspecific symptoms of fever, cough, more systemic symptoms, really fever, cough, abdominal lounges, ear pain, and vaginal discharge. So kind of a lot of symptoms. So maybe one way to group all of those together would be secondary syphilis. You know, because you would, can have sort of any itis and you can certainly have fever, cough would be a little bit atypical, certainly can have myalgias, with secondary syphilis. And the European you can have ODAC, syphilis developing and secondary syphilis. So maybe the rash is the rash of syphilis. So that would be one thing I would consider to lump it all together. So seems a little soon, but what did you say for the length of the relationship?

03:14
It was about one and a half to two months. And the last time they had sex was about three weeks prior to all of these. So that would be

03:23
three months if you say that she had new syphilis, which might be a little quick to get from acquisition to primary to secondary, but I suppose would be possible. So, Let me see if there's anything in the chat. I guess other things you think about would be sort of like if these are separate events, Does she really have another viral illness or you know, some other systemic illness giving her abdominal pain in myalgias? She has chronic lung disease, so you could go down that does she have autoimmune disease, and, and then a separate vaginal complaint titled this unusual? So I'm assuming it's probably not the syphilis

04:10
I started with the most conflicts. But it is it is something you know, we always try to try to tie all the things together for one unifying diagnosis, but that may not truly be possible here. But the sequence events will become a little bit more clear. Okay, already move forward. So the fevers actually brought her to the emergency department. They were relatively persistent and there she was febrile to 102. She did have left upper quadrant abdominal pain and what they had reported also as left flank pain on her laboratory investigation, she had mild transaminitis with her ASD and hlt in the 50s. And the other tests were normal. And this was new for her compared to pre Previous blood work from a few months before, she did have a leukocytosis, but predominantly a lymphocytosis, with reactive lymphocytes, which was also new. She had COVID, influenza and RSV testing that were all negative. And then, at the time, she was told by the provider that they thought she may have pyelonephritis. And she was treated with Bactrim double strength, twice a day for a planned course of 10 days. She did have the rash and the groin folds. And this was thought to be sort of an intertrigo which was, she was given fluconazole, a single dose weekly for four weeks. So at this point, any change to what you had mentioned before, and again, feel free to chime in in the chat.

05:57
Well, I'll still stand by that. You haven't said anything that would say that she doesn't have syphilis, other than maybe the rash is a typical, but she could certainly have a Hepatitis and upper abdominal pain, and the lymphocytosis would also be consistent. So I'll still stick that on there. But she could have pylo, right, she has fever, left flank pain myalgias, the transaminitis and it seems a little odd for pyelonephritis and a reactive lymphocytosis seems a little odd. It looks like they've ruled out COVID and sort of common respiratory viruses. But I would still think about other viral infections, particularly those that could give you a bump in your LFTs. So you'd have to consider, you know, her whole thing could be a mono like illness. So EBV CMV, sort of standard Hepatitis viruses, although it sounds like maybe the LFTs are a little low for that Hep A B or C. Probably neglecting some there's a lot of things that can give you a mild transaminitis but you could go down sort of oddball causes of mono like illness of toxoplasmosis. parvo virus, in a young woman might be something to think about. So basically

viruses that can give you mono like illness, I think. But syphilis could still do it all. Yeah, maybe it's.

07:32
And I do think that the reactive lymphocytes here were not initially sort of noticed. And that's kind of how they got perhaps to Pylo. But she did go to the ED a second time, and that was still persistent. She had actually higher fevers after

07:53
because it looks like the chat is disabled. So in the q&a, we have, can you give more information on the rash? Yes, oh, well, there's, here's a new rash, okay.

08:06
So she actually, through the course of this had multiple different types of rash. The first rash was just a rash, isolated to the skin folds in the groin area, which was erythematous and pruritic, and somewhat kind of a burning sensation. So, however, after she was started on, and that was after she received amoxicillin for treatment of the presumed ear infection. The higher grade fevers actually started after she started Bactrim and or trimethoprim sulfa. And she had more of a diffuse rash involving the extremities, which she described as not really pruritic or painful, but just sort of there and something she could see. For that reason, she actually stopped the medication because she felt like it caused rash and she felt like it made the fever worse. Again, she's in her second ED visits. So the blood cultures were obtained. They told her they were concerned she may be septic. She again had that persistent lymphocytosis leukocytosis. At this point, they did obtain an ultrasound because she still had abdominal pain, and she had markets on a Magalie spleen was over 20 centimeters in size. So they actually wanted to admit the patient, but she declined, but I think some of this helps narrow the differential quite a bit to some of the viral infections that that you mentioned.

09:51
Yeah. So you gave so what she got a rash after amoxicillin?

09:55
She just the rash in the groin after more diffuse rash. Should with after their Bactrim.

10:01
I was excited about that. So that's a sort of classic ID clue to if you've got a different kind of rash, maybe not a not a fungal rash, it sounds like is what you're describing. But if you got a different kind of rash and more diffuse rash of amoxicillin in the setting of a mono like illness is sort of classic for EBV. So I perked up when you said that, that's like you.

10:25
And so actually, the patient also thought this might be the case. She had been reading about this just because it's been going on for so long. So ultimately, she kind of went home without anything. And was referred to an oncologist because now they noticed these lymphocytes that were sort of hanging around. And here they hadn't quite put all the pieces together yet.

10:54
So also sort of classic for another infectious disease, mono like illness. So this is a pretty good description of acute CMV infection, which typically has about three weeks of illness before the diagnosis is made, because you go down several false starts and think it's the more common EBV. And, and the classical description is fever, myalgia mono like illness and persistently growing reactive lymphocytosis with some elevated TransAm and aces, I guess the thing we should have mentioned, the other virus to consider here would be HIV, acute HIV, which can also look very much like this. So maybe that's what it was, but I'm betting

11:46
see a little bit more testing down this line when she saw the oncologist. So they did of course, hematologic workup, which was unrevealing, but then they did do the testing, as you mentioned, so she was HIV negative. She had EBV, or Epstein Barr testing, which was most consistent with past infection. And she did have both, excuse me, that's a typo. Her CMV IgG and IgM were both positive. So she was diagnosed with Acute CMV. Sorry about that.

12:23
So CMA PCR,

12:26
they did not do a CMV PCR. By the time she had gotten to this point, she had already started to feel better. This was several weeks and so so she she had sort of stopped there, but she was concerned because unfortunately, she developed some new symptoms after she started to feel better, so the respiratory symptoms, abdominal pain, the fever, those completely resolved after, by the time four weeks came around. She still had this sensation of vaginal discharge pruritic rash and the growing area. But then, sometime after she had started the Bactrim, she had developed this rash on the trunk and her extremities. And that had persisted for a few weeks, and was really just a macular rash that was most notable on her arms, but sort of more faint on the trunk and other areas. She also developed what she described as a pimple like rash in the buttock area. And that this was about two days prior to her seeking care again, and then shortly after that on the face area as well but confined to sort of the distribution of where her surgical mask is. So she does say she's a picker and she kind of gets sort of pimple like rashes in

the buttock area chronically and then usually it just kind of goes away on its own. But she is more of a full folliculitis they just occur in different locations. If there's an ingrown hair or something like that, but she described this as quite different. It's continuing to kind of pick up the area but she developed ulcer type lesions on the buttocks and that kind of periodontal area. And on the face was were different appearing lesions but also a couple that had scabbed over she was also you know, putting topical things on these to try to treat them so she had done some peroxide she did some desiccant she did some toothpaste, some Neosporin. So lots of different things going on to the open wounds.

14:59
US have. So initially Bactrim is a common cause of rash CMD. Not so associated with rash, although I think it can occur, but I think it all sort of rash would be quite unusual. But now am I right that we're now four weeks later? So now from the original sexual contact where we're, we're about four months now. We weeks? Pardon?

15:27
Not four months. She's just she's over four weeks.

15:31
She's four weeks of her illness. Right? And that the actual contact was three weeks. Oh, yes. So yeah, so so maybe I'll raise my syphilis again, a second time to see maybe.

15:45
And we don't have the information about whether she had other partners before this new partner at the time that the all that was just that she had recalled this new partner.

16:00
I guess the other the rash sounds a bit atypical, but it seems like the sexual partner had a lot of other partners and she's clearly had sexually transmitted CMV. So she would be at risk for all the other STIs and so, syphilis, herpes. disseminated gonorrhea seems like it'd be a stretch for her to get to unusual infections and one relationship. That's or maybe she does, in fact, have a drug reaction to either amoxicillin or Bactrim. I guess that would be my initial thoughts

16:37
in this with this sort of with these new symptoms, she actually thought they could be related to CMV. So she had asked for a specialty evaluation for CMV. So we talked about the possibilities here. So on her next evaluation, she was noted to have a hoarse voice, which she actually had said, sort of started with all the CMV and the pharyngeal edema, but sort of resolved or was resolving. She had a normal appearing posterior fair. Next, she had this diffuse macular rash on

the trunk and extremities, which had been present for about at least three weeks at that time. She had the raised kind of macular confluent rash in the groin and gluteal folds. Vaginal insert vaginal Bolton cervix were unremarkable as were the MX. So on the buttocks, there were several ones one and a half centimeter ulcerations with some overlying exudates that were kind of in the peri anal area, and kind of spreading over to the buttock posterior Lee. And then on the face, she had multiple posture type lesions on the lower face and the distribution of surgical mask. As I mentioned before, some of them were sort of open excoriated some with scabbing. She had no splenomegaly. And she, you know, she was actually concerned at this point. She said, Do I have monkey pox? I don't think I do, but do so what testing would you suggest based on this, and I actually I think there's something in the chat here. Oh, okay. Nevermind.

18:43
Well, so what my RTR

18:48
right, so she needs some STI testing, which she has

18:51
testing. I mean, I would be concerned about multiplex also, although the confluent macular rash doesn't doesn't really sound typical. The descriptions we've heard of monkey pox, but

19:03
she had very different she had three different types of rash on her body at this point. So at least three and her the timing of this, which we can't sort of describe exact was prior to the last time she had had a sexual encounter or any really exposure outside of her household was prior to monkeypox. So your RPR 32 She had a positive HSV two from the Baltic lesion but not from the face. It was there was a concern with all the picking that she was doing that she might have self inoculated from the buttock area to the face if it was HSV. She actually also had a positive trick test as well in honor and Chlamydia testing were negative. So she was diagnosed with secondary syphilis, which was treated with benzathine. Penicillin. She got metronidazole for the trick. And this was her first sort of known as HSV outbreak. So she did receive Valtrex as well, or valley Valley cyclo Vir. Those symptoms had been more recent onset, but it's possible that she had had this diagnosis were previously and just not been aware of it. Not entirely clear. The other dermatitis, the other areas of dermatitis, not clearly explained, but some of this may have been made worse by the various kinds of noxious topical agents that were being applied in the CMV. Of course, it's sort of resolving and just managed supportively. Any any final thoughts?

21:06

Well, that is that is the lesson to test when you have one STI to consider that you could have more than one. So that's pretty impressive.

21:18
And probably the amoxicillin and all the other antibiotics did trigger some vaginal itis and inter Igo as well, but she'd certainly had a trick that explains a lot of that.

21:38
Okay, impressive case.

21:44
So before we go to case two, I'm actually going to stop sharing and we'll do a couple of Dr. Urban's keys.

22:05
Okay, I don't know if anybody has any comments on that first case, that's kind of a complicated case.

22:12
Especially with, you know, acute CMV and how much is acute CMV. And how much is syphilis? I think a lot of her symptoms were acute CMV. But definitely some of the dermatologic things were syphilis, you can also see, you know, mild transient rhinitis with both infection, you know, so it's difficult to say but the prolonged illness with those high fevers the reactive lymphocytes, think she definitely had acute CMV.

22:43
Was there any sort of syphilis testing done early before the rash? No. All right, well, we'll speed through some work. So I'm going to present three cases, actually, and some of you may have heard the first case because it's one that Dr. Zucker from Columbia shared with me and I, I believe he presented this at a national presentation. So case, one is a man who's in his mid 30s, who is identified as a cisgender. He has well controlled HIV and is sexually active with other men. And his first presentation was some mild eye irritation that he initially thought were allergies. But it progressed in over three days seemed worse. And he started to feel warm and took his temperature and found that he had a low grade fever at 100.7. He had some worse, worsening if erythema and drainage. And he was concerned because he had some recent sexual encounters. And he was concerned that he got some fluids in his eye. And he was told by a partner that his partner had recently tested positive for both gonorrhea and chlamydia. So he was worried about GC and Chlamydia VI. So he went to his emergency department on day four

of illness and this is a photo of the eye. And you can see he has some injected conjunctiva and looks irritated. So I don't know if anybody wants to weigh in on what you would do.

24:39
not see anything. Yeah.

24:44
So I have three cases, so I'm going to keep going. So they did je unit testing only for gonorrhea and chlamydia in this emergency department. They sent an RPR they sent an HIV viral load and a CD for count. But none of those results were available to the emergency department clinicians. So they treated him because he gave the history of exposure to GC and Chlamydia with sub Triax zone as a single dose and doxycycline for a week, and also gave him some quinolone Ciprofloxacin up damage drops. And they also set him up to see an ophthalmologist. So two days later, he gets to the ophthalmologist and now he has what is described as pustular lesions along the conjunctiva. And this was not in the same system. So they again, they actually directly cultured the eye for G's area. And they also did a direct culture of the eye for other bacteria. And they changed the Ciprofloxacin drops to a different antibiotic drop for for the eye, and also erythromycin ointment. Meanwhile, by this point it now it's two days later, so the tests that were sent from the IDI have now come back. And it turns out that the GU exposure, the GU testing for gonorrhea and chlamydia were negative. But of course, no extra genital tests were done. The RPR was low titer, I believe one to one, and he's had a previously treated syphilis. And this was an except an appropriate level for him. His HIV viral load remained undetectable. And his CD for count, which was normally over 500 was in the low three hundreds or high 200. So it was different than his usual value. He was concerned that he was still very worried about GC and chlamydia. So on that same day, he left the eye clinic and he went to a local sexual health clinic. And there, he had a more extensive exam. And for the first time, he's noted to have pustules on his left wrist, left forearm and left shoulder, and also in the scrotum. And these lesions, some were pustules, some were macules. And one was ulcerated, they got a more detailed sexual history at the sexual health clinic. And he reported for sexual partners in the past month, all well known to him, a one had told him about the GC and Chlamydia that had been diagnosed after their encounter. And none of them had any sort of similar lesions. So at this point, the sexual health clinic looked at those swabs and did both herpes and vz V of these lesions, and I'll show you some pictures of the lesions. And now they did extra genital testing of for GC and chlamydia. And they went ahead and treated again, for GC and chlamydia. With a plan for close follow up, and I'll just show you these are the lesions on the wrist and forearm. So you can see they've started to open up, the patient actually was not too bothered by these and hadn't hadn't paid much attention and didn't think that they were there at the beginning of the eye symptoms. Here's a lesion that was sort of developing on the back that was sort of becoming pustular. So I'm sure you know where I'm going with this. So on day 11, he had

worsening eye symptoms with swelling, erythema and blurry vision. And now he has quite a number of lesions on the extremities, genitals and feet. And and that area on the conjunctiva lid had become more like, like a caterpillar form kind of lesion. And by this point, he then returns on day 13. And this was earlier in our outbreak of monkey pox, where by now the test is available, it wasn't available when he first appeared. And he was positive diagnosed 17 days after illness. He ultimately did well, his his he had no long term visual complications. Although we know now that you would treat I involvement like this with tech reviewer, Matt, this would be an indication for treatment, because as I say this was quite early in the outbreak and and so that that wasn't done, we didn't have the testing at the time. I just want to show you two other cases and then we can talk about it a bit. This is a 36 year old who presented with rash and sore throat to a sexual health clinic. He had was also identified as a cisgender man who had sex with other men is less sexual and countered was two weeks prior to his visit. And before his visit, he had been sick a two days prior with quite a high fever to 104 that resolve with nonsteroidals. And he wasn't having fever on the day he came in. But what brought him in was really a severe pain in his throat, and some development of sores on his lips and Tom, the pain was quite significant. But although he, he had only taken the nonsteroidal, which he was using ibuprofen for the fever, so he hadn't actually used it to treat the pain in his throat, he was able to eat and drink. And on the day of his visit, he had first noticed a new crash in the groin. And while in the room during the exam, he had sort of evolving rash that was visible to the clinicians who were taking care of him. So this is a picture of lesion on the tongue. And on the lip, he had several similar lesions in the beard area, and he had some even larger lesions, but similarly appearing in the posterior pharynx. Here's the genital area. And you can see sort of characteristic lesions with that central umbilical patien. These were not really pustular they weren't fluid filled. They were they were a bit firmer. I have one more. And while there, you can see right here, he started to develop lesions on the more distal extremities. He was he was in the room for a bit of time while all sorts of samples were collected. And these were actually evolving while they were in the room. And despite these not being actually pustular, they were swapped and put in a dry swab, which was what we were using at the time and sent to Wadsworth, the state lab. And this of course, was positive for monkey pox. And here's another one, this patient was actually from the same day but at a different clinic. 41 year old with well controlled HIV, who came in with a persistent sore throat. He had had a recent illness after attending an out of town convention. And while at this convention, which was on the West Coast, he had a new sexual partner. And while still present at the convention, actually day four of his attendance at the conference, he developed a flu like illness with my Algis a fever to about one on one, sore throat. He just didn't feel well. And while they're out of town, he went and got a test the next day and was COVID Positive. He didn't call his HIV provider right away. But he ended up on day nine of his initial attendance at the convention of being treated for the COVID with pecks, low bid, and all of his symptoms resolved by day 14 Except for this persistent sore throat. So he came in to be seen, he was worried about a PECS loaded rebound from COVID. And he came in

really with complaints only of the sore throat but he was wearing a short sleeve shirt, and the provider noticed this lesion on his exposed arm, and then doing a more extensive exam. He's still had pharyngeal erythema, he had some actually on the left tonsil, and some additional lesions when he actually was undressed, that he had not noticed. So these didn't bother him. And he just didn't see them, even though they appear, sort of noticeable with with a surrounding erythema, again, that central divot. And as you as you expect, this also turned out to be doing a monkey pox.

33:56
So I'm sure everyone on this call is well aware of the monkey pox outbreak. It's a global outbreak with I think, over 31,000 cases now, globally. The total as of yesterday in the US was approaching 9400. I put these here, this used to be a much smaller list, but now it's spread quite widely in the United States. But the only two areas with more than 1000 cases are California, where the third patient had been at the conference and New York, where we lead the nation with 2100 cases overwhelmingly in New York City, as you know, there was I'll just call your attention to recent mm WR article that was released on Friday, and they do a description of the first about 1200 cases out of the 20 891 reported cases in the US between mid May and July. They received case report forms on about 1200 to 41%. And they present essentially the epidemiologic and clinical presentations to give us some ideas. So we're not constantly doing, you know, this is what I'm seeing, this is what you're seeing. And when you look at the the tables, they're quite consistent with a similar article that came out in late July, in the New England Journal that reported on 500, in some cases, from around the world with a number of the cases being from Western Europe. So what's reported in the mm WR and quite consistent with the New England Journal article is, as I'm sure you're aware, through the news, that overwhelmingly, this outbreak presently, has been occurring in those who are reported to be male, it's 98, or 99%. In the published reports, there are some cases in those who are transgender or gender non binary, there are a few cases and women. And I don't have age here, but there have been now a few cases, two in the US and at least one in the Netherlands and children. This is the racial breakdown in the US, which does reflect a disproportionately high percentage in persons of color compared to the percent of the general population. And that is a little bit different than that reported in the New England Journal article. And here are the symptoms that are described in these. Now here, because of the number of data they have, they have ever experienced or initially experiencing, and rash of course, which is the hallmark that we're using to diagnose the disease is reported in 100%. Ever, and initially only in 41%, you can see about 40%, with fevers and chills and with about 40% also reporting fever initially, about 40% With add an apathy. But that's less common initially. And then you can see scattered here in my Algis malaise, a quite high proportion, reporting rectal pain. So none of these three cases that I told you about had proctitis. But that is quite a common feature that that we're hearing of presenting with significant pain, and often with blood or pus in the stools, or

sometimes even with the inability to have a bowel movement at all. And this is a principal reason for hospitalization of severe pain, particularly in the rectum or sometime in the throat. And you can see down here other other significant symptoms of abdominal pain, rectal bleeding cetera, for the rash. The genital area is the most common ly reported initially with 55% 56% in these cases and 46% overall. And then you can see a smattering of other areas including the periphery arms and legs, including periodontal area and including face mouth lesions are also quite common, though less common initially, but 75% At some point during the illness, and then with concerns about other STIs looking like other STIs palms of hands being seen here about 20% of the time. And this is the New England Journal Article I mentioned with many are similar. They do report where people are presented and in there, this is of course of global with largely Western Europe and the US. So about 23% presented to sexual health clinics and 20% to emergency departments and about 30% to HIV clinics. And they do report suspected route of transmission and they report not nonsexual close contact to be quite low and sexual close contact quite high, with known contact amongst epochs only being about 26%. And then just another note for a very recent publication was interim guidance for prevention and treatment of monkeypox in persons with HIV. This also was released on Friday with an early release. And essentially it's what was being said before this guidance that that really the risk for dissemination or for severe infection would likely be higher for those with significant immunocompromised so those with advanced HIV who are not biologically suppressed or might not be on AR T post exposure prophylaxis and antivirals are available for those living with HIV vaccination vaccination should be with Juno's and not with a cam 2000, which is a live virus that can replicate. So that would be contracted indicated in those living with HIV. There are no significant drug returns with the antiviral that's being used. And they'll continue to update this. And then you probably heard like late yesterday on the news that it looks like the FDA is expanding the the indications for how to administer Genie is the vaccine for monkey pox to include intradermal administration, and that will significantly increase the US supply. I couldn't find anything other than news reports, I couldn't find like a formal listing on the FDA or CDC website yet today about how this will be rolled out. So I'll end there and see if there's any questions or comments. I see. One question is Monkey pox now an STI. So far, monkey pox has not been classified as an STI in the standard way we use that term. Certainly, it's transmitted through so close sexual contact as occurs with with sexual contact. And the same has been identified by PCR in a high proportion of specimens that have been tested thus far, which is still a fairly low number in Sema, and has been identified in vaginal fluids as well by PCR, and as far as I know, has only been identified by culture so you would know that it was live virus, in one case in semen, again, because so few tests have been done thus far. And if anybody else knows something more updated than that this is really changing almost hourly. But thus far, it's not officially an STI, although it's clear that the organism is present in sexual fluids, but whether it's present in a, in a form that is transmissible or in a quantity that that results in infection is not yet established.

42:19
Okay, so I'll go to my second case. This is a 42 year old cisgender female who's presenting to gynecology clinic with painful left labia area for about five days. And it's been getting progressively worse. She hasn't been able to visualize the areas so she's not sure at that point what's, what's going on. She is sexually active and she had multiple partners in group gatherings. And her partners are of multiple different genders, including those who are transgender, both male and female, and different, both including both sex assigned male and sex assigned female at birth, and she uses condoms with vaginal sex and anal sex, oral sex during the group encounters. This is what she described as a trusted group and they share STI testing with each other about every six months. She also has a male partner outside of this group, who she describes as a trusted partner. She does not use condoms with this partner, but they don't share STI test results. And she has oral vaginal and anal sex and occasionally sex toys are used as part of the sexual encounters. Her history is also notable for type two diabetes without having achieved glycemic control. So on that initial exam at the gynecology clinic, she was found to have a left labile alter with raised borders, there was some surrounding erythema involving the labia. And it was quite painful during the examination that she also had some mild left inguinal ad and apathy as well. The remainder of exam was reported to be unremarkable. So here, what testing would you obtain at this point, you know, what things are you thinking about for diagnosis? And then how might you manage the patient while you're waiting on these results? And I again, I apologize with the chat not active it's not easy to interact. But if you'd like to throw something in the q&a, using it as the chat that's perfectly fine.

44:50
All right. No takers so far. That's okay. So sort of solitary but painful bolster lesion in the genital area could be a lot of different things, right? So, it could be a typical type of chancre, we're hearing reports, particularly from Orange County of painful chancre in various places, not just well, including the oral area as well. Could be herpes, different types of monkey pox, and some other different types of Ulcerative STIs that we really don't see here and in this area, but you can see in other areas as well. Yep.

45:44
Could be could be LGB. Also, where they do testing for LGB. From lesions they find it can be painful occasionally.

45:55
We we often think of LTV and in terms of proctitis, but we don't want to forget that LGB can also present with an ulcer that can be painful, can even look more like a papule before it evolves. And you can have some at an apogee with that as well. So, definitely some

comprehensive STI testing for this individual that included things like herpes and syphilis, Chlamydia testing, gonorrhea testing, and also HIV testing. Would you give her anything while you're waiting for your test results or just wait for the results?

46:35
How large is it?

46:38
It sounded like it was about two centimeters.

46:41
Oh, so pretty big for herpes. So it sounds like a fair amount of risk even even in the setting of certain partners. So I might, I might be inclined to treat empirically for syphilis.

47:01
I think I would do the same based on the presentation and the history. Here. In this particular case, she didn't get any therapies for the syphilis but she did have, she was provided some empiric treatment for herpes. She did have all this testing sent out they didn't have the ability to do point of care testing. Her RPR later returned one to eight. And all her remaining tests were negative. So she was called back and told that she had what they thought to be primary syphilis, but they weren't completely sold on the diagnosis. It sounds like because of the painful presentation. But we do know, again, that we're seeing some cases of painful ulcers but civic syphilis can present in an atypical way. You can have multiple shakers, you can have painful lesions, so not not a way to completely exclude the diagnosis. But she was given a dose of penicillin. They didn't have it in the clinic. So they did have to order it for her there was some delay. And it sounds like this is not a medication they gave frequently. The patient reported the injection site that sounded somewhat atypical and sort of a lower gluteal area and may not have have achieved that intramuscular location. She came back about a week and a half later with persistent pain and a persistent ulcer in the area in her RPR. You know, this was about three weeks later, but Sean from eight to 32. So the clinic was concerned that she had sort of treatment refractory syphilis, and she was referred to a specialty clinic for additional evaluation. But what sort of what would you be thinking? Dr. Urban

49:15
so the eighth was not the day she got the treatment?

49:18
Nope the eight was before Yep, so So one

49:22
situation is if this really is primary syphilis, we know that our RPRs go up fairly quickly, I seek Caitlyn has written in Was there ever a specific antibody test? So do we know for sure that this was a true RPR?

49:37
She did. She had a T palette of antibodies that was also positive. Okay,

49:42
so T pallidum was positive. So one possibility is that RPR sort of rapidly rises, you know, as you transition from primary to secondary and so maybe she wasn't eight on the day that she got treated and the one to 32 is lower or even the same or You know, as the day she got treated, it could be as you said, you sound like uncertain that the dose actually reached the muscle where you would need to have penicillin to, to provide adequate treatment. And so if if the injection was not into the right location, she may not be adequately treated and so her RPR you know, that explains her RPR you said HSV one and two and I wasn't clear if that was an antibody or lesion test on the initial slide. So it's still possible she you can have coinfected chancre and with herpes, I, I've seen that before. So maybe she's persisting because she actually did have herpes, although seems like it's lasting a bit long for that.

50:56
They were legion PCR,

50:59
PCR, so it's not herpes. Yeah. Um, I guess that's, that's where I would end I guess.

51:08
Yeah. Yeah. Infection,

51:11
I guess it could look super infected. Right, right, unrelated to the RPR. But maybe she had an open lesion.

51:18
That was one of the possibilities raised by the second clinic, particularly with uncontrolled diabetes, that there could be some super infection in this area. So on reassessment again, persistent chancre inguinal adenopathy relatively unchanged. In the interim, she did say she had performed oral sex with the one trusted partner without condoms, but she hasn't had any vaginal sex or exposure. And there was concerned that the penicillin injection did not reach the

intramuscular target due to the patient's body habitus for BMI was, I believe, 40, if I'm remembering correctly, it's, though they did use them and I am needle it was not sure I am needle that's recommended for persons with higher BMI. And when the patient demonstrated the actual injection site, with the size needle use, it was probably not anywhere near the muscle, the gluteal muscle that it actually reached. So next steps, and I think I'll kind of move through a bit because we're almost out of time. But she ultimately created due to the concern that she didn't receive the effective dose of penicillin in the area needed to really maintain those levels for treatment. But she was quite adamant that she wasn't going to get any more injection. So she was treated with doxycycline, twice a day for two weeks. There was a concern also that she had had another sexual encounter with this partner, who was suspected to be the partner she acquired syphilis from an untreated partner. So regardless, she was retreated with Doxy. And actually her her symptoms resolved over the two week course. So unclear if that was coincidental, or in response to the doxycycline. And her RPR has not yet been repeated. This is a pending she's not yet due for follow up. So I think this is the end of case two, and we have about two minutes left. So we'll save the last case for next time. But anyone have any kind of comments or questions about this particular case?

[End Transcript]