Comment on "Histopathologic features distinguishing secondary syphilis from its mimickers"

To the Editor: We read with interest Flamm et al's description[1] of the histopathologic features that help distinguish between secondary syphilis and its mimickers, such as pityriasis lichenoides (PL). The investigators describe a number of features shared by secondary syphilis and PL but conclude that there are no features that reliably distinguish between these 2 entities—only suggestive features. We have several comments on these findings—notably with regard to our recent study[2] of a large cohort of patients with PL and an earlier publication by Flamm et al[3] on the histologic features of secondary syphilis.

Indeed, we recently showed that certain features may be very helpful in differentiating between these 2 disease entities. With regard to epidermal modifications, Flamm et al[1] rightly pointed out that both entities present with vacuolar changes among the basal keratinocytes. However, in cases of PL, the presence of necrotic keratinocytes, particularly in the upper epidermis (observed in 100% of our cases of PL), pallor of the upper epidermis (42%), red blood cell extravasation (83%), and intraepidermal erythrocyte exocytosis (32%) may be useful clues. With regard to dermal changes, interstitial inflammation may be observed in cases of PL (as mentioned by Flamm et al),[1-3] but it is always associated with perivascular and periadnexal inflammation. In our opinion, a deep dermal lymphocytic infiltrate (in addition to a superficial infiltrate) is a very frequent sign of PL. In addition, this deep dermal infiltrate commonly displays a periadnexal arrangement, with conspicuous adnexotropism. The infiltrate has a T-shaped aspect or—when several adnexal structures are involved—an African-tree aspect.[2] In our opinion, this feature is highly suggestive of PL and has never been described in syphilis. Finally, the inflammatory infiltrate in PL is primarily composed of lymphocytes and contains few plasma cells. However, we did not study the prevalence of plasma cells in our cases of PL.

The ability of each of these features to reliably distinguish between secondary syphilis and PL should be investigated further.

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