Indications for Lumbar Puncture in Patients With Early Active Syphilis and Human Immunodeficiency Virus Coinfection: Experience in a Tertiary Level Hospital in La Coruña, Spain, 2003-2006

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Abstract. Introduction: In the last years, the incidence of syphilis has incremented in Spain and coinfection with HIV occurs in a high percentage. In HIV-infected patients with syphilis, neurological complications, treatment failure and relapse appear to be slightly raised. Therefore, careful follow-up must be carried out because of the risk of developing neurosyphilis. According to the guidelines, lumbar puncture (LP) is indicated in HIV-infected patients with late latent syphilis or syphilis of unknown duration, but it is discussed in HIV-infected patients with early active syphilis. Recent research has been developed in order to determine clinical and analytical findings for identification of patients with high neurosyphilis risk. We review different opinions about this topic and report our experience.

Methods. We have performed LP in all HIV-infected patients with early active syphilis during 2003-2006.

Results. Of the eight studied patients, none met criteria for neurosyphilis. Three of eight (38 %) had a peripheral blood CD4 cell count CD4 + ≤ 350 cells/µL. Seven of eight (87.5 %) had RPR ≥ 1:32.

Conclusion. In these patients, performance of LP could be over indicated because of lack of well-established criterion. Our results are in agreement over to recent studies which restrict indication of LP to specific groups.

Key words: syphilis, human immunodeficiency virus, lumbar puncture, neurosyphilis, venereal disease research laboratory test, rapid plasma reagin test.

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Introduction

With highly active antiretroviral therapy (HAART), human immunodeficiency virus (HIV) infection is now considered a chronic disease. The false sense of security regarding HIV infection has been cited as the cause of the increasing incidence of syphilis and other sexually transmitted diseases, particularly among men who have sex with other men and even in populations with stable HIV infection rates.\(^1\)\(^4\)

Although syphilis may still follow an atypical course (more aggressive and less responsive to treatment) in patients with HIV infection, thanks to HAART, the disease now develops in a similar manner in patients with and without infection.\(^5\)\(^6\)

One aspect that needs to be elucidated in the management of syphilis in patients with HIV infection is whether or not to perform lumbar puncture to exclude asymptomatic neurosyphilis. The dramatic increase in syphilis incidence detected in recent years in Spain and other western countries\(^4\)\(^7\)\(^-\)\(^14\) has heightened interest in establishing clear guidelines for action in such cases.

We present our experience with systematic lumbar puncture performed over 4 years in patients with primary or secondary syphilis of less than a year’s duration at a tertiary care hospital in La Coruña, Spain.

Material and Methods

Between January 2003 and December 2006, we performed a lumbar puncture in every patient with HIV infection and early syphilis (primary or secondary syphilis of less than a year’s duration) treated by the dermatology department at Complejo Hospitalario Universitario Juan Canalejo, La Coruña, Spain.

All the patients underwent physical examination including a neurologic examination. Patients with visual signs or symptoms also underwent an ophthalmologic examination with a slit lamp.

Laboratory and other tests were ordered in accordance with clinical findings and in all cases included a complete blood count, white blood cell (WBC) differential count, erythrocyte sedimentation rate, routine biochemistry, a protein profile, rapid plasma reagin (RPR), fluorescent treponemal antibody absorption (FTA-ABS), HIV, and CD4\(^+\) cell counts in peripheral blood.

Analysis of cerebrospinal fluid (CSF) included evaluation of glucose, proteins, white and red blood cells, Venereal Disease Research Laboratory (VDRL) titers, and Gram staining and culture for bacteria, mycobacteria, and fungi.

Diagnosis of neurosyphilis was based on a pleocytosis of greater than 20 WBC/mm\(^3\) or a positive CSF-VDRL test.\(^5\)\(^15\)

Results

We performed a lumbar puncture in 8 patients with syphilis and HIV infection between 2003 and 2006. They all had secondary syphilis and the results of the neurologic examination were unremarkable. None of them had visual or auditory signs or symptoms.

The diagnostic criteria for neurosyphilis were not met in any of the patients and the CSF findings were within normal ranges or consistent with HIV infection. Four patients (50%) had a CD4\(^+\) count of ≤350/L and 7 (87.5%) had a serum RPR titer of ≥1:32 (Table 1).

Table 1. Clinical and Laboratory Data for Patients Studied

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex</th>
<th>Age, y</th>
<th>Clinical Stage</th>
<th>VDRL Titers</th>
<th>CSF WBC/mm(^3)</th>
<th>FTA-ABS</th>
<th>RPR</th>
<th>CD4(^+) Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>41</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>3</td>
<td>–</td>
<td>1/256</td>
<td>613</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>52</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>3</td>
<td>–</td>
<td>1/64</td>
<td>337</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>50</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>0</td>
<td>–</td>
<td>1/16</td>
<td>360</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>43</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>0</td>
<td>–</td>
<td>1/32</td>
<td>70</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>43</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>0</td>
<td>–</td>
<td>1/256</td>
<td>237</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>44</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>5</td>
<td>–</td>
<td>1/64</td>
<td>171</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>41</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>2</td>
<td>–</td>
<td>1/128</td>
<td>428</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>41</td>
<td>Secondary syphilis</td>
<td>–</td>
<td>14</td>
<td>–</td>
<td>1/256</td>
<td>401</td>
</tr>
</tbody>
</table>

Abbreviations: CSF, cerebrospinal fluid; FTA-ABS, fluorescent treponemal antibody absorption; M, male; RPR, rapid plasma reagin; VDRL, Venereal Disease Research Laboratory; WBC, white blood cells.
syphilis within 18 to 25 years.

such as tabes dorsalis, general paralysis, or gummatous syphilis within 5 to 12 years, and into later forms of syphilis clinically (causing acute symptomatic meningitis). If left persist (causing asymptomatic meningitis), or develop and vice versa.

HIV infection facilitates invasion of the CNS by infection is not known but it has been demonstrated that Borrelia Vsp-OspC lipoproteins in natural tissues might be involved as they facilitate pallidum invasion of the CNS without triggering an immune response.6

Once in the CNS, T pallidum may be cleared spontaneously, persist (causing asymptomatic meningitis), or develop clinically (causing acute symptomatic meningitis). If left untreated, the infection can develop into meningocephalovascular syphilis within 5 to 12 years, and into later forms of syphilis such as tabes dorsalis, general paralysis, or gummatous syphilis within 18 to 25 years.

Between 4% and 9% of patients with untreated syphilis without HIV infection syphilis develop neurosyphilis.6,16 The corresponding percentage in patients with HIV infection is not known but it has been demonstrated that HIV infection facilitates invasion of the CNS by T pallidum and vice versa.17 If we also consider that T pallidum is not entirely cleared from the CNS in immunocompromised patients, the greater concern to rule out neurosyphilis (by analyzing CSF) in patients with HIV infection is understandable.

Diagnosis of neurosyphilis is based on consideration of clinical history, physical examination, and CSF findings. It is well known that both HIV and neurosyphilis can cause pleocytosis and increased CSF protein levels. HIV infection, however, tends to produce mild pleocytosis and this is why a WBC count of over 20 cells/mm³ is highly suggestive of neurosyphilis.6,17

The CSF-VDRL test has high specificity,18 which is why it is routinely used in the diagnosis of neurosyphilis, but it also has low sensitivity (30%).19 In other words, a positive result will confirm disease but a negative one will not rule it out. It is also important to bear in mind that blood in the CSF caused by a traumatic lumbar puncture may cause a false positive.

Some specialists recommend performing an FTA-ABS test because of its high negative predictive value18 (a negative result would rule out neurosyphilis). While hemagglutination tests are useful for diagnosing neurosyphilis, they are not recommended for patients with HIV infection as interpretation can be difficult.6,20

The indications for treating neurosyphilis are clear but there is a lack of consensus regarding lumbar puncture, particularly where patients with HIV coinfection are concerned.

In the 1980s and 1990s, there were many reports of cases involving patients with early syphilis and HIV infection who, despite receiving appropriate treatment, developed neurosyphilis within weeks and in some cases even months of treatment. There were no such reports, however, in patients without HIV infection. Since then, many experts have recommended performing lumbar puncture in all patients with HIV coinfection but this opinion is not shared by all.

The latest guidelines from the Centers for Disease Control and Prevention (CDC), issued in 2002 and 2006 (Table 2), recommend lumbar puncture in patients with HIV infection and late latent syphilis or latent syphilis of unknown duration.

The 2002 CDC guidelines mention that some specialists recommend lumbar puncture in patients with latent syphilis and a serum RPR titer of ≥1:32 and the 2006 guidelines state that this is now also an option in patients with HIV infection and a CD4+ count of ≤350/L. Abbreviation: HIV, human immunodeficiency virus.

### Table 2. Indications for Lumbar Puncture According to the Centers for Disease Control and Prevention (CDC) Guidelines for 2002 and 2006

<table>
<thead>
<tr>
<th>Neurologic/ophthalmic signs</th>
<th>Late syphilis</th>
<th>Treatment failure</th>
<th>Patient with HIV infection and late latent syphilis or syphilis of unknown duration</th>
</tr>
</thead>
</table>

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### Discussion

In early syphilis, *Treponema pallidum* invades the central nervous system (CNS) in 25% to 60% of cases. Although the reason for this neurotropism is still unknown, it has been suggested that *Borrelia* Vsp-OspC lipoproteins in natural tissues might be involved as they facilitate *pallidum* invasion of the CNS without triggering an immune response.6

Once in the CNS, *T. pallidum* may be cleared spontaneously, persist (causing asymptomatic meningitis), or develop clinically (causing acute symptomatic meningitis). If left untreated, the infection can develop into meningocephalovascular syphilis within 5 to 12 years, and into later forms of syphilis such as tabes dorsalis, general paralysis, or gummatous syphilis within 18 to 25 years.

Between 4% and 9% of patients with untreated syphilis without HIV infection syphilis develop neurosyphilis. The corresponding percentage in patients with HIV infection is not known but it has been demonstrated that HIV infection facilitates invasion of the CNS by *T. pallidum* and vice versa. If we also consider that *T. pallidum* is not entirely cleared from the CNS in immunocompromised patients, the greater concern to rule out neurosyphilis (by analyzing CSF) in patients with HIV infection is understandable.

Diagnosis of neurosyphilis is based on consideration of clinical history, physical examination, and CSF findings. It is well known that both HIV and neurosyphilis can cause pleocytosis and increased CSF protein levels. HIV infection, however, tends to produce mild pleocytosis and this is why a WBC count of over 20 cells/mm³ is highly suggestive of neurosyphilis.

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The latest guidelines from the Centers for Disease Control and Prevention (CDC), issued in 2002 and 2006 (Table 2), recommend lumbar puncture in patients with HIV infection and late latent syphilis or latent syphilis of unknown duration.

Although the 2001 European guideline for the management of syphilis coincides with the CDC’s recommendation of performing lumbar puncture in patients with CNS disease and late syphilis, it also recommends that this procedure be performed 2 years after treating patients with early syphilis and HIV infection.

Whether or not lumbar puncture should be performed in patients with HIV infection and early syphilis is therefore the subject of continuous debate. While some physicians will never perform this procedure in the absence of clinical suspicion of neurosyphilis, others will do so 2 years after treating early syphilis. Both options carry the risk of the patient dying and of neurosyphilis going undetected and therefore untreated. Experts with a more conservative approach prefer to perform systematic lumbar puncture in patients with syphilis and HIV infection before initiating treatment and some even recommend repeating the procedure periodically.

Several studies have been conducted in search of clinical and analytical parameters that might help to identify patients with an increased risk of neurosyphilis as it is these patients, and particularly those with latent syphilis, who would benefit most from lumbar puncture.

As has already been mentioned, the CDC does not indicate lumbar puncture for patients with HIV infection and early syphilis, arguing that the clinical and prognostic significance of the CSF abnormalities seen in these patients is unknown, that reactive VDRL tests during early syphilis...
How to proceed with a patient with early syphilis and human immunodeficiency virus coinfection: Experience in a Tertiary Level Hospital in La Coruña, Spain, 2003-2006

1. Are there neurologic (NRL), ophthalmic (OPH), or auditory (AUD) signs or symptoms?
2. Has treatment failed?
3. Is the serum RPR titer \( \geq 1:32 \)?
4. Is the CD4+ count in peripheral blood \( \leq 350/\text{L}\)?

**NRL/OFT/AUD signs/symptoms or treatment failure?**

<table>
<thead>
<tr>
<th>Yes: lumbar puncture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum RPR titer ( \geq 1:32 ) or CD4+ count ( \leq 350 )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No: monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform lumbar puncture or</td>
</tr>
<tr>
<td>2. Delay lumbar puncture for 6 to 12 months.</td>
</tr>
</tbody>
</table>

Figure. How to proceed with a patient with early syphilis and human immunodeficiency virus infection.\(^6,18,21,24,25\) RPR indicates rapid plasma reagin.

become nonreactive without specific treatment for neurosyphilis, and that more cases would have been detected if there were considerable neurologic involvement.

To date, however, there has been no evidence that a reactive CSF-VDRL test is any less suggestive of neurosyphilis in a patient with early syphilis than in one with late latent syphilis or syphilis of unknown duration. The true incidence of neurosyphilis is unknown because it is not a notifiable disease and because lumbar puncture is not performed in many cases.\(^24\)

It was recently demonstrated that patients coinfected with syphilis and HIV, regardless of disease stage or history of previous treatment, had a 6-fold increased risk of developing neurosyphilis if they had a serum RPR titer of \( \geq 1:32 \)\(^24,25\) and a 3-fold increased risk if they had a peripheral blood CD4+ count of \( \leq 350/\text{L} \). These are independent factors, so if they coincide, the risk increases by 18.\(^24\)

Accordingly, if lumbar puncture is only performed in patients with HIV infection and late latent syphilis or syphilis of unknown duration, we will be neglecting patients with a high risk of neurosyphilis (those with HIV infection and early syphilis and a serum RPR titer of \( \geq 1:32 \) or a CD4+ count of \( \leq 350/\text{L} \)) and performing unnecessary tests in patients with a low risk (those with HIV infection and late latent syphilis or syphilis of unknown duration and a serum RPR titer of \( \leq 1:32 \) or a CD4+ count of \( \geq 350/\text{L} \)).\(^24,26\)

In the absence of clearly defined criteria on when lumbar puncture might be indicated in patients with HIV and early syphilis infection, we believe that the procedure has been overindicated to date.

Our findings support the idea that lumbar puncture should be limited to patients with relevant risk as it is an invasive test that carries risk and requires expertise. Nausea, ringing in the ears, and persistent headache have been reported in 37% of patients who have undergone lumbar puncture.\(^27\)

Because HAART has changed the course of HIV infection and syphilis in coinfected patients, and in view of recent findings,\(^24,25\) it would seem logical to only perform lumbar puncture in patients with poor immune response and massive spirochetemia, and not to base decisions on clinical disease stage or HIV positivity, as has been the case to date (Figure).

**Author’s note.** We have followed the patients from when this article was accepted to date and none of them have developed neurologic signs or symptoms.

Conflicts of Interest
The authors declare no conflicts of interest.

References


