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Case Report

Sexual abuse leading to secondary syphilis in an intellectually disabled person: a case report

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ABSTRACT

Syphilis is a sexual transmitted infection (STI) caused by a spirochete, *Treponema pallidum*. Condylomata lata is a characteristic lesion seen in secondary syphilis. Here we reported a case of 24 year old unmarried male with intellectual disability who presented with condyloma lata over the scrotum, prepuce and perianal region and with moth eaten alopecia over scalp since 1 month. Here the patients mother revealed he had promiscuous relationship with multiple friends, which is a sexual abuse since the patient is intellectually disabled. Clinically diagnosed as secondary syphilis. Venereal disease research laboratory (VDRL) test titre was reactive at 1:32 and *Treponema pallidum* hemagglutination test (TPHA) was positive. Biopsy was also done, which confirmed diagnosis. Single dose of injection benzathine penicillin G, 2.4 million units was administered intramuscularly. Patient did not develop a Jarisch-herxheimer reaction. On follow up his lesions healed and VDRL titres also came down and non-reactive at 3 months. Here in this case sexual abuse lead to secondary syphilis since patient was intellectually disabled so he couldn't address his complaints clearly. Hence counselling was done to the patient and family members by dermatologist and psychiatrist.

Keywords: *T. pallidum*, Secondary syphilis, Condyloma lata, Sexual abuse

INTRODUCTION

Syphilis is a STI caused by a spirochete, *T. pallidum*. If primary syphilis is unnoticed or not treated it goes into secondary syphilis. Condylomata lata is a characteristic clinical feature during this stage. They are non-keratinized, painless, broad based, flat, velvety, wart like lesions, which tend to develop in warm, moist sites of the genitals and perineum.[1] We reported a case of secondary syphilis due to sexual abuse in an intellectually disabled person.

CASE REPORT

A 24 year old unmarried male with intellectual disability presented with pain less moist raised lesions over the scrotum, prepuce and perianal region since 1 month and associated with patchy hair loss over scalp (Figure 1). No history of any other mucocutaneous lesions or ulcer. His systemic examination was normal. Patient denied history of sexual exposure, but his mother revealed he had promiscuous relationship with multiple friends. Bilateral inguinal lymph nodes were enlarged along with right sided cervical lymphnode. Serology was done, VDRL titre was reactive at 1:32 and TPHA was positive. Human immune deficiency virus (HIV) combination antibody test and hepatitis B surface antigen test were negative.

Biopsy was also done, which showed features suggestive of condylomata lata with characterisitic plasma cells (Figure 2). The patient was treated with injection benzathine penicillin G 2.4 million units intramuscular. On follow up his lesions improved, size of lesions over perianal region reduced, prepucial and scrotal lesions resolved. Serology was also negative on follow up.

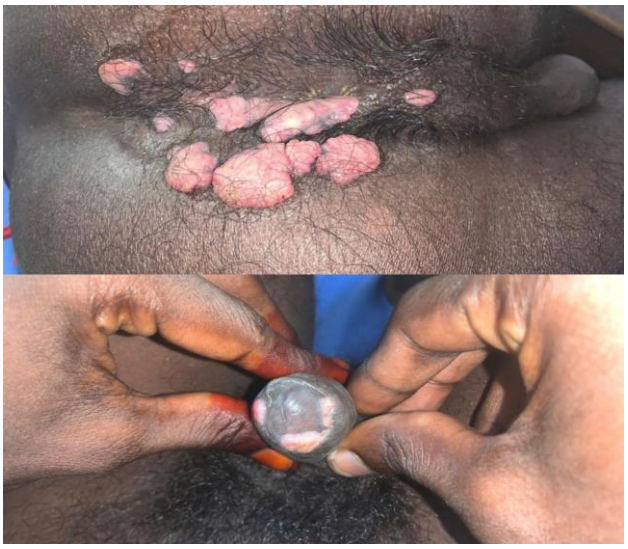

Figure 1: Moist plaques and papules present over the perianal region and prepuce.

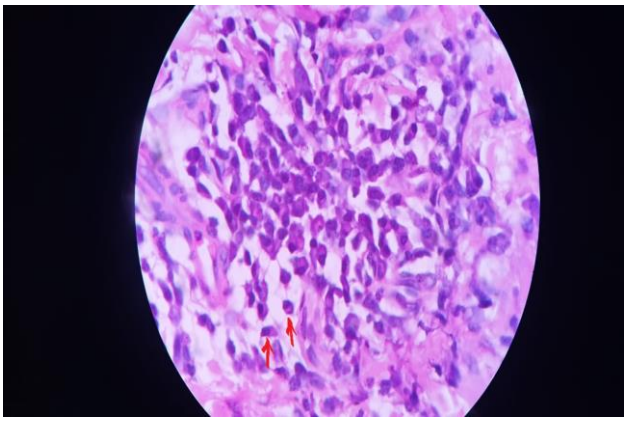

Figure 2: Histopathology showing abundant characteristic plasma cells (red arrows).

DISCUSSION

Secondary syphilis begins at 2-12 weeks after appearance of primary chancre. Commonly involved tissues are skin, mucous membranes and lymph nodes. Mucocutaneous lesions included macular syphilide, papular syphilide, condylomata lata, pustular syphilide, mucous patch and patchy moth eaten alopecia .Constitutional symptoms like low grade fever, malaise, headache and anorexia were present.

Sexual assault/abuse is a violent crime that affected men, women and children of all ages. STIs may be transmitted during sexual assault. The commonly transmitted infections were gonorrhoea, trichomoniasis, syphillis, genital warts, condyloma accuminata, bacterial vaginosis, herpes and HIV.

Over the past 3 decades, sexual abuse involving young and vulnerable people had emerged as an issue of major social significance. In a study by Tomsa et al the prevalence of sexual abuse in adults with intellectually disability was 32.9% and increased prevalence was seen in institutionalized individuals.[1] A study by Gil-Llario et al showed that prevalence was 6.10% when self-reported and 28.6% when reported by professionals.[2]

International studies on prevalence determine rates of abuse among women range from 7.4% to 60%, in men varies between 4.2% to 30%. The prevalence of lifetime sexual violence was 13.9% among men with intellectual disability and they were four times more likely to get victimized compared to men without disabilities.

Data on sexual abuse in men with intellectual disability were scarcer than those on women and also presented with greater variability. Men with intellectual disability tend to experience less overprotection than their female counterparts, greater opportunities for involvement in the community without supervision puts them at higher risk of abuse, peers were the most prevalent abusers.[3]

In another study by McCarthy et al the prevalence rate of abuse was higher for women (61%) than men (25%), the abuse was revealed by the victims themselves, but they were unaware of its social meaning. Most of them found it was difficult to disclose the abuse due to embarrassment, shame, fear of consequences.[4]

Basically there were two types of abuses, type A abuses were contrary to law and covers sex with people with severe or profound disabilities who were not able to give informed consent; abuse from a member of staff; incest; and where violence or force was used or threatened; type B abuse was not strictly defined by law, but by inequality, undue pressure or compliance, included exploitation of a difference in ability or power; situations where valid consent was impossible or meaningless; the presence of pressure or violence in a relationship which ensured one partner's general compliance; and the deliberate targeting of a vulnerable person with intellectual disabilities for sexual gain.

Kinds of abuse included indecent exposure, verbal sexual harassment, touching of genitals, bottom, breasts through clothes, victim made to masturbate perpetrator/vice versa. Victim made to give oral sex to perpetrator, attempted acute vaginal or anal penetration, physical injury to non-sexual parts of the body.[5] In most cases victims don't have knowledge of the kind of abuse; it was frequent occurrence in the lives of many people with intellectual disabilities. Perpetrators having long-term access to the victims abuse them continuously over long periods. Most

commonly these were fathers of men with intellectual disabilities.

The symptomatology of victims included verbal and physical aggression, self-harm, sexualized behaviors and less frequently, anxiety symptoms. Victim's own place of residence was shown to pose the greatest danger to women and men. Increased language difficulties, lack of sex education in victims also posed a risk, abuse most frequently occured within the close or extended family. Majority of abuse was committed against those with disability in mild to moderate range.

The complex and varied home circumstances of many victims included discontinuity of care, parental separation, multi-generation living arrangements, serial monogamy, fostering and part-time residential care.[6] In our case on detailed history in psychiatry we found that patient was alone in house, parents/caretakers didn't supervise him all the time and he used to go out with his friends for promiscuous activities.

Largely abuse happened to the men while they actively seek sexual contacts with other men in public toilets and parks. For both women and men with intellectual disabilities, men with intellectual disabilities were frequently the perpetrators which predominantly included fathers and step fathers. In our case history of perpetrators couldn't be assessed.

In the majority of cases victims felt quite ambivalent about what happened to them, they can have positive, negative or mixed feelings about the abuse, men with homosexuality have mixed feelings with their abusers. Perpetrators overcome resistance of victims by use of threat or force, intimidation or a weapon and sudden attacks which don't give the victim opportunity to resist.

Presence of power differences acted as barriers to consent to sex for people with intellectual disabilities. Perpetrators relied on more than one power difference to ensure the compliance of the person with intellectual disabilities.[7] Most often intellectually disabled persons shared their abuse history without being aware of what they have gone through as was the case in our patient. Victims don't provide proper history of abuse, don't disclose it as it would affect their relationship with the perpetrator.[8] The greater the degree of disability, more difficulty in disclosure.

Victims needed utmost care and counseling by doctors and healthcare service providers, therapeutic and specialist care services should be given, increased supervision and follow up, check them for other STIs and pregnancy, psychologic support and sex education should be given.[9] Awareness among community, families of victims and caregivers about high incidence of sexual assault on intellectually disabled people should be given.

Perpetrators were to be identified and counseled with appropriate sex education, prosecuted for abuse, verbally have to be reprimanded, availability of victims to them must be deprived and increased supervision to be done so that they don't commit abuse again.[10]

In our case, patient is intellectually disabled, so patient couldn't able to tell the complaint and sexual abuse the patient underwent. His mother gave the history, relevant investigations were done and was treated. Patient is on regular follow up with psychiatrist for counselling.

CONCLUSION

Secondary syphilis is not common nowadays due to rise of antibiotics. In our case, detailed history, clinical findings, investigations and biopsy, supported our diagnosis. So we found out sexual abuse in an intellectually disabled person leading to secondary syphilis. People with intellectual disability can be misused for promiscuous activities and they can present with several STIs. This case report presents a rare case of secondary syphilis in our setting and an important social issue with respect to intellectually disabled persons.

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