

GUMMATOUS SYPHILIS (A case report)

K. M. ACHARYA,* P. K. KSHATRIYA,† P. J. VYAS,‡ L. U. GAMI|| AND
V. M. DANIDHARIA §

Summary

A rare case of gummatous syphilis of the scalp involving underlying bones in a 50 years old male is reported. The diagnosis was confirmed by history, clinical examination, serological and radiological findings. Salient radiological features regarding gummatous osteitis are described.

The peak incidence of lesions of tertiary syphilis is from 3 to 10 years after the primary infection¹, after which there is a sharp drop². Yet there have been isolated reports of gumma appearing many years after the infection even as long as 60 years².

Herewith we are reporting a rare case of tertiary syphilis which developed 25 years after the primary infection and involved the scalp as well as the underlying bones.

Case Reports :

A 50 years old Hindu watchman was admitted to the Skin ward, Irwin Group of Hospitals, Jamnagar on 15-4-1978 with chronic, non-healing ulcers of the scalp of 3 years' duration. A detailed history revealed that he had sexual

exposure 25 years before. After 4 weeks of exposure, he developed a penile sore followed by bilateral inguinal lymphadenopathy. No treatment was taken for this. The sore and lymphadenopathy subsided on their own. Thereafter, he was all right, till 3 years prior to admission when he developed a slow growing, painless swelling on the frontal region of the scalp, which ruptured and resulted in ulceration. This healed without any treatment within 2 months, leaving noncontractile, atrophic scarring. Similar lesions started on the fronto-parietal region after 3 months and again subsided spontaneously leaving atrophic scarring. Patient developed another ulcer in the parietal region one year prior to his hospital visit. For this he was treated by various doctors with topical agents without any benefit.

Detailed systemic examination did not reveal any abnormality.

Local Examination :

Revealed non contractile, irregular atrophic scars of the previous ulcers on the frontal and fronto-parietal regions. A well defined, irregular, painless ulcer was seen on the parietal region with

* Assistant Professor in Dermatology and Venereology, MP Shah Medical College, Jamnagar.

† Professor and Head of Department of Radiology, MP Shah Medical College, Jamnagar.

‡ Registrar in Dermatology & Venereology

|| House Physician in Dermatology and Venereology.

§ House Physician in Dermatology and Venereology.

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serous discharge and granulation tissue in the base (Fig 1).



Fig. 1 Showing gummatous ulceration on parietal region and atrophic, non-contractile scarring on fronto-parietal region of previous healed ulcers.

Investigation :

Routine blood, urine and stool examinations showed no abnormality. Blood V.D.R.L. test was positive. C.S.F. examination including C.S.F. V.D.R.L. was normal. X-ray of the skull (A.P. view) showed mottled pattern of decreased and increased density with ill-defined edges, mainly involving frontal and parietal bones on both sides. The lateral view of skull revealed irregular outline of external diploe extending fairly deep into the diploic space without involvement of inner diploe. These uneven areas showed sclerotic changes and one small sequestrum beneath the scalp. The mixed pattern of osteolysis and sclerosis with involvement of external diploe and very small sequestrum in superficial areas were consistent with a diagnosis of syphilitic infection due to acquired syphilis^{3,4} (Gummatous Osteitis), (Fig. 2 & 3). Radiological examination of the chest, bones of forearms and legs did not show any patho-

logical change. Histo-pathological examination of the ulcer showed features consistent with gumma.



Fig. 2 AP view of the skull

Discussion

A gumma is a mass of syphilitic granulation tissue. It most often starts in the subcutis, grows into the dermis and into the underlying tissues^{2,5}. Gumma is nearly always painless. It shows characteristically necrosis, which begins in the centre where the tissue



Fig. 3 Lateral view of the skull

turns into a slimy, stringy mass, the "gumma"⁵. Gumma may appear anywhere on the skin but are particularly common on the scalp, face (forehead,

nose and lips), skin over the sternum and sterno-clavicular joints^{1,5}. The bones most commonly involved are the tibiae, the cranial bones, shoulder girdle, femur, fibula, humerus and the bones of forearms. Endarteritis produces ischaemia, necrosis, sloughing, destruction and scarring. These lesions are non-infectious and are apparently due to massive reaction (? allergic) to a small number of organisms.

Our case was typical in its clinical, serological and radiological features but was interesting in the unusually delayed occurrence of this late manifestation of syphilis.

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References

1. King A & Nicol C: Venereal Diseases : ELBS, 2nd Ed 1969, p-30.
2. Richard L, Sutton RL: Diseases of the skin : CV Mosby Co. St. Louis, 1956, p-403.
3. Murray RO & Jacobson HG: Radiology of skeletal disorders : Churchill Livingstone Publishers, London, Vol : 1, 2nd Ed. 1977, p-415.
4. Sutton D & Grainger RG: Textbook of Radiology : Churchill Livingstone Publishers, London, 2nd Ed. 1975, P-58.
5. Rook A, Wilkinson DS and Ebling FJG: Textbook of Dermatology : Blackwell Scientific Publication, Oxford, London, Vol 1, 2nd Ed. 1972, p-655.

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— *Managing Editor*