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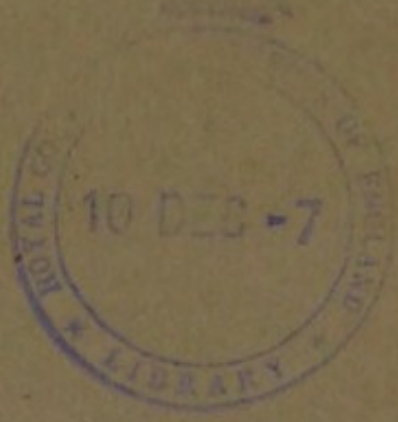

MANIFESTATIONS OF SYPHILIS ASSOCIATED WITH PULMONARY TUBERCULOSIS.*

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While some textbooks devote attention to the methods employed in distinguishing between the lesions of syphilis and tuberculosis, the recognition of the coexistence of the two affections has not received the consideration which it seems to deserve.

During the last two years I have observed fifteen cases of syphilitic disease associated with pulmonary tuberculosis. The diagnosis of tuberculosis was verified by the finding of bacilli in all the cases cited. In every instance a complete history of syphilis was obtained. All the patients had the initial lesion, marked secondary manifestations, and had undergone treatment. At the time of observation the interval which had elapsed since the appearance of secondary symptoms varied from one to fifteen years.

The cases are divided into two groups for clinical purposes. Eight exhibited syphilitic lesions and seven showed symptomatic manifestations, which promptly responded to the therapeutic test. The

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distinct, specific lesions found in seven patients were infiltration and ulceration of the larynx, pharynx, soft palate, nasal cavity, and tongue. Without exception these lesions had been regarded as tuberculous and the treatment was based upon that belief. In one instance a gumma of the neck had been followed by deep ulceration, which had existed for three weeks. It had been pronounced a carbuncle, and later ascribed to tuberculosis. In this series of cases proper local and constitutional treatment was followed by prompt relief and recovery. The mistake in diagnosis was apparently due to the fact that tuberculosis was held accountable because that disease was known to be present. Of the patients suffering from symptomatic manifestations, one complained of persistent frontal headache and myalgia, involving the muscles of the shoulders; one insisted that he had attacks of aphasia, vertigo, and numbness of a portion of the left arm: one suffered from neuralgia of the legs, particularly at night; sometimes the pain was confined to the heels alone, and four under the most favorable conditions showed no gain, or only slight increase in weight; anemia, languor, fitful appetite, and a daily rise of temperature to 100° or 101° for weeks. Suspicion of the latter group was aroused, because they were all incipient and favorable cases of tuberculosis. Complete rest, open-air treatment, and increased alimentation for a period varying from three to six weeks was not accompanied by improvement, or the symptoms grew more pronounced. When closely questioned, the history of syphilis was elicited and antisyphilitic treatment was followed by remarkable improvement.

Allow me at this time to anticipate the natural comment that any of these symptoms, and especially

the diurnal rise in temperature, could have been caused by tuberculosis or mixed infection. Of the fifteen cases presented as suffering from the double infection of syphilis and tuberculosis twelve were regarded as incipient and favorable and three were moderately advanced.

We do not expect patients with a slight tuberculous lesion and little evidence of constitutional derangement to maintain a daily rise of temperature to 100° or 102° for weeks under modern methods of control. It is admitted that this may occur, but the fact that such behavior is unusual should incite a search for another cause, and syphilis should be suspected, particularly if gastrointestinal disturbance is absent.

Twelve of the fifteen cases were characterized by an evening elevation of temperature above 100°, and in three cases the temperature showed a persistent rise over that of the preceding day. I regard this manifestation in the class of patients under consideration as one of important diagnostic value. The effect of treatment upon the fever was most marked. In two instances the temperature dropped to normal in four days, and in the remainder it fell to normal, or 99°, in eight days.

At the present time we are still compelled to accept the therapeutic test as evidence in the detection of syphilis and its multiform phases. It is doubtful if the dual infection or association of the two diseases renders a prognosis as unfavorable as the literature might lead one to presume. Eight of the patients apparently recovered from tuberculosis, and in seven the disease was arrested. Of course sufficient time has not elapsed to pass judgment upon the ultimate result.

The difficulties in the administration of the

iodides to the syphilitic and tuberculous patient have been exaggerated. This is particularly true of persons afflicted with incipient tuberculosis. Iodide of potassium was given in solution, or with the essence of pepsin, in doses ranging from five grains to fifty grains three times daily, and was not followed by any more disturbance than that usually encountered when syphilis exists alone. Careful attention was paid to the behavior of the tuberculous focus in the lung with reference to the influence of iodide of potassium upon the diseased process. In one instance the moist râles and the amount of expectoration were increased, but in all others no change of this character was detected.

Mention should be made of one case characterized by the interesting clinical phenomena which have sometimes proved puzzling.

B. F., aged forty-five, had secondary manifestations twelve years ago; no symptoms since. Four months before coming under observation was treated for pleurisy at base of left lung. Three months ago he began to lose weight, developed some evening temperature, and a cough with expectoration. One month ago bacilli were found, and a diagnosis made of pulmonary tuberculosis. Upon examination I found evidence of a lesion at the left apex, and also one at the base of the left lung. Both were active, and the one at the base seemed to be undergoing softening. Bronchial breathing and an abundance of fine, moist râles were present. After three weeks had elapsed I noted that his general condition was improved, but the temperature gradually rose in spite of absolute rest. Suddenly he developed nervous symptoms, which seemed distinctly syphilitic in origin. A full history of syphilitic infection was admitted. During my absence for a period of two

weeks his symptoms became more pronounced and he was given thirty-five grains of iodide of potassium three times a day with daily inunctions of mercury. After three weeks of this treatment I found that all pathological physical signs had disappeared from the base of the lung, with the exception of slight relative dullness, and the improvement in the signs at the apex was quite remarkable. The great change in the physical condition and signs and the decline of the temperature to normal led an able clinician, who had observed the patient during my absence, to the conclusion that the thoracic disease was entirely due to syphilis, and the diagnosis of associated tuberculosis was regarded as erroneous. Three weeks later I examined the patient again and found no evidence of disease at the base, but the signs of a quiescent or arrested lesion at the apex. The temperature continued normal. It seems fair to assume that he was suffering from a dual infection of the lung, and it seems probable that the disease at the base of the left lung was syphilitic and that at the apex tuberculous.

Some years ago I observed two advanced cases in hospital practice of the type earlier described as syphilitic phthisis. They were cases of tuberculosis with syphilitic taint, and possibly a closer study will sometimes explain the rôle played by obscure manifestations of syphilitic poison in changing the clinical picture exhibited as due to hopeless tuberculosis.

The purpose of this brief and general presentation of a few cases is to attract attention to the following conclusions:

Pulmonary tuberculosis is often held responsible for too many manifestations of disease which are due to other causes.

The fact that a patient has tuberculosis should not

be an excuse for disregarding these conditions, which often have a decided influence upon the prognosis and cause much avoidable discomfort.

Syphilis is a common disease, and physical debility combined with worry and mental distress, which may accompany tuberculosis, may arouse a latent syphilitic taint.

The association of the two morbid conditions may be disguised and the symptoms confused.

Furthermore, many of the manifestations of syphilis are quite similar to those produced by tuberculosis.

The diagnosis of syphilis, in connection with tuberculosis, will require close scrutiny, and often the therapeutic test.

Persistent fever above 99.5° in incipient cases of tuberculosis, when the lesion is slight and the general condition not much impaired, and when rest with proper treatment for a period of three or more weeks fails to secure an amelioration, should be viewed with suspicion and the possibility of associated syphilis thoughtfully considered. This is also true when atypical pneumonia or intractable subacute bronchitis supervenes.

It is questionable at least if the prognosis in tuberculosis of the lung of an incipient type is rendered any more unfavorable when syphilis, particularly of the tertiary form, is also actively present.

The improvement in the tuberculous case following antisyphilitic treatment is most marked, and at times surprising. This is particularly noticeable in reference to the prompt and decided drop in temperature.

Unless my experience has been very unusual, syphilis is more often associated with pulmonary

tuberculosis than the paucity of the literature upon the subject would indicate.

The concurrence of the two diseases must be more common in hospital, dispensary, and sanatorium practice than is assumed by most authorities.

In this paper no allusion is made to the differentiation between the two affections. The simple intent is to emphasize the importance of recognizing their coexistence and the efficacy of proper treatment.

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