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and far between, although cases are on record where both gonococci and tubercle bacilli have been isolated in excised specimens. Schuchardt is quoted by Watson Cheyne as having found tubercle bacilli present in some cases of gonorrhoea. Of four cases with quiescent testicular tuberculosis whom Keyes saw through attacks of gonorrhoea, two had testicular exacerbations and two did not. Lastly Campbell, in a review of 3,000 cases of gonococcal epididymitis, states that, whereas acute epididymitis due to other organisms may occur even in the presence of a gonococcal urethritis, such cases are most rare and open to question.

As a rule the presence of an acute epididymitis in association with a gonococcal urethritis is regarded as diagnostic of gonococcal epididymitis. The occurrence of a gonococcal epididymitis in an organ which is already the site of a latent tuberculosis is rare, and for this reason the possibility that reactivated tuberculosis is responsible for the continuance of the epididymitis may quite easily be overlooked. The alternative explanation, which from the onset and history seems less likely, is that tubercle bacilli from the pulmonary focus have attacked an epididymis already damaged by gonococcal infection. The unusually prolonged course of an acute gonococcal epididymitis and the formation of the cold abscess led to the consideration of tuberculosis as the probably correct diagnosis. In this case the history of a previous epididymectomy and orchidectomy was another clear indication that a latent tuberculosis might have been reactivated, thus causing the persistence of the epididymal lesion.

An analogous diagnostic problem was described by Salmond in a case of tuberculous salpingitis associated with an acute gonorrhoea.

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REFERENCES


(2) LATE ONSET OF BUPHTHALMOS IN ASSOCIATION WITH CONGENITAL SYPHILIS

Two cases which exhibited the association have been seen at this clinic during the past eighteen months.

Case histories

Case 1.—This female patient first attended the clinic in June 1943, at the age of 26 years. She had been undergoing irregular treatment at other clinics since 1934, when a diagnosis of congenital syphilis (interstitial keratitis, Hutchinson’s teeth and positive Wassermann reaction) was established. Before she came under our observation and treatment she had had a total of 22-85 grammes of neoarsphenamine, 13-8 grammes of bismuth and 1 gramme of mercury. There had been a recurrence of the interstitial keratitis in 1939. The last Wassermann reaction, tested in 1941, had given a positive result.

On examination there was a subacute interstitial keratitis of the right eye; the left eye showed residual corneal opacities and the iris was slightly distorted. The Wassermann reaction result was doubtful. On clinical examination of the central nervous system no abnormality could be detected and the cerebro-spinal fluid was completely negative.

Treatment was resumed and in the next three months she was given 4-95 grammes of neoarsphenamine and 2-8 grammes of bismuth, after which she had a rest of one month. When she returned she had developed a buphthalmos of the right eye; the Wassermann reaction was now negative. As it was considered possible that the buphthalmos might have been precipitated by over-zealous treatment, the patient was referred to the Eye Infirmary for the ophthalmologist’s opinion; we were advised to continue treatment. Three more courses of neoarsphenamine and bismuth were given, during which there was a slow improvement in the sight of the right eye. The Wassermann reaction remained negative.
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Case 2.—This patient was sent to the clinic from the Eye Infirmary in 1934 when she was 14½ years old. She had bilateral interstitial keratitis, Hutchinson's teeth and deafness; the Wassermann reaction was positive.

Anti-syphilitic treatment was begun at once and continued irregularly until 1940, by which time 9 grammes of neoarsphenamine, 17-5 grammes of bismuth and 1-5 grammes of mercury had been given. The condition of the eyes responded poorly to treatment; in 1937 an increasing intra-ocular tension was observed and she developed buphthalmos of both eyes. She was referred again to the Eye Infirmary, where a wide iridectomy was performed on the left eye. The right eye was blind and enucleation was advised; this was not carried out until after the supervention of a severe glaucoma in 1940.

Commentary

Buphthalmos (infantile glaucoma, ox-eye) is usually described as a congenital condition due to a developmental abnormality at the angle of the anterior chamber, which obstructs the free drainage of the aqueous humour, so that the intra-ocular tension is raised and a condition of congenital glaucoma results. The coats of the eye are sufficiently plastic in the young to stretch under the increased tension, so that the whole eye is enlarged.

Cases have been encountered, however, of supposed inflammatory origin and the two cases described appear to be of this nature. Although the infection was undoubtedly congenital in both cases, the eyes were apparently normal until the onset of interstitial keratitis and associated irido-cyclitis at the ages of 14 and 16 years respectively. The inflammatory changes at the angle of the anterior chamber led to a secondary glaucoma and stretching of the coats of the eye at an unusually late age (17½ and 26 years respectively). Congenital syphilis as a possible aetiological factor has not, so far as I am aware, been suggested previously.

REFERENCES


(3) GONOCOCCAL ARTHRITIS RESISTANT TO HYPERPYREXIA

A female patient aged 40 years was admitted on 1st February 1943, when she was seven months pregnant, with the following history.

On 5th November 1942 the patient had attended another clinic, where an early gonococcal infection was diagnosed; smears showed gonococci in the urethra but not in the cervix; the Wassermann reaction and gonococcal complement fixation test were negative; there were no complications.

Treatment was begun with sulphathiazole 3 grammes daily for seven days, assisted by douches and urethral irrigations from the 9th November. On 23rd November smears showed no gonococci in the urethra, but gonococci were now found in the cervix, and on her next attendance a further course of sulphathiazole was given—4 grammes daily for three days, then 3 grammes daily for four days. Local treatment was continued as before. On 10th December gonococci were again found in the cervical smear.

A month later the patient was admitted to hospital with acute arthritis of the right knee. The gonococcal complement fixation test was strongly positive. Details of the subsequent treatment were not available. Nineteen days before she was transferred to Newcastle the right leg had been encased in a plaster which was removed after eleven days, when aspiration of the knee joint yielded a purulent exudate.

Condition on admission (1st February 1943). The right knee joint showed marked swelling and thickening of the periarticular structures. The head of the tibia was subluxated and there was a contracture to about 25°—30° of flexion; movement was extremely painful and limited to 10° or 15°.

Genital examination revealed no abnormality apart from a slight muco-purulent vaginal discharge; smears from urethra and cervix were negative for gonococci.

Whereas hyperpyrexial treatment was obviously the method of choice, the possible effect of this on the pregnancy had to be considered. In one previous case—a tabetic in whom pregnancy had not been detected—a series of six fevers