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CASE REPORT

Sexual Abuse as a Cause of Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV) in a Bisexual Adolescent Indonesian: A Case Report

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Abstract: Sexual abuse is any non-consensual sexual act or behavior using force, with significant concern in "men who have sex with men" (MSM), and younger individuals. The incidence of sexually transmitted infections (STI) is also prevalent in the cases of sexual abuse in this population, showing the need for comprehensive medical and psychological intervention. This study presents a case of a 15-year-old Indonesian MSM adolescent who experienced three forced sexual intercourse with a mid-thirties male friend 6 months before the consultation. Psychological evaluation showed signs of moderate depression, then the patient reported erythematous macules and collarettes on the palms and soles. These symptoms appeared 1 month before consultation, without associated pain or pruritus. Additionally, moist, skin-colored verrucous papules and plaques were observed in the perianal area, along with a history of unintentional weight loss. The Kinsey score was calculated as three, showing bisexuality. Testing confirmed positive results for both HIV and syphilis, leading to the secondary diagnosis. The patient tested negative for additional STI and was treated with benzathine benzylpenicillin G 2.4 million international unit (IU) and antiretroviral therapy. After one month, the skin lesions improved and the patient was referred to the psychiatric department for psychological treatment. Syphilis and HIV are the predominant infections, showing the critical necessity of administering appropriate medical treatment, such as antiretroviral therapy and comprehensive STI management, with psychological assessment and management to enhance the psychological well-being of sexually abused individuals.

Keywords: bisexual, human immunodeficiency virus, Indonesian, men sex with men, secondary syphilis, sexual abuse

Introduction

Sexual abuse is any non-consensual sexual act, regardless of the relationship between the victim and the perpetrator. This term includes a range of inappropriate sexual behaviors, such as assault, coercion, and abuse. Sexual abuse is relevant in both intimate relationships and situations that include strangers or vulnerable individuals. Historically, studies on sexual abuse focused on women, children, and adolescents, leaving a gap in understanding the experiences of men, specifically in "men who have sex with men" (MSM) population.[1] Men who engage in sexual activity with other men, regardless of gender identity, are referred to MSM.[2] Previous studies have shown that MSM faced a higher tendency of sexual abuse compared to heterosexual men, which was often worsened by social stigma, discrimination, and the complexity of sexual orientation.[1] A study conducted across 12 Brazilian cities showed that MSM was frequently subjected to repeated episodes of sexual abuse, often commencing in childhood or adolescence, and continuing into adulthood.[3] According to Canadian statistics, around 3.5% of sexually active boys were reported to engage in sexual relationships with someone of the same gender in the past year, although only 1.5% identified as bisexual, mostly homosexual, or 100% homosexual. Remafedi et al also showed similar data

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as 1.1% of American teens identified as gay or bisexual, but 4.5% stated that the main sexual attraction was to individuals of the same sex.[4] A study conducted in Islamic and Public Junior High Schools in Indonesia in 2023 shows homosexual incidence of 7% and 5% for each population. Factors contributing to this result on homosexual sexual orientation were trauma, bad household environment, and access to pornography.[5]

The consequences of sexual abuse extend beyond the immediate physical and psychological trauma, significantly increasing the risk of sexually transmitted infections (STI).[3] Among MSM who have experienced sexual abuse, there is a significantly higher incidence of STI, including syphilis and human immunodeficiency virus (HIV).[6] Both infections facilitate the acquisition of each other and may aggravate the clinical course of the disease. HIV positive patients risk of having syphilis was up to 8 times compared to non-HIV patients.[7] According to the United States Centers for Disease Control and Prevention, more than 50% of MSM with syphilis were also infected by HIV. Recent global trends shows that the incidence of syphilis among MSM has significantly increased, accounting for up to 93.8% of total reported syphilis cases. Moreover, the proportion of MSM infected with HIV and newly diagnosed syphilis between 2003 and 2013 increased from 9.3% to 19.0%. This rate is significantly higher than the percentage of MSM without HIV but recently diagnosed with syphilis varied between 1.7% and 2.7%.[2]

A significant factor that contributes to the occurrence of STI in this population is the decline in condom use. WHO stated that between 2014 and 2022 there was a significant decrease in the use of condoms in active adolescents, including both boys and girls.[8] The prevalence of condom use in 2015–2019 in Indonesian adolescents was quite low.[9] This low prevalence also occurred in MSM population, even among those who report risky sexual behavior.[10] Therefore, this case report aimed to present a case of a 15-year-old Indonesian MSM patient who had been sexually abused and developed secondary syphilis with HIV infection.

Case Report

A 15-year-old male visits Venereology Clinic Doctor Hasan Sadikin General Hospital (RSHS) with erythematous, non-itchy, and non-painful macules with scales on the palms and soles for 3 months. Skin-colored papules in perianal area gradually enlarged and multiplied, forming multiple plaques, as shown in Figure 1. The patient reported no history of genital ulcers, headache, dizziness, seizures, or sensory loss. Following these complaints, the patient consulted a dermatologist who diagnosed syphilis and recommended testing for syphilis and HIV, both yielding positive results. The patient was referred to RSHS, where HIV infection was confirmed, and antiretroviral therapy (ART) was prescribed. Unintentional weight loss was also reported but there was no fever, cough, and night sweats.

Six months before consultation, the patient reported initial sexual intercourse, specifically anogenital contact with a peer. The perpetrator was described as a mid-thirties male who worked at a nearby kiosk. The patient initially interacted with the perpetrator near the school but was subsequently transported to the residence, where sexual coercion occurred. In this context, the patient was the receptive partner during the intercourse, and no condoms were used. Two weeks later, the same individual coerced the patient into two more anogenital sexual acts, threatening harm in the event of refusal. The patient denies any other sexual activity with others and there was no history of using blood transfusion, sharing needles, biting, spitting, or contact with body fluid from others. After experiencing sexual abuse, the patient tended to be alone and lost interest in the daily activities and routines. Following the experience of sexual abuse, there was a significant decline in engagement in previously enjoyed activities, such as daily singing. Subsequent emotional distress manifested as persistent sadness, caused by lack of support due to nondisclosure to family members. Additionally, the patient exhibited altered behavioral patterns, characterized by increased sleep frequency, decreased motivation for activities, reduced appetite and fluid intake, self-blame, and culpability regarding the incident. The individual reported recurring thoughts of harming the perpetrator following the sexual abuse incident. Self-harming behaviors were observed, characterized by frequent limb beating, occurring almost daily, but there were no suicidal ideations. Emotional distress manifested as feelings of a ruined future, stemming from the incident. The Patient Health Questionnaire-9 (PHQ-9) score of 13 showed moderate depression.

Physical examination showed normal vital signs and body mass index. Symmetrical erythematous macules with collarette scales were observed on the palms and soles. Venereological examination showed skin-colored verrucous plaques in the perianal area, ranging from 0.5 cm x 0.5 cm x 0.1 cm to 2 cm x 2 cm x 0.2 cm. The Kinsey score was three, suggesting bisexual, and the acetowhite test on perianal lesions was negative. HIV and syphilis tests were positive, with Treponema

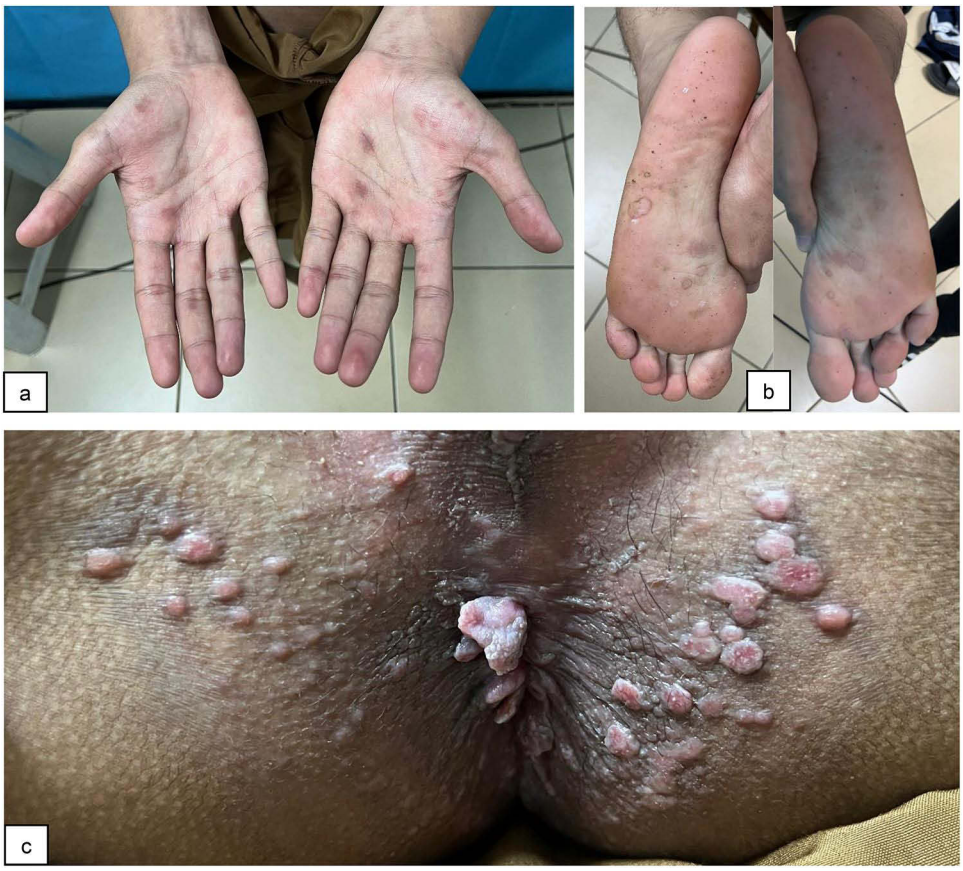

Figure 1 Erythematous macules and collarette scales on palms on soles **(a** and **b)**. Skin colored papules and plaques on perianal area **(c)**.

pallidum Hemagglutination Assay (TPHA) and Venereal Disease Research Laboratory (VDRL) titer of 1:64. Rectal samples were negative for gonococcal and non-gonococcal infections. Furthermore, the hepatitis B test was negative and a biopsy of the perianal lesion showed acanthotic and exophytic epithelial cells, neutrophils exocytosis, stromal plasmacytic infiltration, and endothelial swelling. This result is consistent with secondary syphilis verrucous lesions, as shown in Figure 2. Neurosyphilis was ruled out after a lumbar puncture and the patient received a single dose of 2.4 million IU of intramuscular benzathine benzylpenicillin G for secondary syphilis. After the treatment, erythematous macules and perianal lesions improved, but anogenital warts developed, necessitating a second biopsy, as shown in Figure 3. The patient was referred to

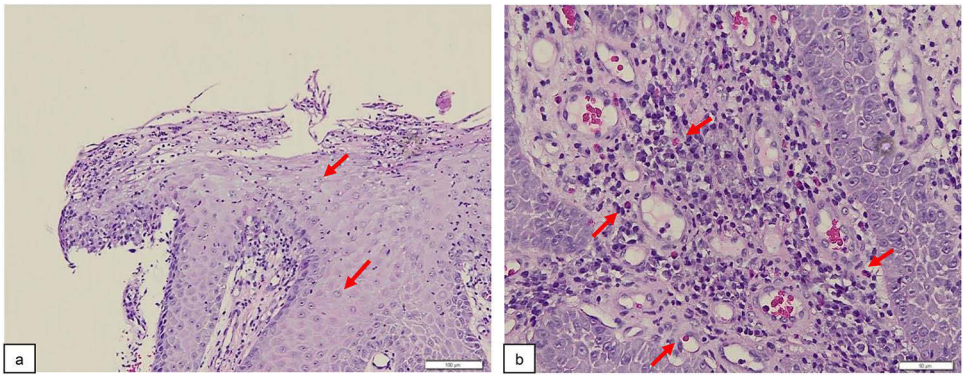

Figure 2 Neutrophil exocytosis in epidermis (red arrow) **(a)**. Plasmacytic cells with stromal inflammation (red arrow) **(b)**.

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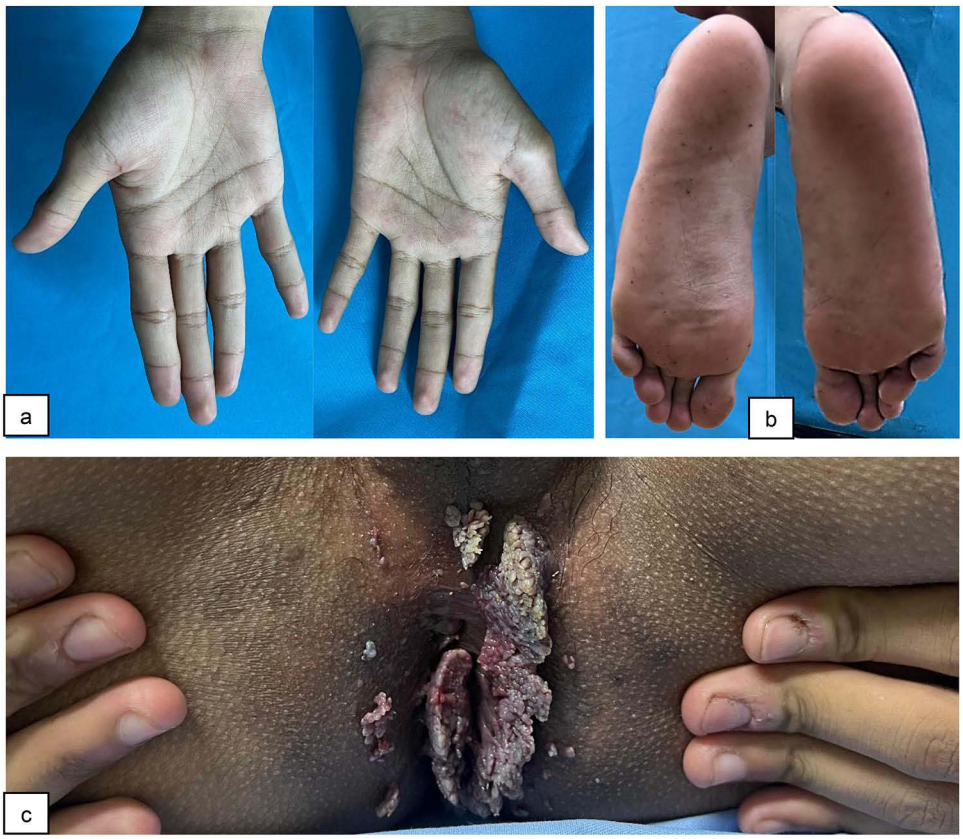

Figure 3 Erythematous macules with collarette scales on palms and soles **(a** and **b)**, and skin-colored papules and plaques on perianal area **(c)** after one month therapy benzathine benzylpenicillin G.

the psychiatric department due to a history of sexual abuse and was diagnosed with an episode of moderate depression. The patient refused to consume medication and was given supportive psychotherapy.

Discussion

Sexual abuse is a widespread issue affecting human rights and public health. This condition affects individuals regardless of race, class, socioeconomic status, sexual orientation, or gender identity.[11] Sexual abuse is a critical public health issue that demands considerable attention from the public, society, and the judicial system. Current estimates show that over 27% of men and more than 32% of women have experienced sexual abuse at some point in lives.[6] Multiple risk factors contributed to the increased vulnerability to sexual abuse, particularly among certain populations. A key risk factor is young age, with those under 18 reporting the highest rate of sexual abuse.[11] In a study of 20 adolescents in Dublin Ireland, the majority of abuse was commenced before the age of 10, although delays in disclosure were evident and many children did not report the abuse.[12] Additionally, homophobic prejudice, recent membership in MSM communities, and a history of sexual abuse or violence were also associated with an elevated risk of experiencing sexual abuse.[11]

A study by William et al in America found that over one-third of MSM population, both homosexual and bisexual, experienced sexual abuse.[13] WHO defines sexual abuse as any act, attempt to obtain a sexual act, unwanted comments or advances, or acts to traffic, or otherwise directed, against an individual sexuality using forces, in any setting, including but not limited to home and work. Sexual abuse, particularly in MSM, significantly increases the risk of HIV transmission, often through unprotected anogenital intercourse, and is commonly associated with infections, such as *N. gonorrhoeae* and *C. trachomatis*. Victims should also be screened and treated prophylactically for other diseases, including syphilis.[14] Centers for Disease Control and Prevention (CDC) provided guidelines for evaluating and treating sexual abuse victims. CDC recommends that MSM need to undergo anal screening for *C. trachomatis* and *N. gonorrhoeae*, as well as serum testing for HIV, hepatitis B virus (HBV), and syphilis.[15] Screening for STI is becoming increasingly important due to the high

incidence of MSM group.[2] In 2003 and 2013, the proportion of MSM infected with HIV and newly diagnosed syphilis increased from 9.3% to 19.0%. According to a previous study, aggressive treatment was needed for HIV patients with syphilis.[2] CDC recommendation showed the triple elimination program by WHO which primarily targeted pregnant women to prevent transmission to the child. This program needs to expand to MSM population,[16] as marrying man might become a silent mode of transmission among couples in Indonesia.[17]

Correct and consistent condom use is the most effective method to prevent HIV and other STI including syphilis in sexually active MSM. Data from the USA National Survey of Family Growth from 2002, 2006–2010, and 2011–2013 showed that only 31% of MSM reported condom use at last sexual intercourse.[10] In addition, data from WHO reports a decline in condom use among sexually active adolescents from 2014 to 2022, with usage dropping to 61% from 70% among males and to 57% from 63% among females.[8] The prevalence of condom use in Indonesian adolescents in 2015–2019 was below 13%.[9]

Sexual coercion, the act of being physically, psychologically, financially, or otherwise forced or tricked into engaging in sexual activity increases the risk of adolescents for infection with HIV and other STI including syphilis.[18] According to Kalichman et all, one-third of gay and bisexual men reported sexual coercion revictimization.[19] Adolescents often select not to disclose sexual abuse, thereby preventing access to help and allowing perpetrators to continue undetected. Based on the study conducted by Mc Elvaney et al (2014) on adolescence age 8–18 in Ireland, up to 73% of subjects had a delay in disclosure of abuse by vaginal and anal intercourse ranging from 1–9 years. The reasons for delay include limited support, perceived negative consequences, and feelings of self-blame, as well as shame and guilt.[20] A study conducted by Tomori et al found that 289 (2.5%) of the 11,788 MSM participants experienced childhood sexual abuse. This occurrence was associated with HIV-related behavior, and an increase in the rate of lifetime HIV-related behaviors and experience.[21]

The incidence of syphilis among HIV-positive patients, particularly MSM, ranges from 2.9 to 6.2 per 100 individuals in Europe, with prevalence in Asian cities from 0.9% to 30.9% between 2000 and 2019. Countries, such as Indonesia, Bangladesh, Myanmar, and India report significant rates of syphilis. In these countries, there was a strong correlation between syphilis in MSM and HIV, where 50% of cases are HIV-positive.[22] The term MSM includes a diverse group, such as homosexual, bisexual, transgender, and self-identified heterosexual men who engage in same sexual activities.[13] The Kinsey Scale, developed in 1948, showed sexual orientation as a continuum with seven points ranging from exclusively heterosexual to homosexual.[23]

Syphilis is an STI caused by *Treponema pallidum* (*T. pallidum*) and transmitted sexually or vertically. Sexual transmission occurs through oral, vaginal, or anal contact, while vertical transmission passes from an infected mother to her unborn child through the bloodstream.[24,25] In Brazil, the detection rate of syphilis among adolescents aged 13 to 19 has increased by 1,654%, showing the critical nature of the epidemic.[24] Key populations affected include MSM, transgender, people who inject drugs, female sex workers, and clients.[25] This case report presents a 15-year-old MSM who contracted syphilis through anogenital intercourse.

Syphilis progresses through four distinct stages, namely primary, secondary, latent, and tertiary.[26] Secondary syphilis occurs when *T. pallidum* reaches peak concentration in the bloodstream and tissues.[27] About 75% of secondary syphilis cases have erythematous macules and collarette scales on the palms and soles, typically appearing three to 12 weeks after the initial lesion.[28,29] Other signs include patchy non-scarring alopecia (moth-eaten alopecia), mucous patches in mucous membranes, and condyloma lata, which are moist, wart-like papules or plaques commonly found in the anogenital area.[30] In this case, the patient had erythematous macules and collarette scales, as well as skin-colored papules and plaques, suggesting secondary syphilis.

Diagnosis of syphilis can be confirmed through serological assays, such as TPHA and VDRL.[25] Individuals with immunodeficiency, particularly those with a CD4+ T lymphocyte count of 350 cells/mm^3 or fewer, or a VDRL titer of 1:32 or higher, are at increased risk for cerebrospinal fluid abnormalities.[31] In this case report, the patient tested positive for syphilis with VDRL titer of 1:64 and reactive TPHA. Although a lumbar puncture for neurosyphilis screening was negative, a biopsy of perianal papules showed histological results consistent with verrucous secondary syphilis. Treatment was administered following the 2016 Indonesian Ministry of Health guidelines,[32] with the patient receiving a single dose of 2.4 million IU benzathine benzylpenicillin G, resulting in clinical improvement.

The consequences of sexual abuse include physical and psychological trauma which increases the risk of having STI.[3] Psychological effects of sexual abuse include low self-esteem, depression, post-traumatic stress disorder, sleep difficulties, self-injury, suicidal behavior, psychotic disorder, and auditory hallucination.[33] Male adolescent victims of sexual

abuse used drugs more frequently, experienced depression, had lower self-esteem, and were more hopeless about the future. This group also had more difficulty controlling sexual feelings and was more concerned about physical appearance than the non-abused counterpart.[34] Due to the abuse, the patient was diagnosed with episode of moderate depression, characterized by loss of interest, persistent sadness, hypersomnia, decreased motivation, self-blame, and self-harming behaviors without suicidal intent, the patient was then treated with supportive psychotherapy.

Conclusion

In conclusion, syphilis and HIV infection were highly prevalent in MSM patients, with sexual abuse being a common contributing factor. To improve management, a thorough evaluation of individuals who experienced sexual abuse including implying the triple elimination to this population was essential for the provision of treatment for STI and also psychological evaluation and management.

Ethical Statement

The patient's mother gave full permission in the form of written consent for the publication of photographs, and textual material (case histories) in the publication. Institutional approval was obtained to publish the case details from Dr. Hasan Sadikin Hospital Ethical Committee with ethical approval number DP.04.03/D.XIV.6.5/483/2024.

Consent Statement

The authors attested to be in the position of all necessary patient permission paperwork. A consent form allowing the release of the case data and figures was signed.

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Disclosure

The authors report no conflicts of interest in this work.

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