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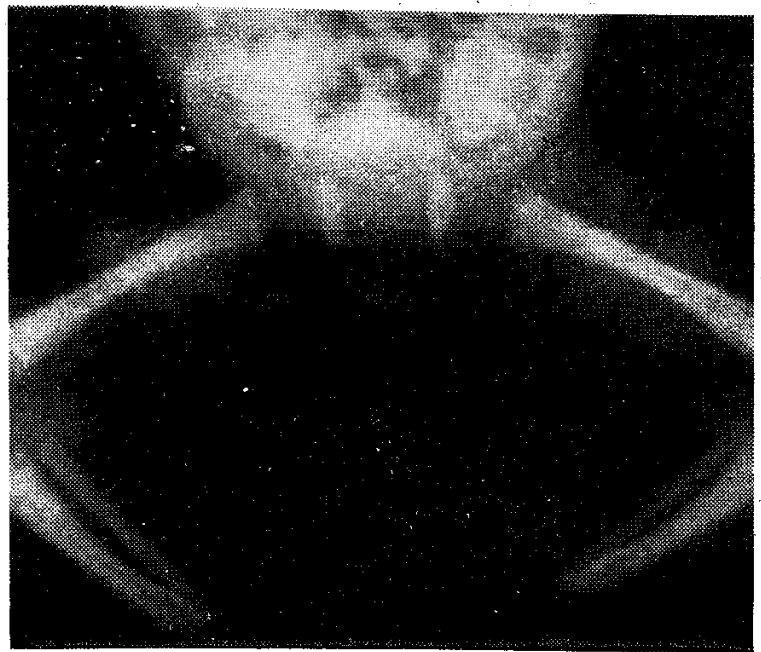
## Neonatal Syphilis with Glaucoma and Periosteitis

Almost all neonates born to mothers with "early syphilis" and 70% of those born to mothers with "late syphilis" are affected(1,2). Contrary to the earlier belief, infection of the embryo or fetus can occur any time during pregnancy(1,2). Most syphilitic infants lack manifestations at birth(1-3); ocular lesions are relatively uncommon(2,4). We report a rare case of congenital syphilis with the uncommon presentation of glaucoma and generalized periosteitis.

A female infant weighing 1.5 kg, was born to an unbooked primigravida at 32 weeks of gestation. The baby was severely asphyxiated (Apgar 3/10 at 1 min) and needed active resuscitation. She had a pot belly, wizened appearance, dry shiny skin, mild proptosis, corneal opacity, watering of the eyes, hepatosplenomegaly, bilateral symmetrical exfoliative lesions of hands and feet (excluding palms and soles) and respiratory distress. The mean intraocular

pressures after local anesthesia were 25.8 Hg in both the eyes and the corneal diameter was 15 mm. The fundus was not clearly visualized. The baby was treated with intravenous fluids, oxygen and antibiotics. She progressively deteriorated and expired after 2 days. The skiagram (*Fig.*) showed metaphysitis, generalized periosteitis with corneal thickening of long bones. There were infiltrative lesions in the lungs. Blood VDRL titres of mother and baby were highly positive (more than 1 : 64). Postmortem liver biopsy showed extramedullary hematopoiesis, the skin, lungs and kidneys were normal. A diagnosis of congenital syphilis with glaucoma was made. Both the parents gave history of promiscuity. The mother showed generalized lymphadenopathy and significant hepatosplenomegaly and gave history of painless genital ulcer 3 months earlier.

Ocular lesions in congenital syphilis are rare and include chorioretinitis, glaucoma,



*Fig. Radiograph of legs showing periosteal elevation and thickening, with rarefaction and bands at metaphyses.*

uveitis and chancre of eyelids(2,4); of these chorioretinitis is more common(5). The present case, had markedly increased intraocular pressure as against a mean (SD) of 11.4 (2.4) mm Hg(6). Enlarged cloudy cornea (normal diameter less than 12 mm), proptosis and excessive watering seen in our case indicated a diagnosis of glaucoma(2,3). The proliferative and destructive lesions in bones present as increased density alternating with rarefaction on radiography(2). Classically symmetrical moth-eaten lesions in the upper part of tibia are described. Generalized periosteitis seen in our case is a rare manifestation at birth. Syphilitic osteochondritis requires approximately 5 weeks to become radiologically visible and periosteitis is usually seen after 16 weeks. When both are present perinatally, it suggests that the baby was infected during the second trimester(2).

The various factors contributing to death of present baby were low birth weight, birth asphyxia, pneumonitis and severe systemic involvement. Myocarditis may be present in 10% of infants who die due to syphilis(2). However, this patient did not show any evidence of myocarditis. In view of the poor immediate and long term outcome in cases with congenital syphilis, antenatal detection of the disease in the mother and adequate treatment are the best measures to prevent morbidity and mortality from this condition.

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## Tongue-Tie: Myths and Truths

In complete ankyloglossia inferior, a very rare condition, the tongue is fused to the floor of the mouth. Partial ankyloglossia inferior (tongue-tie) is relatively common in infancy. It is quite upsetting to the infants' parents and a slight delay in the speech prompts them to seek surgical help. This leads to unnecessary surgery in many a patient. In 1991 alone, 148 patients underwent the release of tongue-tie in our department. But the truth is that lingual frenulum is sufficiently thin in most of the