COMPLICATED CATARACT BY SYPHILITIC CYCLITIS

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A case of latent syphilis presented with unilateral cataract which developed most probably as a complication of syphilitic cyclitis which he had during the secondary stage of the disease. Blood VDRL was reactive at 1:32, but CSF was normal. Aqueous humour and the extracted lens material did not contain any *Treponema pallidum*.

Key words : Ocular syphilis, Cyclitis, Cataract, Uveitis.

Syphilis can involve practically every structure of the body in its course. In the eye, uveitis is the commonest manifestation.[1-4] It develops late in the course of secondary syphilis[4] and it is sometimes the only manifestation of relapsing early syphilis. These patients usually present with pain and redness of the affected eye. Recently, we observed a patient with latent syphilis who reported for defective vision of one eye. Examination revealed unilateral complicated cataract which most probably followed syphilitic cyclitis.

Case Report

A 32-year-old unmarried male reported for defective vision of his right eye since 6 months. He had had recurrent attacks of mild pain and redness of that eye for 5 months before the onset of defective vision. He had been applying various eye ointments which contained corticosteroid and antibiotics, but without any relief. He gave history of an ulcer on his genitalia which developed one month after sexual intercourse with a prostitute, 1½ years ago. The ulcer healed spontaneously in 5 weeks, but the patient developed a generalised rash associated with arthralgia. He had not received any specific treatment for this. He denied history of any trauma to the eye. There was no personal or family history of tuberculosis. General physical and systemic examination did not reveal any abnormality. There was a circular, thin and atrophic scar on the prepuce. In the right eye, the vision was reduced to mere perception of hand movements. There were no obvious signs of anterior uveitis like circumcorneal congestion, loss of iris pattern, irregularity of pupillary border due to posterior synechiae and uveal pigment deposition on the anterior surface of the lens. The lens was found to be cataractous (Fig. 1). The intraocular tension was normal. Slit lamp examination revealed a few small keratic precipitates on the endothelial surface of the lower part of the cornea. There was no aqueous flare. The left eye was found to be normal.

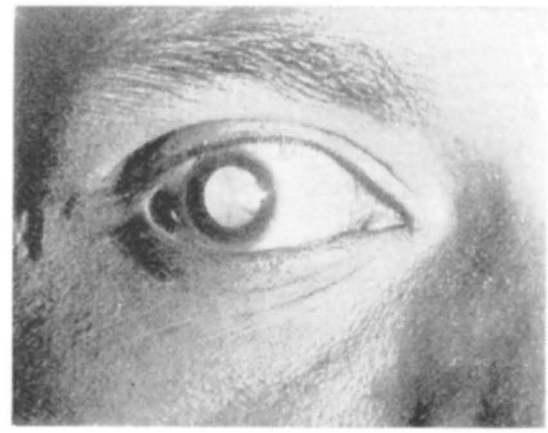

Fig. 1. Unilateral cataract of the lens in a patient with latent syphilis.

Routine laboratory tests on blood, urine and stools were normal. Blood VDRL test was reactive at 1 : 32 on two occasions. Mantoux test was negative. ECG and X-ray of the chest

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were normal. VDRL test on CSF was negative and there was no increase in cells. The concentrations of sugar and proteins also were normal. Intra-capsular lens extraction was done under local anaesthesia. One ml of aqueous humour was collected during surgery. Dark-field microscopic examination showed no *Treponema pallidum* in the aqueous humour. VDRL test also gave a negative result with this fluid. Histopathology of the extracted lens material did not show any spirochaetes on Levaditti's stain. The post-operative period was uneventful. He was given antisyphilitic treatment with one injection of 2.4 mega units of benzathine penicillin. In the follow-up period, ophthalmoscopy showed normal fundi. Vision was improved to normal 6/6 with aphakic correction. There was a gradual fall in the reaginic titre in blood which gave a negative result to VDRL test at the end of one year.

Comments

Anterior uveitis is the common ophthalmological manifestation of secondary syphilis. Development of a generalised rash and eye lesions following an ulcer on the genitalia after a sexual exposure suggest that the patient had secondary syphilis in the past. There were no signs and symptoms of activity of the eye lesion when he was seen by us. He had only a complicated cataract most probably secondary to syphilitic cyclitis. Examination did not show any evidence or sequelae of anterior uveitis. Involvement of the ciliary body alone in secondary syphilis is rare, though syphiloma may involve only the ciliary body.[5] Our patient had been applying corticosteroid eye ointments. In the absence of appropriate treatment for syphilis, corticosteroid therapy is highly dangerous. A case of syphilitic anterior uveitis reported by Kranias et al[3] failed to respond to increasingly aggressive therapy with topical and systemic corticosteroids and his disease progressed to pan-uveitis and neuroretinitis, but was finally cured with penicillin therapy. Because of the resurgence of syphilis in the general population and the dire consequences for the patient in the absence of appropriate therapy, every ophthalmologist needs to consider the possibility of syphilis in his patient with uveitis. He should undertake serologic tests for syphilis at the earliest. Cataract would not have developed in the present case if he had received antisyphilitic treatment in the early stage itself.

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