Clinical and Other Notes.

TABES DORSALIS, AORTIC ANEURISM, AND CUTANEOUS SYPHILIS PRESENTING IN THE SAME PATIENT.

BY
Lieutenant-Colonel J. W. EAMES.
Royal Army Medical Corps.
Adviser in Venereology to the Army.

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The simultaneous existence of tabes dorsalis, aortic aneurism, and nodular cutaneous syphilis is considered to be of sufficient rarity and interest for the case described below to be worthy of record. For while it is most improbable that this combination has not been described before, a thorough search of the available literature has failed to find any reference to this.

The combination of cardiovascular and cerebrospinal syphilis is much more common than was supposed to be the case early in the present century. Holger Buch (1945) quotes Berger, Rosenbach, Ruge Huthner, Rogge Muller, and Stadler as stating that cardiovascular lesions were complicated by tabes in only 4 to 10 per cent of cases, whereas later figures proved to be considerably higher. Moore, Danglade, and Reisinger are quoted as having found syphilitic skin lesions in 2.5 per cent of patients with aortic aneurism. Cole and Usilton (1936) from observation of a series of cases of syphilitic aortitis state that concomitant involvement of the skin is rare, i.e. 4 per cent of cases, and that the most frequent co-existent involvement noted by them was cerebrospinal syphilis—45 per cent of cases—25 per cent parenchymatous. It was also observed that concomitant syphilis of the central nervous system in cases of aortitis with aneurism was parenchymatous in nearly all instances. Skin involvement and aortic aneurism only occurred together in one patient of their series.

The patient, a Service man, 37 years of age, married, with two children (boy, 10 years, and girl, 3 years) was referred to the Special Treatment Centre at this hospital on April 22, 1947. He had a history of having had a rash for some years, recently the W.R. had been found to be positive, and on further examination by X-ray it had been discovered that there was dilatation of the aortic arch. The patient stated that he had always led a strenuous life, and also played games regularly. His work had been very hard physically since the age of 19, but for the last two and a half years, as he had been directing operations, he had been in a position to avoid actual exertion. This fact he had taken advantage of, as he had found that recently he tired more easily.

He had always been perfectly fit and well until four years ago, when in India he started to have attacks of "palpitations" at irregular intervals of about two months. Each attack commences with palpitation, followed by a feeling of constriction of the chest and pain over the precordium, and finally a feeling of faintness, but no loss of consciousness. The attack is followed by intense frontal headache and a "tired feeling."
Both exertion and excitement seem to precipitate these attacks, which have continued with much the same periodicity and severity until the present time.

At about the same time as the above symptoms commenced, he states that he began to wake up at night to find that he had either voided urine, or had the desire to micturate, and was unable to hold his urine until he could reach the latrine. His records show that on three occasions during 1943 he was investigated for cystitis, and in June, 1946, was treated for an attack of B. colit cystitis. These urinary symptoms have occurred on and off irregularly up to the present time. His urine had been repeatedly examined during the last few months, but no abnormality had been noted. No history suggestive of lightning pains or impairment of sexual function could be elicited.

In India during May, 1945, the patient stated that he broke out in a rash over the face, forehead, axilla, right shoulder and upper arm. He described the rash as being scaly and circinate in character. According to records the condition was diagnosed as tinea corporis, but fungus was not found in scrapings from the lesions. There was no record of a Wassermann reaction or Kahn test having been carried out. He was treated with fungicidal preparations, both as an in-patient and an out-patient, and by August, 1946, all areas had cleared except those on the right shoulder and upper arm. These areas failed to heal in spite of repeated treatment, and his return to England, he states.

The patient has denied all history at all suggestive of his having had venereal disease. But he admits to having “taken possible risks on occasion, but with precaution” prior to his marriage twelve years ago.

As regards family history, the patient states that his mother died when he was 2 years old—cause of death unknown. He himself was the fifth child of the marriage—two brothers died before he was born, one at under 1 year of age, and the other at under 2 years of age, cause of death unknown. The patient has two older sisters—born in 1903 and 1906 respectively, both of whom are alive, and he thinks in good health. His father is in good health aged 83. As regards the patient’s wife and children, there is nothing suggestive of a past or present luetic infection, from either history or physical examination, and repeated W.R. and Kahn tests have been negative.

When first seen the patient was a well-nourished man. His speech was normal and there were no apparent mental changes. His gait was somewhat unsteady, especially on turning. On examination there was some suggestion of frontal bossing, flattening of the malar regions, and a suspicion of rhagâdes at the angles of the mouth. The hard palate had a narrow high arch. There were two small round brownish-red nodules each about 1/3 inch in diameter on the right side of the chin, which the patient stated had been present for the last three months.

On the front of the right shoulder there were two typical annular syphilitic lesions covering an area of about 3 inches in diameter, and there was one similar lesion about 1 inch in diameter on the middle of the lateral aspect of the right arm. Each of these lesions consisted of a circle of small brownish-red nodules. Repeated dark-ground examinations of scrapings failed to show T. pallidum.

The clavicles and tibias appeared normal, and X-ray examination revealed no abnormality. The pulse was 80 and regular. The blood-pressure was 110/80 mm.Hg in both arms. On percussion, the area of cardiac dullness at the second interspace extended 2 inches to the right of the sternal margin. On auscultation the aortic second sound was found to be markedly accentuated. X-ray of the heart and vessels showed a mediumsized aneurismal dilatation of the ascending aorta commencing close to the aortic ring and exhibiting forcible pulsation.

The pupils reacted sluggishly to light, otherwise the cranial nerves were normal. The optic discs were normal. The abdominal reflexes were present, but all deep reflexes were absent. Plantar reflexes gave a flexor response. There was a loss of appreciation of light touch, and of sensibility to superficial pain over both shins. There was loss of sensation of pain on deep pressure in both tendo Achillis and calf muscles. There was no loss of vibration sense. Rombergism was marked and the gait unsteady, otherwise co-ordination was normal. Motor power was normal.
The blood Wassermann reaction was found to be positive (confirmed), and the quantitative Kahn test 10 Kahn units. The cerebrospinal fluid was clear and not under pressure. Laboratory examination of the cerebrospinal fluid showed: Cells 1 per c.mm. Protein 40 mg. per 100 c.c. Globulin slightly increased. Lange normal. W.R. positive.

In view of the possibility of a Herxheimer reaction, the patient was first given weekly intramuscular injections of 0.2 gramme bismuth before commencing penicillin, and the cutaneous lesions of the face, right shoulder and arm at once began to heal rapidly. During the early part of treatment he had an exacerbation of the urinary symptoms previously described, and B. coli were cultured from the urine. The infection responded to sulphonamides.

**Comment.**

This case shows two interesting features. The patient when first seen was found to be suffering from an annular cutaneous syphilide, an aneurism of the ascending aorta, and tabes dorsalis. Judging from the history, it would appear to be possible that the tabetic symptoms and the symptoms referable to the aneurism appeared almost simultaneously, and the cutaneous lesions appeared about twelve months later.

While it is impossible to be certain that this is not a case of acquired lues, the family history, the absence of any previous lesions, the slender but suggestive evidence of facial appearance, and the fact that the disease was not transmitted to the patient's wife and children would all suggest that the infection might possibly be congenital in origin. Unfortunately, the other members of the family could not be examined, and so further confirmatory evidence is lacking.

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**References.**


**Lichen Planus Linearis.**

**By**

Major R. J. McGill, M.B.

*Indian Medical Service.*

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The following case of lichen planus linearis in an African soldier had some unusual features.

**Case-history.**—Private K., aged 23, of normal physique and temperament, stated that at the end of March, 1943, he developed fever with malaise and nausea but no vomiting, and accompanied by generalized pruritus, day and night. After one week, the fever subsided, but coincidentally a rash with linear distribution appeared on the left of the