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Clinical Case – Secondary Syphilis and Family Dysfunction: The Role of the Family Doctor

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Abstract

Syphilis is a sexually transmitted infection (STI) caused by Treponema pallidum, with diverse clinical manifestations according to disease stage. Its increasing incidence worldwide reinforces the importance of early diagnosis and comprehensive management, particularly in primary care. We report the case of a 37-year-old married male factory worker from a lower-middle socioeconomic background, with moderate family dysfunction. His past medical history included eosinophilic esophagitis. A rare attender of healthcare services, he presented multiple times to the acute care clinic over a two-week period, initially driven by fear of illness rather than specific symptoms. He later developed non-pruritic erythematous maculopapular lesions on the trunk, sparing the palms and soles. Sexually transmitted infection screening was requested. Two days later, his wife sought medical care due to anxiety and depressive symptoms following the discovery of her husband's positive VDRL result. The patient subsequently disclosed unprotected extramarital sexual intercourse and was found to have a painless penile lesion. A diagnosis of secondary syphilis was established, and he was treated with intramuscular benzathine penicillin. Both partners required regular follow-up due to significant emotional distress, suicidal ideation, and family disruption, which ultimately led to the initiation of divorce proceedings. This case highlights not only the clinical relevance of recognizing secondary syphilis, but also the essential role of the family physician as the first point of contact in managing the medical, emotional, and relational consequences of disease, emphasizing the holistic and multifaceted nature of family medicine.

Keywords: Secondary Syphilis, Sexually Transmitted Infections, Family Dysfunction, Family Physician, Holistic Care.

Introduction

Syphilis is a chronic sexually transmitted infection caused by the spirochete Treponema pallidum. Despite effective and widely available treatment, its incidence has increased significantly in recent years, representing a persistent public health concern. The disease evolves through distinct stages, with secondary syphilis often presenting with systemic and dermatological manifestations that may mimic other conditions.

In primary care, family physicians are frequently the first point of contact for patients with nonspecific symptoms or psychosocial complaints. Beyond diagnosing and treating infections, they are uniquely positioned to assess family dynamics, emotional well-being, and social context. This case report illustrates the diagnostic challenges of secondary syphilis and emphasizes the central role of the family physician in addressing the broader impact of disease on individuals and families.

Case Presentation

A 37-year-old married male factory worker, from a lower-middle socioeconomic background (Graffar classification), attended his Family Health Unit. His personal medical history included eosinophilic esophagitis, and his family history was notable for pancreatic cancer in his father. Family assessment using the APGAR scale revealed moderate family dysfunction.

The patient was a rare attender of primary care services. Over a two-week period, he attended multiple acute care consultations, initially motivated by fear of becoming ill rather than specific physical complaints. No objective abnormalities were identified at the first visit.

Five days later, he returned with a three-week history of non-pruritic erythematous maculopapular lesions on the trunk, without involvement of the palms or soles. The patient associated symptom onset with a recent bicycle ride. Physical examination was

otherwise, unremarkable. A presumptive diagnosis of urticaria was made, antihistamine therapy was initiated, and laboratory investigations were requested, including screening for sexually transmitted infections.

Two days later, the patient's wife presented to the health center with anxiety and depressive symptoms after becoming aware of her husband's positive VDRL result. She expressed emotional distress related to suspected infidelity. A family genogram was constructed, revealing relational tension and vulnerability within the family unit.

At a subsequent appointment, the patient admitted to unprotected extramarital sexual intercourse approximately two months earlier. Physical examination revealed a painless penile lesion with one month of evolution. The diagnosis of secondary syphilis was established. He was treated with a single intramuscular dose of 2,400,000 IU benzathine penicillin, in accordance with current guidelines.

As part of partner management, the patient's wife underwent comprehensive screening for sexually transmitted infections, including serological testing for syphilis. All test results were consistently negative throughout follow-up.

Discussion

This case demonstrates the diagnostic complexity of secondary syphilis, which may present with nonspecific cutaneous findings and be initially misinterpreted as benign dermatological conditions. Careful clinical assessment and appropriate sexual history taking remain essential in primary care settings [1].

Equally significant are the psychosocial consequences of the diagnosis. The discovery of syphilis precipitated marked emotional distress, anxiety, depressive symptoms, and suicidal ideation in both partners. Family dysfunction intensified, ultimately leading to the initiation of divorce proceedings. These outcomes highlight how sexually transmitted infections can profoundly disrupt family systems.

Beyond the couple itself, the impact of this diagnosis extended to the couple's children, who became indirect but deeply affected participants in the clinical scenario. In family medicine, children are often the silent recipients of parental conflict, emotional instability, and changes in family structure. In this case, the escalation of marital tension, emotional distress, and the prospect of divorce created an environment of uncertainty and emotional vulnerability for the children. Although they were not directly involved in the medical diagnosis, the repercussions of the illness manifested through altered family dynamics, increased parental emotional unavailability, and heightened household stress. The family physician must remain attentive to these secondary effects, recognizing that children's emotional and psychological well-being is closely linked to the stability of the family unit. Early identification of distress signals in children—such as behavioral changes, school difficulties, or somatic complaints—is essential, even when they are not the primary focus of the consultation.

In this context, the family physician plays a uniquely active and longitudinal role that extends far beyond diagnosis and pharmacological treatment. As the first point of contact within the healthcare system, the family physician is positioned to integrate biomedical care with emotional support, family assessment, and continuity of follow-up. In this case, the physician's role included not only confirming the diagnosis and initiating appropriate antibiotic therapy, but also providing a safe and structured space for dialogue, emotional containment, and guidance for both partners. Regular follow-up consultations allowed for monitoring of mental health symptoms, assessment of suicide risk, and timely referral to mental health services when necessary. The physician also acted as a mediator of care, ensuring that neither partner felt abandoned within the healthcare system during a period of profound emotional crisis.

Family medicine's core strength lies in its holistic approach, which acknowledges that illness rarely exists in isolation from personal history, family relationships, and social context. The use of family assessment tools, such as the family APGAR and genogram, facilitated a deeper understanding of relational patterns, sources of support, and points of vulnerability. This broader perspective enabled the physician to anticipate potential consequences for the children and to reinforce protective factors, such as maintaining routines, encouraging open but age-appropriate communication within the family, and supporting parental capacity despite marital conflict.

Ethical considerations were central to the management of this case, particularly regarding the communication of diagnostic information within the family. The situation in which the wife became aware of her husband's positive VDRL result before a direct medical consultation raises important ethical challenges frequently encountered in primary care. Physicians are bound by principles of confidentiality, autonomy, and non-maleficence, yet they must also navigate complex real-world scenarios where information is sharedinformally within families. In such cases, it is essential that the physician re-centers the clinical encounter on the patient, confirming the diagnosis directly with him, ensuring informed consent, and providing clear, non-judgmental information. The physician must avoid disclosing medical information about one individual to another without explicit consent, while simultaneously acknowledging the emotional reality already present within the family.

When managing diagnoses with implications for partners and family members, particularly sexually transmitted infections, the physician must balance confidentiality with the duty to prevent harm. Encouraging patient-led disclosure, offering counseling on how to communicate sensitive information, and providing joint consultations when appropriate and consented to are ethically sound strategies. In this case, facilitating open communication while maintaining professional boundaries helped mitigate further harm and supported both partners through the diagnostic process. Ethical practice in family medicine does not rely solely on rigid rules, but on clinical judgment, empathy, and respect for individual and family autonomy [2].

Ultimately, this case reinforces that the family physician's role is not passive or episodic, but actively constructed through continuity, trust, and presence over time. The physician becomes a stable reference point amid emotional turbulence, capable of addressing biomedical needs while safeguarding the psychological

and relational health of the family. Such an approach is particularly vital when illness acts as a catalyst for family disruption, as seen in this case. Recognizing and responding to the needs of all family members—including children—represents not an extension, but the very essence of family medicine.

Family physicians play a crucial role as the first point of contact with patients, families, and communities. Their longitudinal relationship with patients enables early identification of psychosocial distress, use of family assessment tools, and provision of ongoing support. This holistic approach is a defining feature of family medicine and is essential for addressing the full impact of illness.

Conclusion

Secondary syphilis remains a clinically relevant diagnosis in contemporary primary care, often presenting with nonspecific manifestations that require vigilance, clinical reasoning, and a high index of suspicion. Early recognition and timely treatment are essential to prevent medical complications and limit transmission.

However, this case illustrates that the consequences of sexually transmitted infections frequently extend beyond the individual patient. The diagnosis acted as a catalyst for family disruption, emotional distress, and psychological vulnerability, with repercussions that reached the couple's children and altered the family system as a whole.

Family physicians are uniquely positioned to respond to this complexity. Through continuity of care, ethical clinical judgment, and a holistic approach, they play an active role in integrating medical treatment with emotional support, family assessment, and guidance through sensitive communication.

This case reinforces the essential role of the family physician as a stable point of reference for patients and families during periods of clinical and emotional uncertainty, highlighting that comprehensive care in primary care extends beyond disease management to encompass the preservation of family health and resilience [3].

Ethical Considerations

Written informed consent was obtained from the patients for publication of this case report. All procedures complied with ethical standards. The authors declare no conflicts of interest and no external funding.

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