ATYPICAL PRESENTATION OF NEUROSYPHILIS

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INTRODUCTION

Syphilitic infections of the nervous system have shown a tremendous decrease during the present century, and particularly since the introduction of penicillin. Early misgivings that the widespread use of penicillin for treating other conditions would often mask early syphilis also appear to have been unfounded. However, partial suppression of infection can lead to neurosyphilis appearing later in atypical and attenuated forms with consequent difficulty in diagnosis¹. Paradoxically the success of treatment brings its own particular risks; as the disease becomes increasingly rare it runs the hazard of being more often overlooked. Neurosyphilis may be rare nowadays but it still represents one of the most important infection of the nervous system, which is encountered in psychiatric practices²⁻⁴. Roberts and Emsley⁵ reported 21 patients admitted to acute psychiatric units with neurosyphilis, in only three of whom the diagnosis had been considered before the results of routine serology were known. The initial diagnoses had encompassed schizophrenia, depression, mania and hysteria, in addition to delirium and dementia. In another series only 24 out of 91 cases were diagnosed as having neurosyphilis from the outset. The most common initial diagnoses were of depressive illness, dementia, confusional states, schizophrenia, hypomania and epilepsy⁶.

CASE REPORT

Mr. N, a 40 years old man presented with gradually progressive intellectual and memory impairment for ten months and repeated episodes of generalized tonic-clonic convulsions for two days. He was managed with tab. carbamazepine 800 mg/day which controlled his seizures but the remained delirious and disoriented. CT Scan (Head) and MRI scan revealed no abnormality. Serum electrolytes, blood sugar, blood urea, serum creatinine and other investigations were also within normal limits. However, his serum VDRL (Venereal Disease Research Laboratory) Test) was positive. Neurosyphilis was strongly suspected and CSF examination was done. CSF VDRL and CSF TPHA (Treponema Pallidum haemagglutination test) were positive. He was diagnosed as a case of Neurosyphilis and injection crystalline penicillin 40 lakh units every six hours intravenously was given for three weeks. He showed gradual improvement and was no more delirious. He became cooperative and ophthalmic examination was possible which revealed that direct reaction was absent, consensual reaction was present and accommodation reflex was weak.

After recovery the patient revealed that he has had multiple sexual contacts with many females including prostitutes since the age of 15 and also had genital ulcer twelve years back for which he received no treatment. He was

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discharged in nearly asymptomatic condition. He was regularly followed; blood and CSF serological tests were repeated after three months, which were negative. Though mild cognitive deficits still persist, he has resumed his normal life except that he is unemployed at present.

reactions and tendon reflexes and to check regularly with serological tests.

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DISCUSSION

In addition to the risk of overlooking the disease on account of its rarity, we nowadays face the additional problem that neurosyphilis can occur in atypical or attenuated forms. This may be due in large measure to unwitting practical suppression of the infection in the earlier stages by antibiotics given for other purpose. Thus while fully developed examples of general paresis and tabes dorsalis have become rare, modified forms of neurosyphilis with atypical presentation and relatively minor symptomatology are increasingly encountered. In a series of 241 patients, almost half presented with unrelated symptoms, the diagnosis being made by routine investigation after suspicion had been aroused by neurological or ocular findings⁷. In a quarter the presentation was with focal or generalized seizures. Twelve percent presented with declining vision or other ophthalmological features, and 11% with confusion following a cerebrovascular accident. Only 5% had the full clinical picture of general paresis. Therefore, it is important for all clinicians to keep neurosyphilis in mind, look carefully for the cardinal signs in the pupillary