A CASE OF SECONDARY SYPHILIS WITH IRIDOCLITIS TREATED WITH LEDERMYIN

By

(Mrs.) K. VIMALA BAI* & LAKSHMI DHANANJAY **

Untreated cases of primary syphilis after a period of one to six months after the appearance of primary sore usually get into the second stage of the disease. Prodromal symptoms of early secondary syphilis are pain all over the body, pain in the joints, severe headache: often worse at nights (nocturnal pains) low fever, loss of appetite, loss of hair, evanascent sore throat etc. when these conditions are rarely diagnosed as due to syphilis. It is specially so when the patient denies the history of exposure and having developed an ulcer over the genitals if at all such a history is asked in the general O.P.D. where he attends for the above mentioned complaints. Patient denies the history either out of shame in the midst of other patients and students who usually crowd themselves in the O.P.D. of the teaching hospitals or he attaches little importance to what has happened some months back. In some cases primary sore would not have been noticed or missed due to the painless nature of the ulcer.

Patients who attend the V. D. Dept. usually come with skin, mucous membrane or muco-cutaneous junction or skeletal syphilis during the second stage of syphilis.

Out of the total number of V. D. cases that attended the V. D. O.P.D. of Gandhi Hospital 3.06% are cases of secondary syphilis which constitute 10.8% of the total cases of syphilis. They attend the department with various mainfestations of secondery syphilis. This stage of syphilis is usually referred to as "early generalised syphilis". Syphilis becomes generalised much earlier than the generalised manifestations are clinically noticed.

It has been pointed out that Tr. Pallida may arrive in the general blood circulation within a few hours or even minutes after inoculation and during the incubation period Tr. Pallida have been recovered from the C. S. F. But six to eight weeks after the formation of chancre, multiplication of Tr. Pallida throughout the body has proceeded to such an extent as to excite reaction in various tissues, more specially in the skin, mucous membrane and lymphatic glande. It is a well known fact that every part of the human system is involved during the second stage of syphilis.

Ocular Syphilis. (Syphilis of the eye).

Congenital syphilis. The most common eye lesion is the interstitial keratitis Chorioretinicis, unassociated with I. K occurs fairly often. There are many small yellow dots and pigment clumps in the peripheral fundus giving the typical salt and

*Civil Surgeon Venereologist, **Tutor in Venereology, Gandhi Medical College, Hyderabad
Received for publication on 19-6-69.

pepper appearance. In other cases chorio retinitis occurs as larger isolated patches or may have the appearance of retinitis pigmentosa. Luetic conjunctivities and Dachroadenitis is rare.

Acquired syphilis. Ocular chancre on the eye lids are rarely seen. Primary lesions on the conjunctiva are even more rare. iritis, iridocyclitis in the second stage of syphilis along with skin rash is seen in about 5% of cases. The iritis is acute with fibrous exudate in the anterior chamber. Posterior synchias are common.

Other less common ocular manifestations of acquired syphilis are interstitial keratitis, chorioretinitis, which occurs much less frequently in acquired than in congenital syphilis. Chorio-retinitis is usually wide spread and ofien destroys useful vision.

During the third stage. Gumma may rarely involve the optic nerve and causes optic atrophy.

Neuro Opthalmological Conditions

1. Argyl Robertson pupil in tabes and tabo paresis. 2. Complete opthalmoplegia. 3. Optic nueritis is due to basal meningitis and may result in retro bulbar nueritis. 4. Optic atrophy follows severs chorio retinitis or optic nueritis. 5. Third cranial nerve is more commonly involved causing individual intra ocular muscular palsies. 6. Sixth nerve is less frequently involved. 7. Fourth nerve is most likely to be involved.

It is found that 16% of the patients attending eye hospitals have shown a positive serology.

The purpose of this article is to present a case of secondary syphilis with Iridocyclitis :—

Name : J. A. V. D. O. P. No. 139/13-2-69. Age : 20 years. Unmarried resident of S. occupation : Sepoy in the army complaint : 1. rash all over the body since 4 months. 2. redness of the eye and waterings since 1 month.

History of Present Illness

Patient first noticed rashes over the inner aspect of both his lower part of the legs, which gradully involed the thighs. By about a month's time, patient says that the rashes involved his upper limbs and back and were reddish in colour. There was no itching from the beginning. After a month's time the rashes turned yellowish in colour, but he says that there was no discharge or puss formation. Patient says that one month back that is 3 months after the appearance of the skin rash while he was travelling in a train he noticed that his right eye was red but there was no watering. A few hours later after reaching home the redness has increased and there was watering and photophobia-left eye was not involved at that time but since one week slight redness of the left eye is noticed.

Patient has not taken any treatment for the complaint till he was admitted in the hospital.

History of exposure 5 months back. Patient is not aware of any ulcer over the genitals after the exposure. Previous illness nothing of importance. Habits: Smokes one packet of cigarettes a day. Drinks once in a way, Diet-Mixed, Sleep-Normal Bowels and Nucturition-Normal, Family History: Unmarried. Mother and father alive and healthy 5 sisters and 2 brothers-all well.

On examination: Patient is a farily nourished young man who speaks English fluently- looks depressed but answers questions politely. Looks anaemic, not jaundiced.

Tongue coated and moist, hair and nails normal.

Skin: Maculo papular rashes in groups on the inner aspect of the arms, thigh, abdomen, chest and back, Face, palms and soles are completely free. The lesions are circular, vary in size from a pin head to a split pea. The lesions are arranged in groups (wide photo) brownish yellow in colour and are indurated. Posterior cervical and Inguinal glands are palpable-epitrochlears are not palpable-No scratch marks are seen. No mucous membrane lesions are seen. No scar on the genitals. Prepuce not phimotic, uncircumcised.

Eyes: Conjunctiva of both eyes is congested, circumcorneal congestion is more marked on the right eye than in the left. Watering of both the eyes plus pupils appear irregular, react to both light and accommodation.

C. V. S: Pulse 96/min. regular. volume and tension good. Resp. System N.A.D. C.N.S. N.A.D. Abdomen, lever and spleen not palpable.

Case referred to the eye specialist and reported as acute Irido cyclitis of both the eyes. With circumcorneal congestion, hypopion with posterior synchiae-Advised atrophin 1% ointment and Efcorlin eye ointment.

Clinical Diagnosis. Secondary syphilis with Iridocyclitis. Investigations V. D. R. L. Reactive in 16 dilution, Total W. B.C. 6,200, Total R.B.C. 3.5 m, blh : 75% D.C,P. 60%, L. 28%. E. 2%, M 10%, Hb 75%,D. C. P. 60%, L. P. done fluid slightly under tension clear. Cell count 2 cells/cc. Proteins 30 mgm %. Sugar 50 mgm % Chlorides 700 mgm %. V. D. R. L. Non-reactive. Treatment. 15-2-69.

1. Ledermysin 300 mgm caps every 8 hours (900 mgm daily).
2. Vit. B. Complex 2 cc I. M. alternative days.
3. Ffcorlin eye ointment to the eye three times daily.
4. Atropine eye ointment to the eye.

25-2-69. The skin lesions became flat and black and like pigmented macular rashes showing signs of healing, congestion of the eye improved, watering and photophobia much less and the patient said he is able to see better.

The same treatment was continued for 20 days and a total of 18 gms of Ledermysin was given.

On 5-3-69. The skin lesions completely cleared at the end of treatment, leaving only a faint macular rash. The congestion round the cornia cleared but the pupils were dilated and grossely irregular. The case was again referred to the eye department for assessment of the result of treatment-clinically there was marked improvement of the eye.

8-3-69. Granulomatous iridocyclitis with posterior synchae fundus: hazy media more in the R. E. than in the L. E. Disc. slightly hyperaemic-Retina and choroid appear normal. Gramulomatous infection of both eyes in the anterior segment only.

14-3-69. Festooned appearance and synechae yet to break up-completely-suggest subconjunctional, Decadron bi-weekly-which was given.

18-3-69. V.D R.L positive-4 dilutions

21-3-69. Pupils regular in shape

Discussion

Syphilitic irritis and iridocyelitis are a frequent affection in tropical practice usually coming on just after the cutaneous rash has faded or during the period of early latency. In this case reported, the condition appeared three months after the appearance of the skin rashes. It is commonly described that one eye is affected first and the other eye follows later. In the case reported also the right eye was involved first and then the left eye was involved. Both the eyes completely cleared with A. ST but the eye lesion took a longer time to heal than the skin lesions. Though both eyes were involved in this case, there was no lesion on the face. Patient was given ledermycin as an alternative to penicillin since the patient gave a history of fainting after taking penicillin injection some months back.

Ledermycin as an alternative to penicillin in the treatment of syphilis was reported by Short and Nose. They presented in an exhibit at the annual convention of the Medical Society of the State of New York on February 14th, 17th, 1966. The authors concluded that cases of infective syphilis treated with total 12 gms and 18 gms schedule of dimethyl chlor tetra cycline (Ledermycin) is an effective antibiotic in the treatment of early syphilis. Both the 12 gms schedule and 18 gms schedule that is 300 mgm. every 6 hours for 10 days and 15 days gave results equal to that of benzathene penicillin and indicated that administration of more than 12 gms offers no advantage.

Summary

Syphilitic affections of the eye are discussed.

A case of syphilitic iridocyclitis with secondary skin rash is presented-Treatment with ledermycin as an alternative to penicillin is discussed.

Acknowledgement

Our thanks are due to Dr. N. R. V. Swamy, Superintendent Gandhi Hospital who permitted us to publish the case.

Our thanks are all due to the Eye Department of Gandhi Hospital who examined the eye condition.

References

1. General Ophthalmology by Danual Vanghan Robert Cook, Taylor Arbusy—page 237
2. Venerial diseases by P. N. Rangiah, Madras Medical Journal September 1961/62—page 13
3. Short D. H & Knox J. M–Syphilis treated with antibiotics other than penicillin–A scientific exhibit presented at the annual convention of the Medical Society of the State of New York, New York City–Feb. 14th–17th 1966.
4. Text Book of Venereal diseases and Trepanomaltosis by R. R. Willcox.