A 41-year-old-male presented with a 1-month history of pruritic lesions on his scalp, neck, and penis. He had attempted a 2-week course of terbinafine cream, with no improvement. The lesions were unaffected by exposure to sunlight. The patient also reported new-onset wrist stiffness and pain. He had been diagnosed with primary syphilis 9 months prior to presentation, with a reactive plasma reagin titer of 1:64, and had been treated with intramuscular penicillin G benzathine 2.4 million units.

Physical examination revealed annular and petaloid plaques with central clearing and raised borders on the scalp, right mandibular angle (Figure 1), and penis (Figure 2). No lesions were observed on the oral mucosa, palms, or soles. No lymphadenopathy or new-onset alopecia was present.

Clinically, the differential diagnosis included discoid lupus erythematosus, lichen planus, tinea infection, sarcoidosis, and annular secondary syphilis. Serology for human immunodeficiency virus was non-reactive, and cutaneous punch biopsy of the mandibular lesion was performed. Histologic sections revealed...
PETALOID DERMATOSIS

Figure 2. Subtle annular plaque (arrow) with central clearing and raised pink borders on the penis.

begin 6 to 8 weeks after the appearance of the primary lesion and resolve within 12 weeks.1

The most common cutaneous presentation of secondary syphilis is a generalized morbilliform rash, usually involving the palms and soles.2 However, secondary syphilis can present as annular secondary syphilis, which is also known as petaloid syphilis owing to its appearance resembling the petals of a flower.2 Lesions in annular secondary syphilis often occur close to the angle of the mandible and frequently spare the palms and soles.1-3 Secondary syphilis typically presents without lymphadenopathy and often affects the genitalia.5

MANAGEMENT OF PETALOID DERMATOSES

The differential diagnosis for annular plaques is broad and depends on clinical history, symptoms, and location and morphology of the lesions. Annular lesions on the head and neck could also be secondary to petaloid seborrheic dermatitis, tinea corporis, discoid lupus erythematosus, subacute lupus erythematosus, cutaneous sarcoidosis, or granuloma annulare.

A thorough history and physical examination, relevant laboratory studies, skin biopsy, and potassium hydroxide preparation of these lesions are helpful in narrowing the diagnosis.

TAKE-HOME POINTS

It is important for clinicians to consider petaloid secondary syphilis in the differential of annular lesions, as it can mimic other inflammatory and infectious etiologies.

DISCLOSURES

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REFERENCES