ĐIỂM BÁO DA LIỄU THÁNG 1/2022

TS.BS. Nguyễn Trọng Hào

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January 15, 2022
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Future of Health

U.S. FDA approves drugs from AbbVie, Pfizer to treat eczema

Reuters

https://www.reuters.com/business/healthcare-pharmaceuticals/fda-approves-expanded-use-abbvies-arthritis-drug-treat-eczema-2022-01-14/

January 14, 2022

U.S. FDA Approves RINVOQ® (upadacitinib) to Treat Adults and Children 12 Years and Older with Refractory, Moderate to Severe Atopic Dermatitis

- Approval of two dose strengths (15 mg and 30 mg) supported by efficacy and safety data from one of the largest registrational Phase 3 programs in atopic dermatitis, with more than 2,500 patients evaluated across three studies[1]
- RINVOQ (upadacitinib) monotherapy or with topical corticosteroids met all primary and ranked secondary endpoints in atopic dermatitis pivotal studies[1-3]
- RINVOQ demonstrated significant improvement in itch (Worst Pruritus NRS ≥4) as early as week one, as well as significant improvements in skin clearance (EASI 75 and vIGA-AD 0/1) at 16 weeks, compared to placebo[1-3]
- RINVOQ also demonstrated significantly higher levels of skin clearance (EASI 90 and 100) at 16 weeks, compared to placebo[1-3]

https://news.abbvie.com/news/press-releases/us-fda-approves-rinvoq-upadacitinib-to-treat-adults-and-children-12-years-and-older-with-refractory-moderate-to-severe-atopic-dermatitis.htm

U.S. FDA Approves Pfizer's CIBINQO® (abrocitinib) for Adults with Moderate-to-Severe Atopic Dermatitis

Friday, January 14, 2022 - 03:30pm

CIBINQO is a once-daily oral treatment with proven efficacy to manage symptoms for adults who have not yet found relief with current options

NEW YORK--(BUSINESS WIRE)-- Pfizer Inc. (NYSE: PFE) announced today that the United States (U.S.) Food and Drug Administration (FDA) approved CIBINQO® (abrocitinib), an oral, once-daily, Janus kinase 1 (JAK1) inhibitor, for the treatment of adults living with refractory, moderate-to-severe atopic dermatitis (AD) whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

https://www.pfizer.com/news/press-release/press-release-detail/us-fda-approves-pfizers-cibinqor-abrocitinib-adults

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Appraisal of Proactive Topical Therapy in Atopic Dermatitis: Pros and Cons

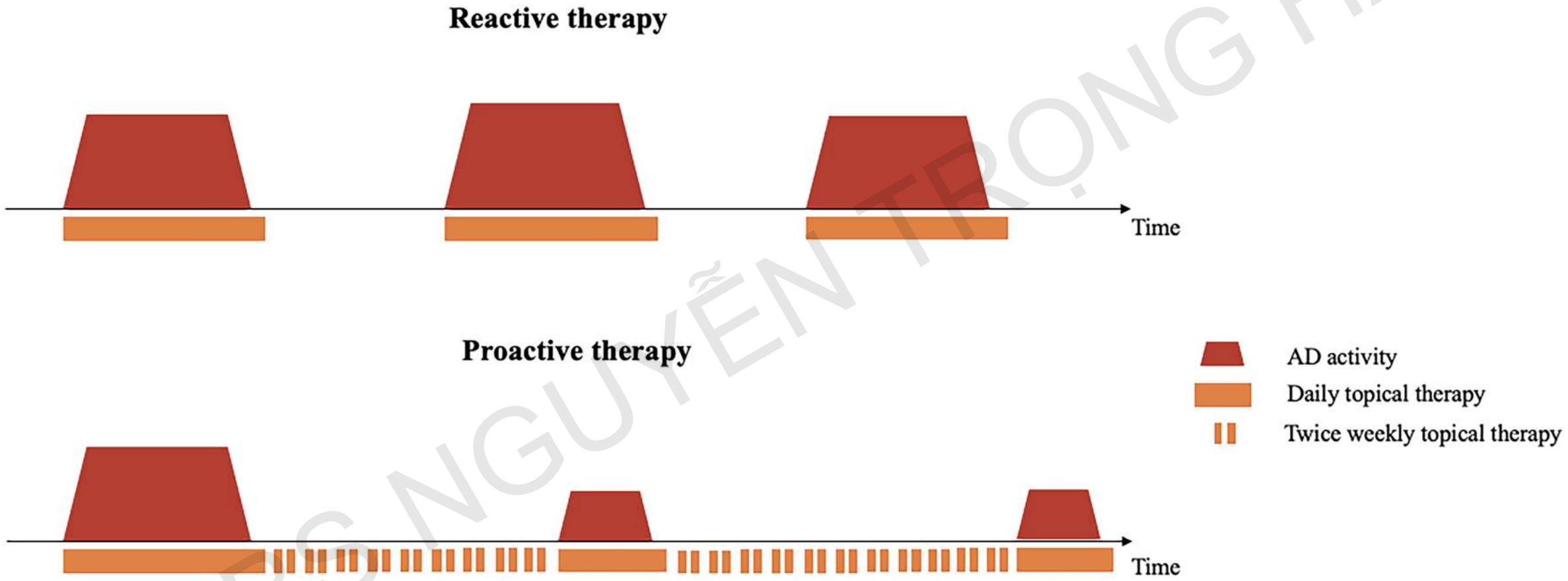
Anne Sofie Frølunde[1] · Jacob Pontoppidan Thyssen[2] · Mette Deleuran[1] · Christian Vestergaard[1]

Accepted: 7 July 2021

Abstract

Atopic dermatitis is a common inflammatory skin disease that can affect both children and adults. It is a chronic disease with recurrent, highly pruritic eczematous lesions. Topical treatment with anti-inflammatory agents is the mainstay of treatment for atopic dermatitis, either in a reactive or proactive approach according to severity of the disease and always in combination with daily application of an emollient cream. Several studies have shown that proactive therapy with either topical corticosteroids or topical calcineurin inhibitors is significantly superior at reducing the number of flares and increasing the interval between flares compared with reactive therapy in patients with moderate and severe disease. The risk of side effects is considered low, and there seem to be no extra economic costs related to this treatment approach. Proactive therapy is an advisable treatment option for patients with moderate and severe atopic dermatitis to gain prolonged disease control; however, long-term safety data and data on when to stop do not yet exist.

Frølunde AS, et al. Am J Clin Dermatol. 2021 Nov;22(6):775-783



Frølunde AS, et al. Am J Clin Dermatol. 2021 Nov;22(6):775-783

Proactive Topical Therapy in Atopic Dermatitis: Cons

- Studies with TCS (4–16 weeks) < tacrolimus ointment (40–52 weeks)
- TCS: 4.5% of children showed biochemical signs of adrenal suppression
- 2% of pediatric patients using low-potency (group I–II) TCS demonstrated reversible, biochemical HPA axis suppression with daily use for 4 weeks; the proportion increased with the increasing potency of TCS
- A lack in the research field/knowledge of proactive therapy is long-term safety
- The lack of evidence on when to stop

Frølunde AS, et al. Am J Clin Dermatol. 2021 Nov;22(6):775-783

CLINICAL SCIENCE

Biological disease-modifying antirheumatic drugs may mitigate the risk of psoriatic arthritis in patients with chronic plaque psoriasis

Paolo Gisondi ,[1] Francesco Bellinato ,[1] Giovanni Targher,[2] Luca Idolazzi,[3] Giampiero Girolomoni[1]

Handling editor Josef S Smolen

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/annrheumdis-2021-219961).

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[3]Section of Rheumatology, Università degli Studi di Verona, Verona, Italy

ABSTRACT

Objective To estimate the incidence of psoriatic arthritis (PsA) in patients with psoriasis who had received a continuous treatment with biological disease-modifying antirheumatic drugs (bDMARDs) compared with phototherapy.

Methods A retrospective non-randomised study involving patients with moderate-to-severe plaque psoriasis, who were prescribed at least 5 years of bDMARDs or at least three narrow-band ultraviolet light B (nb-UVB) phototherapy courses, and did not have a diagnosis of PsA at enrolment. Development of PsA in each patient was assessed by a rheumatologist according to the Classification for Psoriatic Arthritis criteria. The annual and cumulative incidence rate of PsA was estimated by using an event per person-years analysis. Cox proportional hazards models were undertaken to

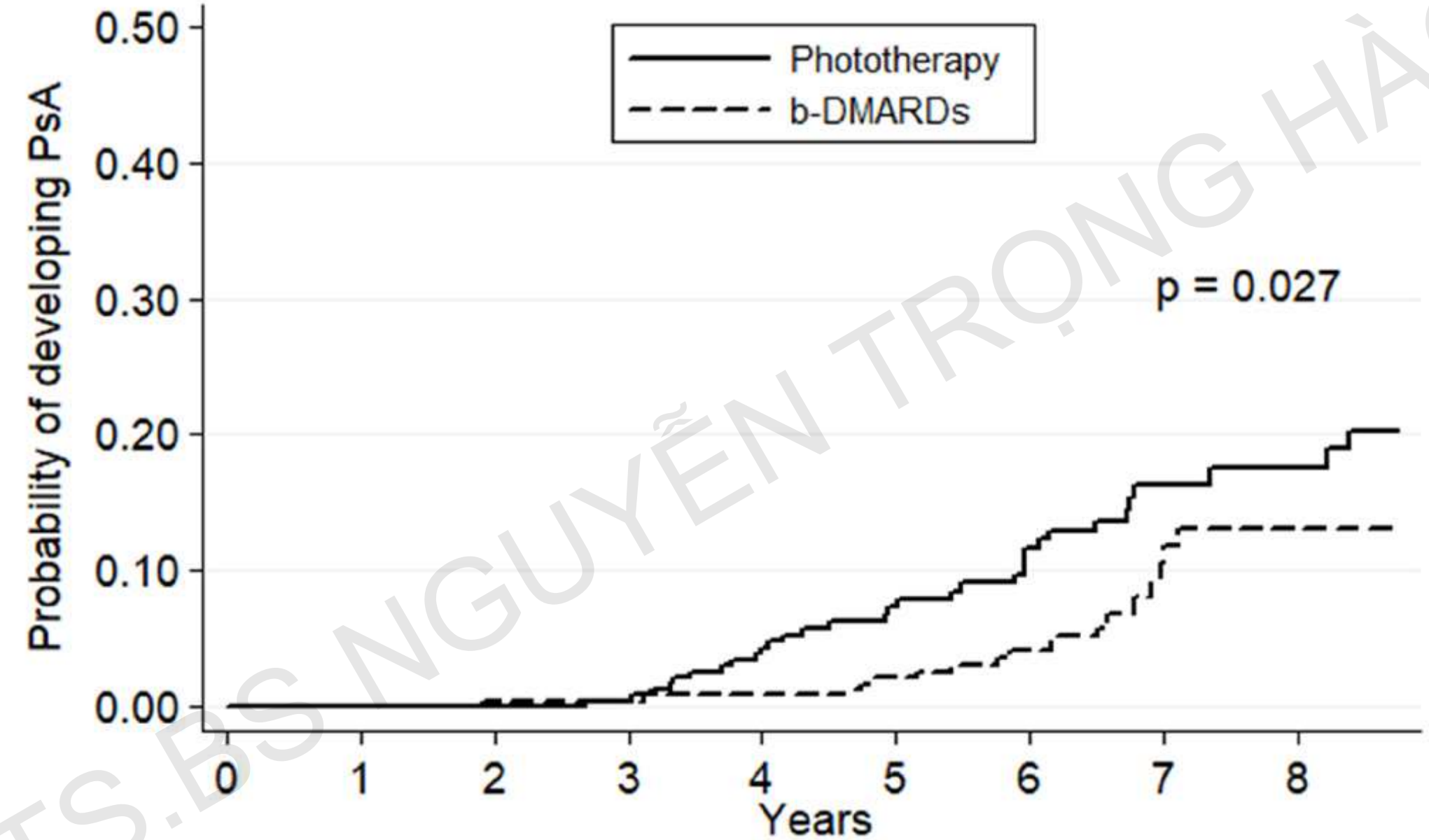
Key messages

What is already know about this subject?

- In most cases, diagnosis of plaque psoriasis may precede that of psoriatic arthritis (PsA) by an average of 5–10 years, and in only a minority of cases PsA precedes the skin disease or occurs simultaneously.
- The transition from psoriasis to PsA may evolve across various phases, that is, preclinical, subclinical and prodromal phases.

What does this study add?

- The major finding of this non-randomised intervention study was that the incidence of PsA was lower in patients treated with biological disease antirheumatic modifying



Gisondi P, et al. Ann Rheum Dis 2022;81:68–73

COVID-19 vaccine safety and efficacy in patients with immune-mediated inflammatory disease: Review of available evidence

Sarah Wack, BS, Timothy Patton, DO, and Laura K. Ferris, MD, PhD
Pittsburgh, Pennsylvania

Dermatologists diagnose and treat many immune-mediated inflammatory diseases (IMID). Understanding the inherent immune dysregulation of these diseases as well as the additional disruption that comes as a result of IMID treatments has been important during the COVID-19 pandemic. With vaccines becoming widely available, dermatologists need to be familiar with the risks and benefits of vaccination in these patients, particularly those taking biologics, in order to have informed discussions with their patients. In this review, we present the current evidence related to COVID-19 vaccine safety and efficacy in patients with IMID and review existing recommendations for vaccination against SARS-CoV-2.

Given the current evidence, there is minimal concern that these patients are at any greater risk of harm from COVID-19 vaccination compared to healthy controls. For most, the benefit of avoiding severe COVID-19 through vaccination will outweigh the theoretical risk of these vaccines. A question that is still outstanding is whether patients on biologics will generate a sufficient immune response to the vaccine, which may be dependent on the specific biologic therapy and indication being treated. This underscores the importance of following patients with IMID after vaccination to determine the safety, efficacy, and duration of the vaccine in this population. (J Am Acad Dermatol 2021;85:1274-84.)

Wack S, et al. J Am Acad Dermatol. 2021 Nov;85(5):1274-1284

Table III. Current society recommendations regarding COVID-19 vaccination

Society	Recommendations
National Psoriasis Foundation[33]	• All patients with psoriasis should accept a vaccine as soon as it becomes available to them • Psoriasis and/or psoriatic arthritis are not contraindications to vaccination
International Psoriasis Council[34]	• No specific guidance regarding vaccination • Stated that registry data should be collected to inform whether SARS-CoV-2 vaccines either positively or negatively affect psoriasis outcome
International Pemphigus and Pemphigoid Foundation[35]	• Patients with autoimmune bullous diseases should be vaccinated when a vaccine is available to them, as these patients are also at high risk for complications of COVID-19 • In most cases, immunosuppressive treatment should not be interrupted to receive a vaccine as this could result in relapse or flare of disease • In patients treated with rituximab, vaccination should be completed 2 weeks prior to the start of rituximab treatment whenever possible, otherwise it is best to wait 4-6 months after the last rituximab infusion
National Eczema Association[36]	• Atopic dermatitis is not a contraindication to vaccination • Any patients with history of anaphylaxis or reaction to a vaccine ingredient should consult with their allergist prior to vaccination

Wack S, et al. J Am Acad Dermatol. 2021 Nov;85(5):1274-1284

Hidradenitis Suppurativa Foundation[37]	• People with HS are not at increased risk for severe COVID-19 due to HS or any subsequent treatment and should be able to safely receive the vaccine when it is available to them • Patients should not stop any biologics in order to receive a vaccine and should speak to their physician regarding any concerns
American College of Rheumatology[38,39]	• Patients with autoimmune and inflammatory rheumatologic disease should be prioritized for vaccination • For patients with rheumatologic conditions, the theoretical risk of disease flares due to COVID-19 vaccination is outweighed by the definite risk of severe COVID-19 infection • For those with well-controlled disease: recommend to hold methotrexate and JAK inhibitors for one week after each vaccine dose, to hold subcutaneous abatacept 1 week prior to and after the first COVID-19 vaccine dose only, and that patients taking cyclophosphamide should time their infusion to be 1 week after each vaccine dose if possible • In patients treated with rituximab: vaccine series should be initiated 4 weeks prior to the next scheduled cycle, and the next dose be delayed for 2-4 weeks after the second vaccine dose, if the patient's disease activity allows • No recommendation for dose or timing modifications for patients taking oral steroids, hydroxychloroquine, IVIG, apremilast, sulfasalazine, leflunamide, oral cyclophosphamide, azathioprine, TNFi, IL-17 inhibitors, IL-12/23 or IL-23 inhibitors, belimumab, or oral calcineurin inhibitors

A CLINICIAN'S PERSPECTIVE

Dermatology patients on biologics and certain other systemic therapies should receive a "booster" messenger RNA COVID-19 vaccine dose: A critical appraisal of recent Food and Drug Administration and Advisory Committee on Immunization Practices recommendations

Reid Alexander Waldman, MD,[a] and Jane M. Grant-Kels, MD[b]
Glastonbury and Farmington, Connecticut

Waldman Raet al. J Am Acad Dermatol. 2021 Nov;85(5):1113-1116

Roles of an Additional Dose

There are two distinct potential uses for an additional vaccine dose:

- **Additional dose after an initial primary vaccine series**: administration of an additional vaccine dose when the initial immune response following a primary vaccine series is likely to be insufficient.

- **Booster dose:** a dose of vaccine administered when the initial sufficient immune response to a primary vaccine series is likely to have waned over time. The need for and timing of a COVID-19 booster dose have not been established

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-08-13/03-COVID-Goswami-508.pdf

Additional dose

1. Active treatment for solid malignancy
2. Prednisone at the dosage of ≥ 20 mg or equivalent daily (chronic use)
3. Transplant-related immunosuppressive drugs
4. Tumor necrosis factor blockers
5. Biologic agents that are immunosuppressive or immunomodulatory
6. Methotrexate

Waldman Raet al. J Am Acad Dermatol. 2021 Nov;85(5):1113-1116

Table I. Author recommendations regarding administration of an additional dose of the messenger RNA COVID-19 vaccine to certain dermatology patient populations

Patient population	Evidence-based risk	Recommendation
Receiving systemic glucocorticoids	Patients receiving >20 mg prednisone or equivalent daily are at risk of inadequate response to the standard 2-dose mRNA COVID-19 vaccine series	(1) Patients receiving systemic glucocorticoids should receive an additional dose of the mRNA COVID-19 vaccine (2) Conscious efforts should be made to taper patients on prednisone below 20 mg daily
Receiving oral immunosuppressants, including methotrexate, mycophenolate mofetil, cyclosporine, and JAKis	Patients receiving oral immunosuppressants are at risk of inadequate response to the standard 2-dose mRNA COVID-19 vaccine series	(1) Patients receiving oral immunosuppressants should receive an additional dose of the mRNA COVID-19 vaccine (2) Patients who have not yet been vaccinated who are receiving these medications or who are considering initiation of these medications should be preferentially offered a less immunosuppressing biologic, if indicated clinically

Waldman Raet al. J Am Acad Dermatol. 2021 Nov;85(5):1113-1116

Receiving B-cell depletion (ie, anti-CD20 monoclonal antibodies)	Patients receiving B-cell depletion are more likely than not to mount an inadequate response to the standard 2-dose mRNA COVID-19 vaccine series	(1) Patients undergoing B-cell depletion should receive an additional dose of the mRNA COVID-19 vaccine. The ideal timing of this additional dose is discussed in the referenced article[5] (2) Patients with conditions that can be adequately treated with therapeutics other than B-cell depletion (eg, bullous pemphigoid) should be preferentially offered a less immunosuppressing biologic, if indicated clinically
Receiving TNF blockers and IL-17 inhibitors	Patients receiving TNF blockers and IL-17 inhibitors may mount lower absolute titers to the standard 2-dose mRNA COVID-19 vaccine series; however, there is insufficient evidence to suggest that these patients are at increased risk of mounting an inadequate immune response to the 2-dose series	(1) As an aggregate, patients receiving TNF blocker and IL-17 inhibitor monotherapy do not appear to need the third dose of the mRNA COVID-19 vaccine based on existing data; however, the third dose may be indicated for patients with comorbidities that predispose the patient to severe COVID-19 infection. Shared decision making with all patients on these medications is recommended. (2) There are no specific data regarding the ideal timing of vaccination; however, like other nonlive vaccinations, the mRNA COVID-19 vaccine can likely be administered without interruption in biologic therapy

Patient population	Evidence-based risk	Recommendation
Receiving IL-12/23, IL-23, and IL-4/13 inhibitors	There are inadequate real-world data to assess the effect of IL-12/23, IL-23, and IL-4/13 inhibitors on mRNA COVID-19 vaccine response	(1) Based on the mechanism of action of these medications, it is unlikely that these medications predispose patients to an increased risk of mounting an inadequate response to the standard 2-dose mRNA COVID-19 vaccine series. Additional prospective data are needed to confirm the presumed immunogenicity of the mRNA COVID-19 vaccine in patients receiving these medications. At this time, shared decision making is recommended given the paucity of available data
Patients with metastatic melanoma, squamous cell carcinoma, or other internal malignancy undergoing active treatment	Patients undergoing treatment for metastatic melanoma, squamous cell carcinoma, and other malignancies are at risk of inadequate response to the standard 2-dose mRNA COVID-19 vaccine series	(1) Patients undergoing treatment for metastatic skin cancer should be encouraged to urgently contact their oncologist about whether they should receive an additional dose of the mRNA COVID-19 vaccine

Most Hand Sanitizers Contain Allergens

By Rob Goodier

January 03, 2022

Added to Email Alerts

REUTERS

NEW YORK (Reuters Health) - A new analysis of 160 hand sanitizers found that 71% contain at least one allergen listed by the North American Contact Dermatitis Group (NACDG).

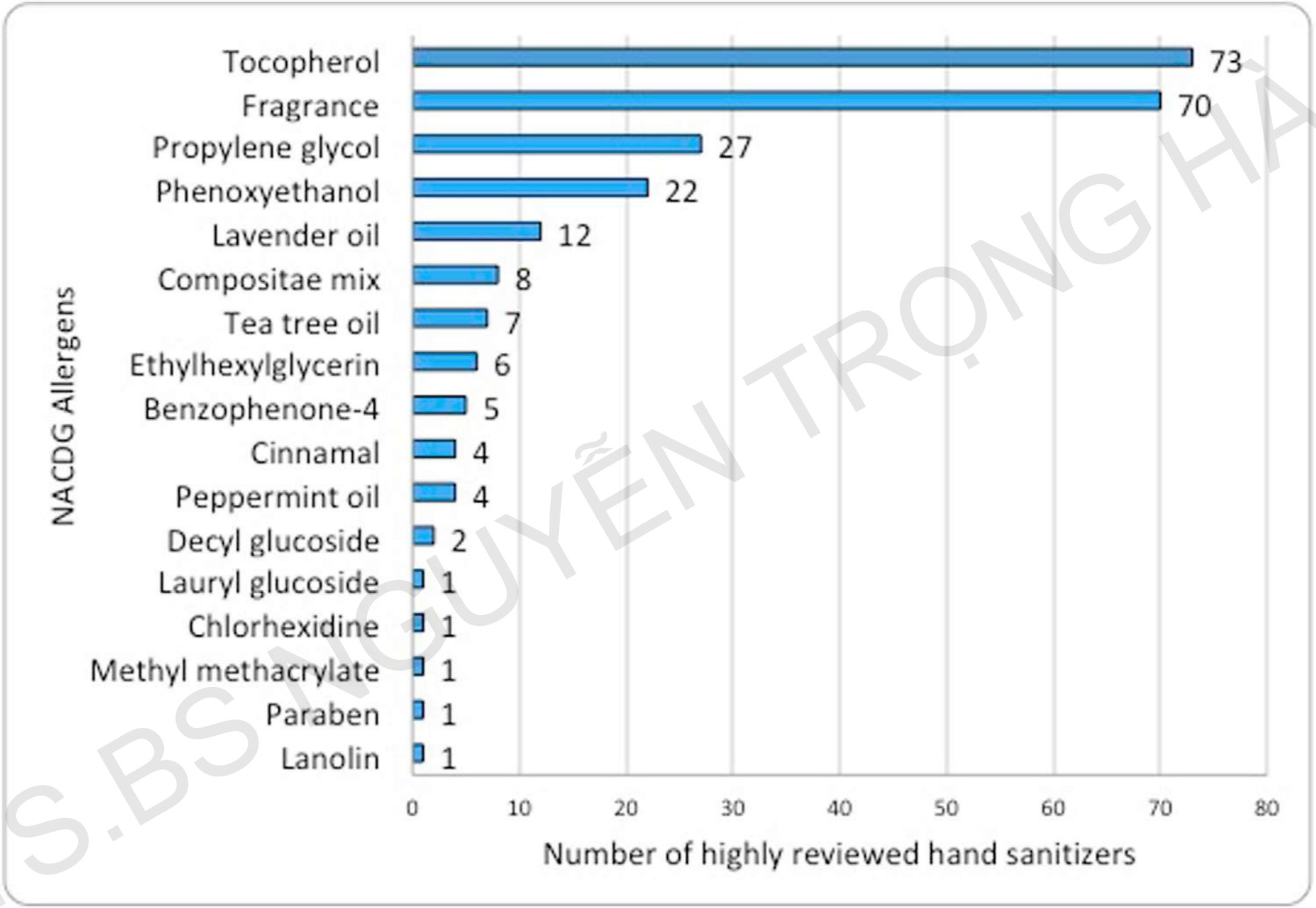
"There are many products out there with an ideal formulation from a medical perspective (compliant with CDC guidelines and devoid of any common irritant or allergens), but it is very challenging for lay people to identify these products because ingredient labels are hard to interpret, and marketing claims are so commonly misleading," Dr. Carina Woodruff, associate director of the Contact Dermatitis Unit at the University of California, San Francisco, told Reuters Health by email.

Allergens and marketing claims in commercial hand sanitizers: A cross-sectional study

To the Editor: Vigorous hand hygiene measures adopted in the setting of the ongoing COVID-19 pandemic translate to an increased risk of contact dermatitis. Dermatologists can help mitigate this by helping patients select effective, hypoallergenic products. We sought to identify contact allergens and salient product features in commercial hand sanitizers.

In May 2021, a total of 160 top-reviewed, commercial hand sanitizers were identified among 5 major online retailers (Walmart, Target, Amazon, Walgreens, and CVS). Ingredients were reviewed to determine the proportion of products that had ingredients listed in the North American Contact fragrance, propylene glycol, and phenoxyethanol (Fig 1). Eighty-four percent of products were sold with marketing claims such as "dermatologist recommended," "moisturizing," "fragrance-free," or "hypoallergenic," the latter 3 of which were verifiable from ingredient lists. All products labeled as "moisturizing" contained at least 1 humectant. Fragrance or cross-reactors were found in 39.1% of the products labeled "fragrance-free." Of the "hypoallergenic" sanitizers, 70.0% had ingredients in the NACDG series and 60% had at least 1 ingredient with a sensitization rate of more than 1%. Overall, 19.5% of the above verifiable claims were misleading. Of the products labeled "dermatologist recommended," 83.3% had at least 1 ingredient in the NACDG series. A quarter of sanitizers had the label "no parabens, sulfates, phthalates, or dyes."

Guo L, et al. J Am Acad Dermatol. 2021 Nov 24:S0190-9622(21)02895-4.



Guo L, et al. J Am Acad Dermatol. 2021 Nov 24:S0190-9622(21)02895-4.

Table I. Low-cost, highly rated hand sanitizers that contain moisturizers and lack common allergens

Product name*	Active ingredient	Retailer	Vehicle type	Price per ounce ($)	Number of reviews	Consumer ratings
SupplyAID	80% ethyl alcohol	Amazon	Gel	0.13	4331	4.6
Hello Bello	80% ethyl alcohol	Walmart	Gel	0.27	294	4.3
Wave Gel	75% alcohol	Amazon	Gel	0.30	520	4.2
SanitizeRx	75% ethyl alcohol	Amazon	Gel	0.31	338	4.5
Hydra Pearl	80% ethyl alcohol	Amazon	Spray	0.34	63	4.8
Suave	65% ethyl alcohol	Target	Gel	0.37	276	4.6
Adam's	75% isopropyl alcohol	Amazon	Spray	0.56	113	4.9
Pipette	65% ethyl alcohol	Target	Gel	0.80	350	4.7
Avagard D	61% ethyl alcohol	Amazon	Gel	0.83	757	4.8

*All products in table 1 were chosen by 2 dermatologists (CMW and NB) based on the American Contact Dermatitis Society's recommendations for hand hygiene[3] and compliance with the Centers for Disease Control and Prevention's recommendations (at least 60% ethyl alcohol or 70% isopropyl alcohol as the active ingredient), absence of North American Contact Dermatitis Group allergens, high ratings by consumers, low cost, and the presence of emollients.

Guo L, et al. J Am Acad Dermatol. 2021 Nov 24:S0190-9622(21)02895-4.

A simple painless technique to drain subungual hematoma

Jean-Baptiste De Villeneuve Bargemon, MD,[a] Samuel Niddam, MD,[a] Auréle Morand, MD,[b] Jean-Camille Mattei, MD,[c] and Charlotte Jaloux, MD[a]
Marseille, France

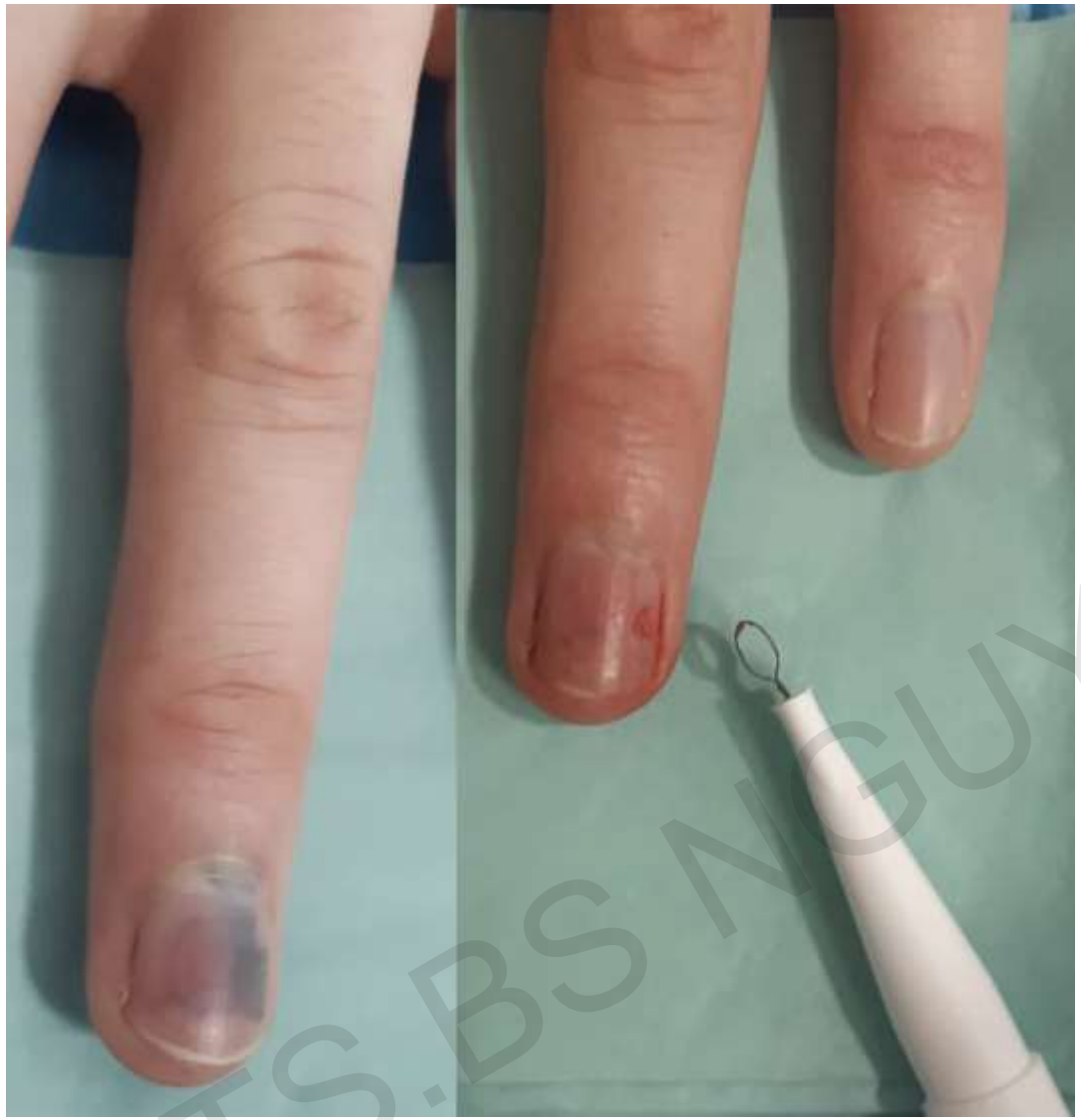
Key words: curette; hematoma; painless; perforation; punch; subungual.

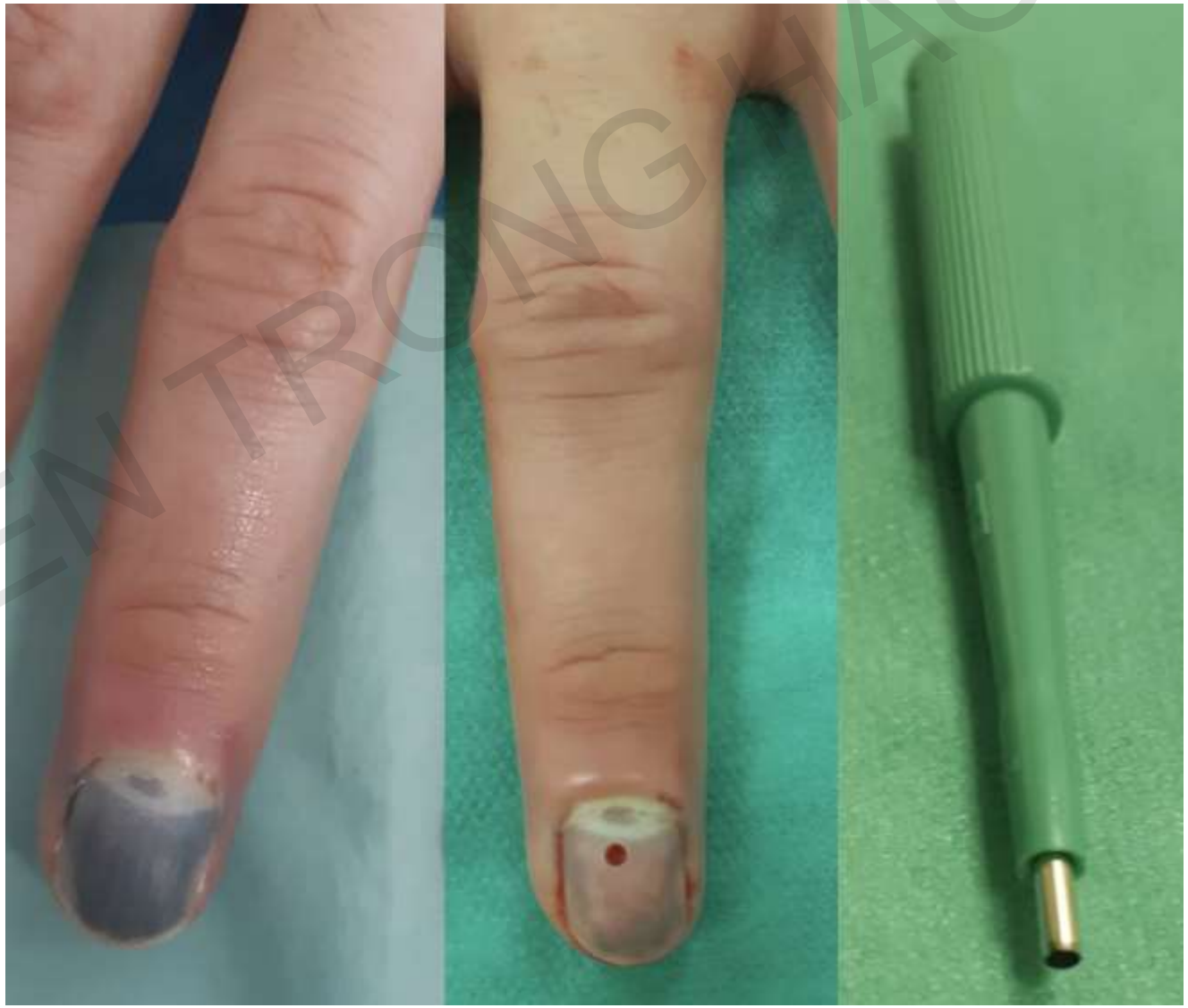
SURGICAL CHALLENGE

Subungual hematoma drainage is indicated whenever the hematoma causes pain or concerns more than 50% of the nail (or more than 25% with an associated fracture).[1] Studies have shown that trephination has the same efficacy as complete removal of the nail. If the subungual hematoma is associated with the complete avulsion of the nail, a displaced phalanx fracture or a proximal fracture involving the germinal matrix, complete removal of the nail with nail bed repair, and repositioning of the perforated nail are required.[1,2]

Trephination with an electrocautery device, a heated 18-gauge needle or paper clip, is a well-known efficient method. However, it is not easy to perform, requires a device to produce enough heat, can be painful, and is usually done under digital nerve block. Also, the hole created is often very small and can be clogged with coagulated blood and become useless.

De Villeneuve Bargemon JB, et al. J Am Acad Dermatol. 2021 Nov;85(5):e283-e285





De Villeneuve Bargemon JB, et al. J Am Acad Dermatol. 2021 Nov;85(5):e283-e285

Use of ultrasound gel to increase efficacy of cryotherapy in treatment of warts

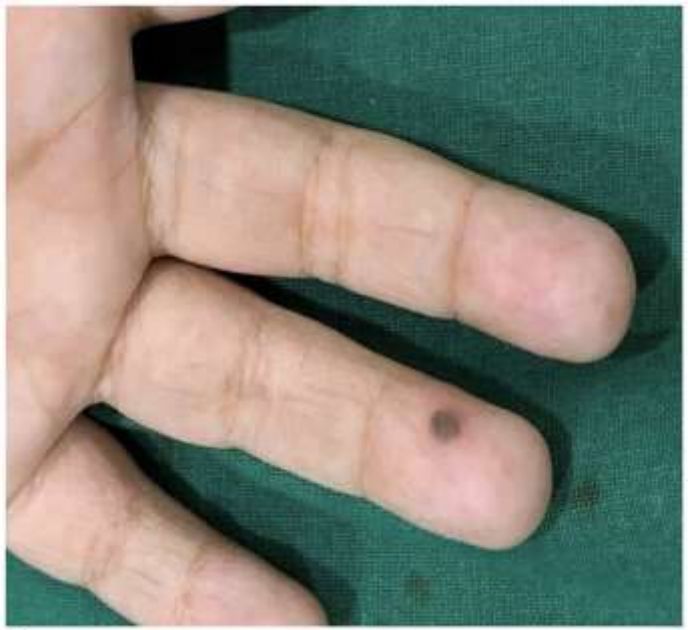
Maya Vedamurthy, MBBS, MD, Sruthy Raghupathy, MBBS, MD, and Priya Vanasekar, MBBS, MD
Chennai, India

Warts are benign tumors that commonly involve the skin and other epithelial tissues and are caused by human papillomavirus infection. The treatment of warts can difficult, although several treatment modalities are available. There is no single treatment that is 100% effective and different types of treatment may be combined. In recalcitrant warts, treatment modalities include cryotherapy, lasers, intralesional bleomycin, and 5% imiquimod, if the lesions are few.

SURGICAL CHALLENGE

Viral warts are caused by human papillomavirus and can grow as papillomas anywhere on the body, commonly on the hands and feet.[1] Although some warts regress spontaneously, most require treatment. Management is difficult, primarily because of recalcitrance to standard therapy and high rates of recurrence.

Vedamurthy M, et al. J Am Acad Dermatol. 2021 Nov;85(5):e275-e277.



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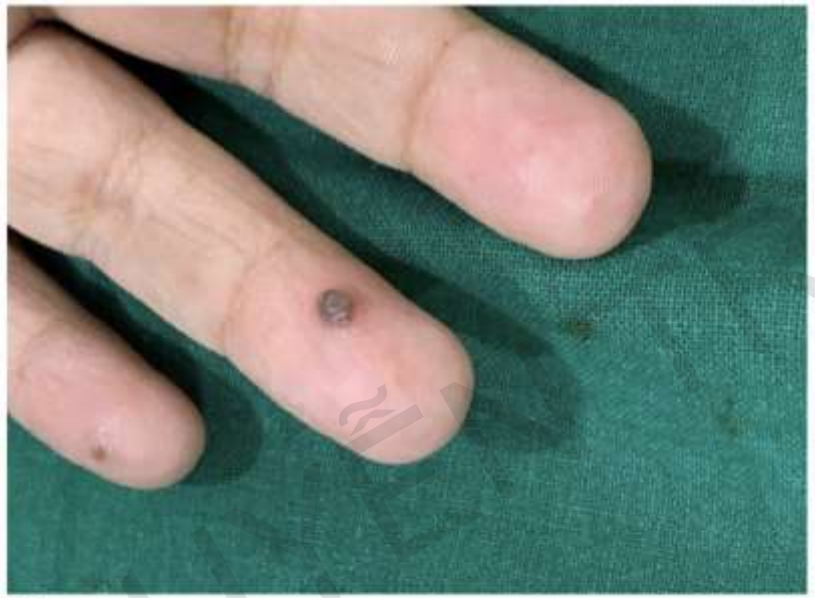

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Vedamurthy M, et al. J Am Acad Dermatol. 2021 Nov;85(5):e275-e277.

JAAD ONLINE: THERAPEUTIC PEARL

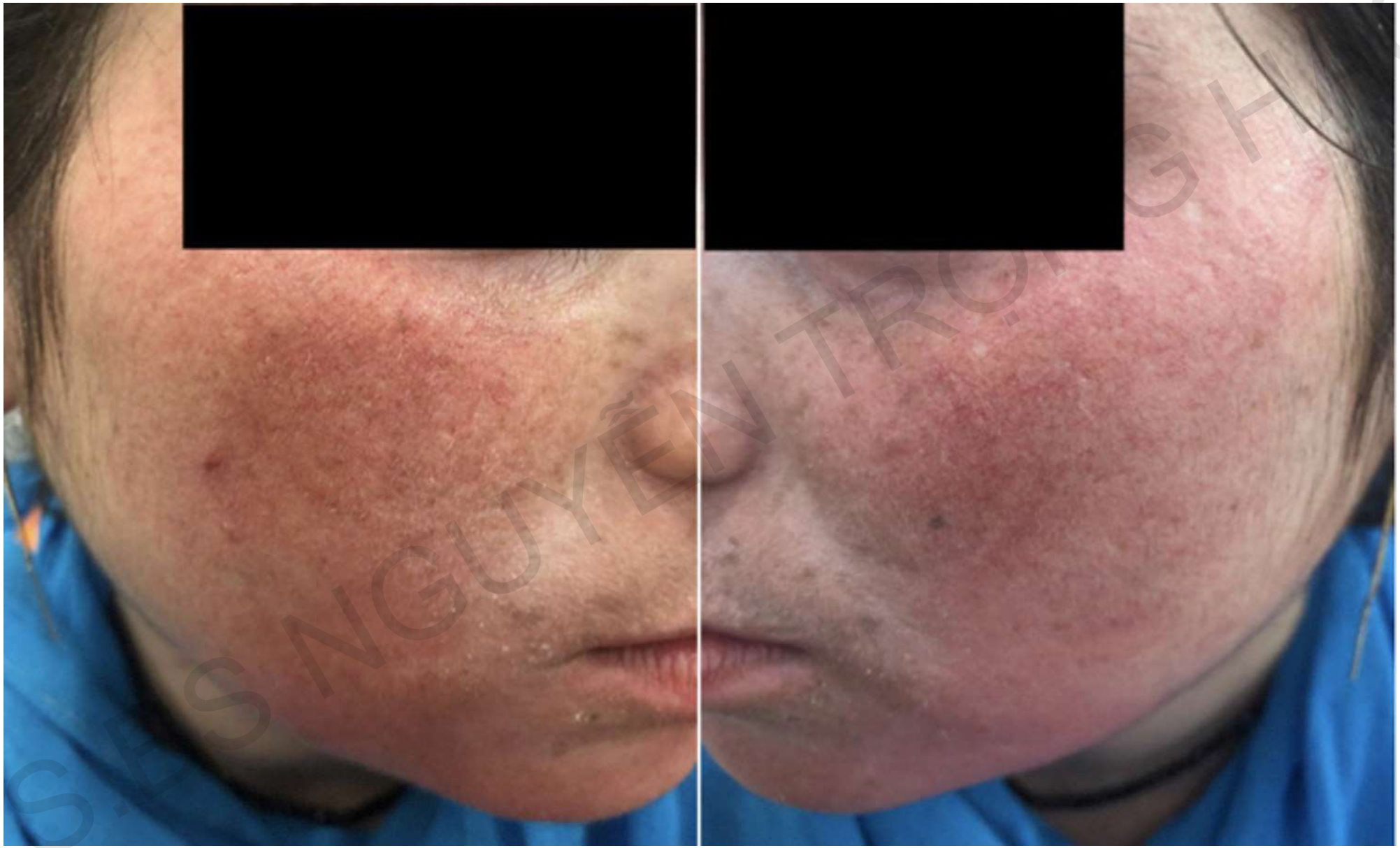
Topical 10% tranexamic acid for erythematotelangiectatic steroid-induced rosacea

Deepak Jakhar, MD, Ishmeet Kaur, MD, and Rachita Misri, MD
New Delhi, India

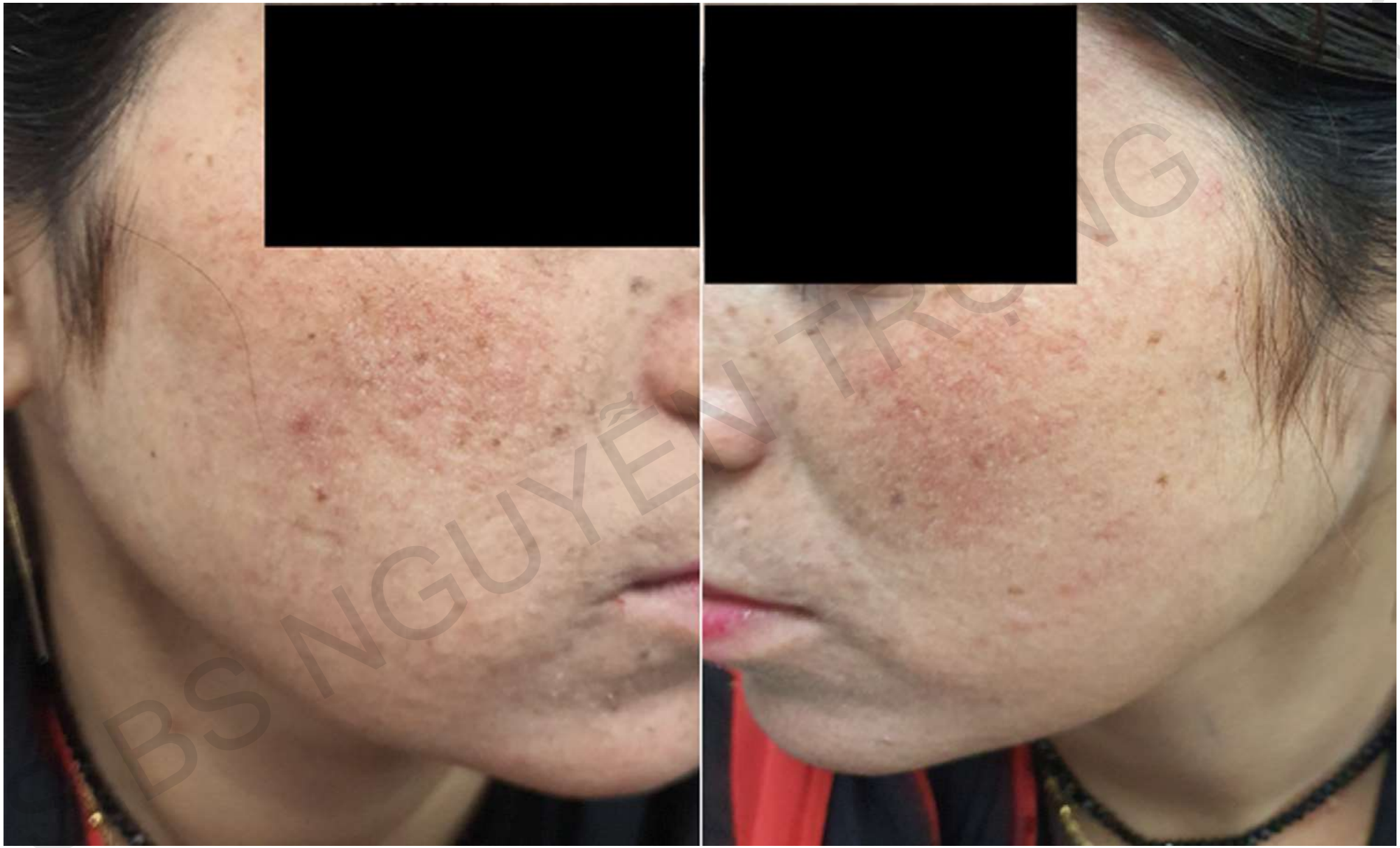
Key words: rosacea; steroid-induced rosacea; topical corticosteroid; tranexamic acid.

Abbreviation used:

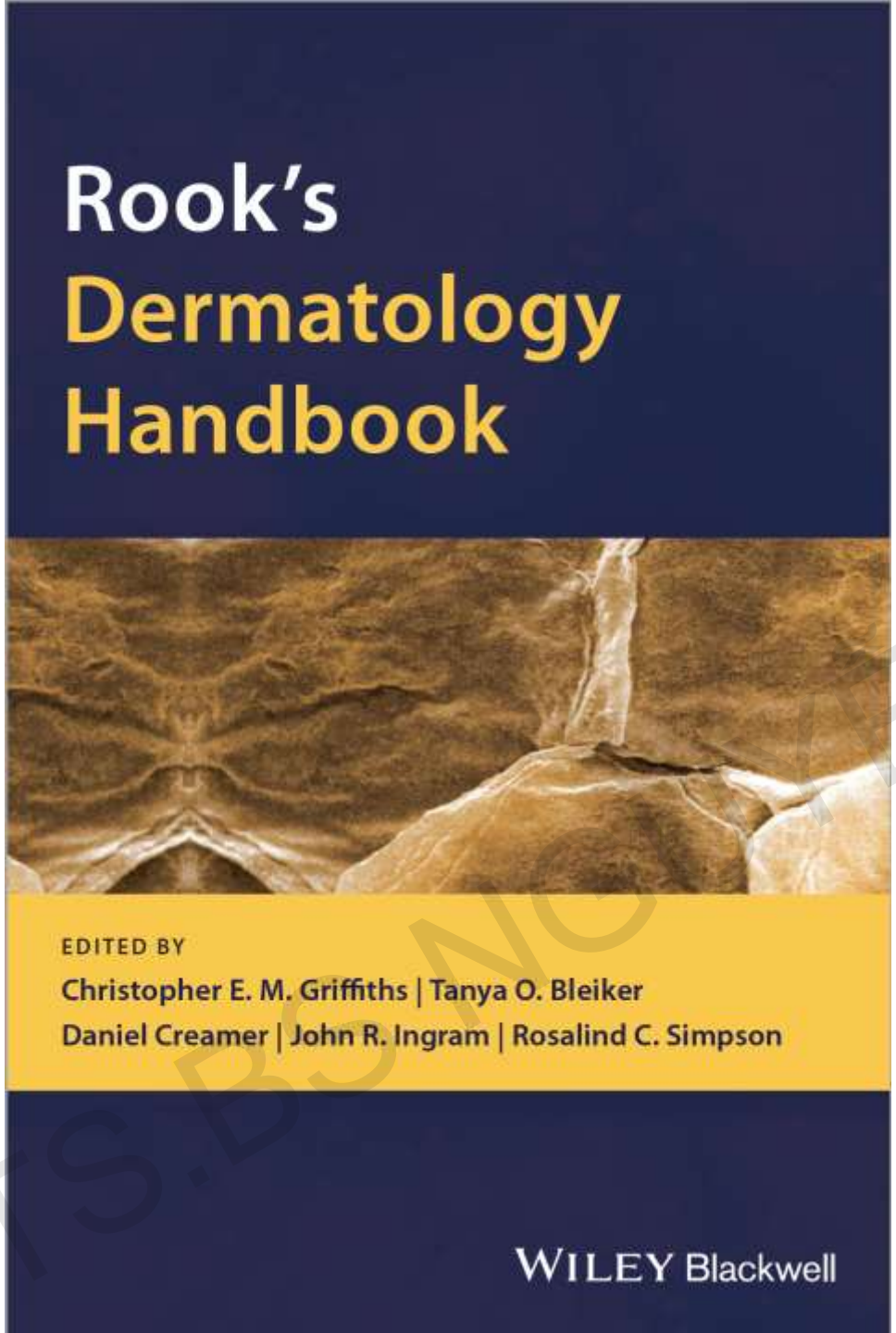
TXA: tranexamic acid



Jakhar D, et al. J Am Acad Dermatol. 2022 Jan;86(1):e1-e2



Jakhar D, et al. J Am Acad Dermatol. 2022 Jan;86(1):e1-e2



Rook's Dermatology Handbook

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Primary syphilis due to genital–nipple friction

Ngo Binh Trinh MD, Hao Trong Nguyen MD, PhD, Thuy Thi Phan Nguyen MD, Giang Huong Tran MD, PhD ... See fewer authors

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Correspondence

Primary syphilis due to genital–nipple friction

Dear Editor,

Primary syphilis is characterized by a chancre, usually located on the genital area which is invaded by *Treponema pallidum*. An extragenital syphilitic chancre is uncommonly detected, especially on the nipples.[1] Primary syphilis on the nipple was first reported in 2006 by Lee et al.[2] Herein, we report a case of an extragenital syphilitic chancre occurring on a nipple created by genital–nipple friction.

A 27-year-old Vietnamese patient presented to our hospital with an asymptomatic ulcer on his right nipple. About 2 weeks prior to presentation, he reported a history of genital–nipple contact with an anonymous male, and an ulcer had formed. He was HIV positive on treatment for 3 years. He denied any personal or family history of atopy. On physical examination, an ulcer covered with crust was noted on the right nipple, and axillary lymph nodes were not detectable (Fig. 1a). No penile ulceration was observed.

On the day of initial presentation, the rapid plasma reagin (RPR) test was weakly reactive and *T pallidum* hemagglutination was positive. After 2 weeks, the RPR test was reactive at a dilution of 1:8. *T pallidum* and polymerase chain reaction of a lesional specimen was positive.

On low power, histological examination revealed lichenoid, perivascular, and periadnexal inflammation and neutrophils in the stratum corneum (Fig. 2a). Marked plasma cells and proliferation of blood vessels were seen on high-power view (Fig. 2b,c).

A single dose of benzathine penicillin G 2.4 million units was administered intramuscularly. Three months later, the lesion on the nipple had resolved (Fig. 1b), and the RPR titer had decreased to 1:2. The RPR test became negative after 6 months.

About 5% of extragenital syphilitic chancres can be seen at any mucocutaneous sites exposed to *T pallidum* sources.[3]

There may be three possible causes of syphilitic transmission. First, if the partner had genital primary syphilis or an oral mucosal lesion of secondary syphilis in his mouth, the active *T pallidum* could have been inoculated directly onto the site of the nipple abrasion. Second, if his partner was an active or latent secondary syphilis patient, *T pallidum* released from minor oral mucosal trauma could be mixed with the saliva and inoculated onto the nipple. Third, Koebner phenomenon could be another explanation for a nipple chancre of an already infected patient.[4]

Our patient denied any other sexually transmitted diseases and any sexual activities such as nibbling and licking; therefore, genital–nipple friction is a possible cause of transmission. The route of transmission in this case is similar to a case reported by Qiao.[5]

Differential diagnoses of nipple ulceration include Paget's disease of the breast, herpes simplex virus infection, eczema, impetigo, skin cancers (melanoma, squamous cell carcinoma, basal cell carcinoma), and erosive adenomatosis of the nipple.[5] A previous history of genital–nipple friction during a homosexual contact, positive serology, histological findings, and a good response to benzathine penicillin G treatment confirmed the diagnosis of primary syphilis.

Primary syphilis involving the nipple is a rare manifestation which can be overlooked in our daily practice. Therefore, we report a case of primary syphilis on the nipple resulting from genital–nipple contact to raise awareness to include primary syphilis as a differential diagnosis of nipple ulceration.

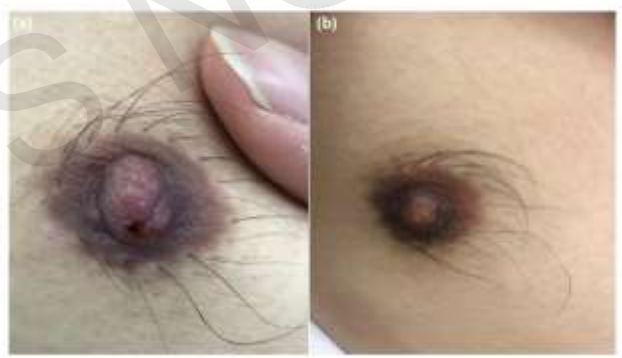

Figure 1 Primary syphilis on the nipple. (a) Asymptomatic ulcer. (b) After 3-month treatment with single dose of benzathine penicillin G 2.4 million units

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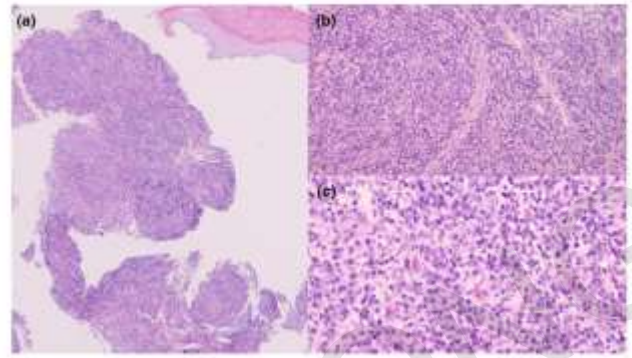

Figure 2 (a) Lichenoid inflammation (hematoxylin and eosin, × 40). (b) Marked plasma cells and proliferation of blood vessels (hematoxylin and eosin, × 100). (c) Marked plasma cells (hematoxylin and eosin, × 200)

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Summary

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