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Epidemiological, clinical and laboratory aspects of pinta in the Brazilian state of Amazonas

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Pinta (purupuru, carate or mal del pinto) is a nonvenereal infectious-contagious disease caused by *Treponema carateum*. It is exclusive to the Americas, being endemic in Venezuela, Colombia, Ecuador, Peru and Brazil. The number of cases is less in Guatemala, Haiti, the Dominican Republic, El Salvador, Honduras, Nicaragua and Bolivia; it is occasionally seen in Cuba, Puerto Rico, Panama, Guadeloupe and the Virgin Isles (Medina, 1976). In Brazil this dermatitis is practically limited to the State of Amazonas north of the Mato Grosso, the State of Acre and the borders of the Roraima Territory with the State of Amazonas. It is endemic in the regions of the upper Solimões, the upper Rio Negro, the Rio Juruá, the Rio Purus, the Rio Içana and some tributaries.

This report presents the main clinical and laboratory findings of a study in Tikuna Indian communities living along the river Solimões and its branches.

MATERIAL AND METHODS

One hundred patients were selected with active clinical lesions and without clinical evidence of prior treatment. The patients were classified into 3 groups: the initial period group (Period I), the period of general skin invasion (Period II), and the late period group (Period III). Period I was characterized by lesions in erythematous-squamous plaques, sometimes trichophytoid and of various sizes. Period II was characterized by lenticular to nummular lesions, which were hypochromic, hyperpigmented or erythematous-squamous, isolated or confluent. The Period III group included cases with the association of achromic, hypochromic or hyperchromic spots, hyperkeratosis, atrophy, licheni-

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TABLE I

Serological (VDRL) results for 100 pinta patients (Periods I, II and III)

Evolutionary phase	Titer								Neg.	Total
	1/1	1/2	1/4	1/8	1/16	1/32	1/64	1/128		
Initial period	2	1	—	—	3	1	1	—	5	13
Period of general skin invasion	—	—	—	2	2	5	3	4	—	16
Late period	—	—	—	3	12	23	21	11	—	70*
Total	2	1	—	5	17	29	25	15	5	99

*The material was insufficient for the examination to be carried out in 1 case.

ications, follicular keratosis and, at times, erythematous-squamous plaques similar to the Period I lesions.

The following laboratory examinations were carried out: (a) Serological reactions: flocculation reaction (VDRL) and reactions with treponemic antigens (complement binding reaction with Reiter's treponema protein antigen and the immunofluorescence reaction with *Treponema pallidum* after adsorption of the serum group antibodies with nonpathogenic treponemas - FTA-ABS). (b) FTA-ABS reaction in the cerebrospinal fluid from 13 patients in the late phase. (c) Direct search for treponemas in the lymph from the lesions in patients in the initial period of the disease.

RESULTS

The 100 cases of pinta were classified as: Period I: 13 cases; Period II: 16 cases; and late pinta: 71 cases.

The results of the serological reactions can be seen in Tables 1 and 2. The FTA-ABS reaction in the cerebrospinal fluid of the 13 patients tested was negative in all cases. The direct search for treponemas in the cutaneous lymph of Period I patients was positive in all cases.

DISCUSSION

The Tikunas express themselves poorly in Portuguese and in the majority of cases it was impossible to obtain data concerning the onset of the

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TABLE 2

Serological results (Reiter's treponemic antigen and FTA-ABS) for 100 pinta patients (Periods I, II and III)

Evolutionary phase	Reiter's treponemic antigen		FTA-ABS	
	Positive	Negative	Positive	Negative
Initial period	7	6	7	6
Period of general skin invasion	15	—	15	—
Late period	66	—	67	—
Total	88*	6	89 ^Λ	6

*Reaction not carried out in 1 of the patients in the dissemination phase and in 5 of the patients in the late phase.

**Reaction not carried out in 1 of the patients in the dissemination phase and in 4 of the patients in the late phase.

condition; its symptoms and the treatments previously carried out. Patients with localized trichophytoid, psoriatic or macular plaques were considered as belonging to Period I (Fig. 1). In some cases in this phase the clinical appearance is very similar to that of dermatophytosis so that mycological examination and a direct search for treponemas are essential for clarification of the diagnosis. In Period II the lesions, in some cases, can give rise to diagnostic confusion with respect to pityriasis versicolor, eczematous states or leprosy (Fig. 2). The late phase presents virtually no diagnostic difficulties. In this phase almost all the patients show an association of achromic, hypochromic and hyperchromic spots, sometimes with erythematous-squamous spots,

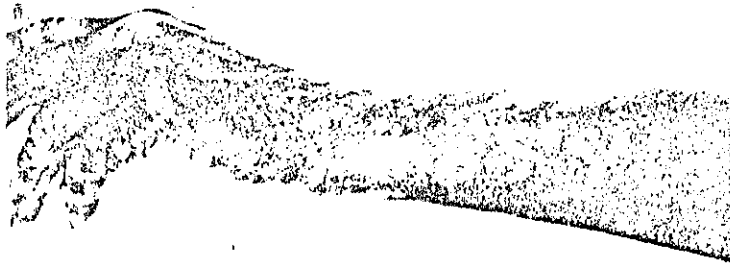


Fig. 1. Pinta in the initial period.

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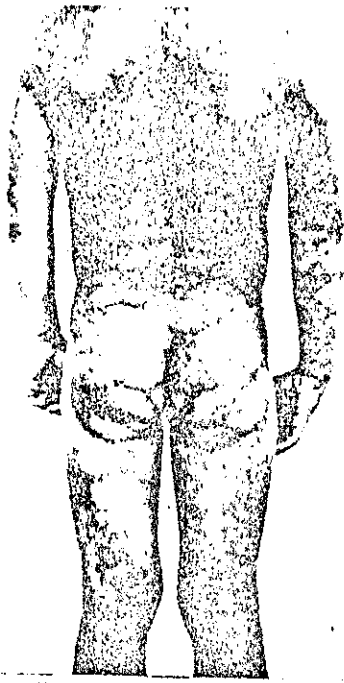


Fig. 2. Pinta in the period of general skin invasion.



Fig. 3. Late pinta.

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giving them a multicolored appearance. In some cases the attack is so intense that the normal skin almost disappears to leave intact only the skin of the interscapular region, the genitals and scalp. Invasion of the scalp region (Fig. 3) together with loss of pigment from the penis and scrotum was observed in 2 cases.

The good general condition of the patients, even those with a long evolution, indicates the benign nature of the disease. The patients carried on their activities normally, and clinical examination revealed no abnormalities whatsoever which could be related to the disease.

In 115 subjects in Period II and III, Mesa et al. (1973) found 73% with positive VDRL reactions and 95% with positive FTA-ABS reactions. Among our cases of pinta there would be 100% positive reaction for the serological tests carried out (VDRL, Reiter and FTA-ABS) if the above-mentioned phases were considered. Negative serological reactions were found only in patients in the Period I/5 with negative VDRL and 6 with negative Reiter and FTA-ABS reactions. In these cases the diagnosis was confirmed by a direct scan for treponemas. According to experimental pinta (Medina, 1962/63; Padilha-Gonçalves, 1964) in the initial period the serological reactions become positive after the second month of illness. Despite the fact that the patients were carefully selected, it is possible that those late phase patients who showed quantitative VDRL reaction titers of 1/8 to 1/16 may have received prior treatment.

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ACKNOWLEDGEMENT

We thank Dr. Mario E. Camargo and Fleury Laboratories (São Paulo) for carrying out the serological reactions.

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