Unusual Presentation in Early Congenital Syphilis

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Occurrence of central nervous system manifestations in the form of tabetic neurosyphilis is uncommon in early congenital syphilis(l). We hereby report a case of early onset congenital syphilis who also had unusual neurological manifestations, buphthalmos and cutaneous eruptions (classically seen in early congenital syphilis) persisting for more than a year.

Case Report

A one-year-old male child, 3rd born to a nonconsanguinous couple, presented with failure to thrive, recurrent skin lesions and recurrent upper respiratory infections. There was a history of skin lesions initially noted over the back as raised red patches which later started peeling and became whitish lesions. The lesions then started appearing on the trunk, scalp, face, mouth and extremities including the palms and soles. The child had six to seven crops of such lesions, each crop lasting for 2-4 weeks.

There was a history of multiple, painful genital ulcers in the mother 10 days prior to child birth, for which she had received some injections. There were no history of abortions or still births. The other two elder siblings were healthy. The father gave history of contracts and genital ulcers but he had not taken any treatment.

On examination, the child was poorly nourished and weighed 4.75 kg, his length was 63 cm, head circumference was 41.5 cm, and chest circumference 38.5 cm. The anterior fontanel was large, and thin, hypopigmented sparse hair with multiple localized areas of alopecia were seen on the scalp. The eyes were protuberent with bilateral extropia and alternating divergent squint. There was megalocornea *(Fig. 1)* (right corneal diameter 14.5 mm and left corneal diameter 13.5 mm) and intraocular tension was increased in the left eye (23 mm of Hg).

The child has rhinorrhea, nasal excoriation and multiple shallow, small erythematous ulcers on the hard palate. The skin, was thin, dry and pale. There were erythematous well defined circular desquamated lesions over the scalp, buttocks, trunk and extremities *(Fig. 2)*. Cervical, axillary and inguinal lymphnodes, were enlarged. They were discrete, nontender and firm in consistency. Abdomen was distended and the liver was palpable 4 cm below the costal margin in the midclavicular line. It was non-tender and firm. The child had generalized wasting of muscles and hypotonia with brisk deep tendon reflexes. The plantar reflexes were bilaterally extensor.

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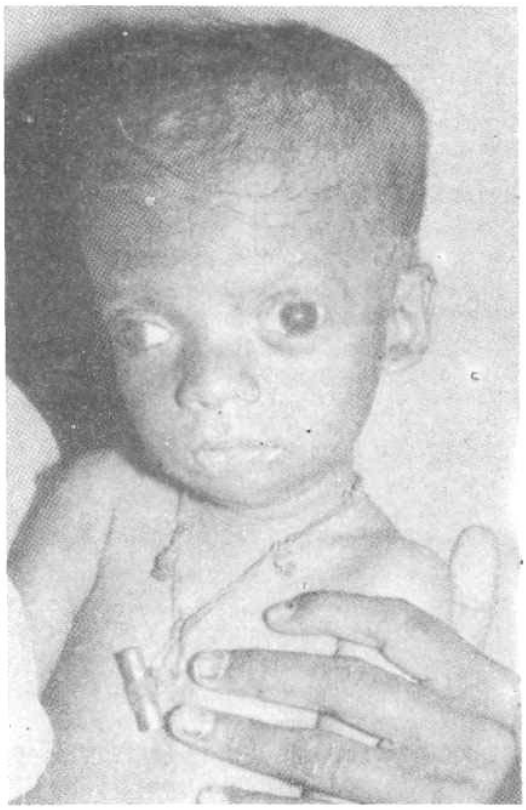

Fig. 1. Bilateral megalocornea, sparse hair and cutaneous lesions on scalp and left shoulder.

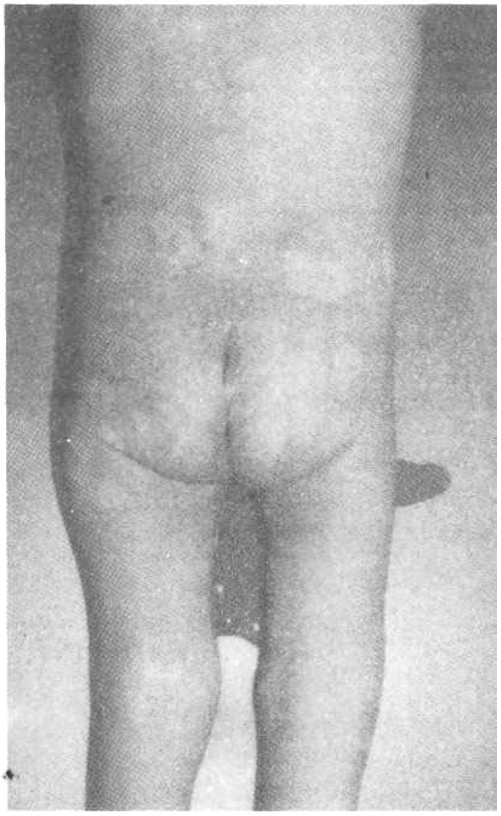

Fig. 2. Multiple well defined circular desquamated lesions.

His hemoglobin was 9 g/dl, erythrocyte sedimentation rate was 60 mm in 1st hour, the total white cell, red blood cell and platelet counts were normal, with predominant lymphocytosis (59%) and a microcytic blood picture. Other investigations like urine analysis, cerebrospinal fluid analysis (cytochemical and VDRL), liver function tests, X-ray of both knee joints and. neurosonogram were normal. VDRL was reactive 1 : 32 in the mother and the child and 1 : 16 in the father. The child responded well to pencillin.

Discussion

Syphilitic neurological involvement in the form of hyptonia with brisk reflexes and extensor plantar responses as was seen in this child is of rare occurence. The common neurological manifestations reported in **early** congenital syphilis are postneonatal Erb's palsy, pseudoparalysis and meningitis(2).

Other manifestations in early infancy are infantile hemiplegia like presentation secondary to stroke with involvement of cerebrum, brainstem or spinal cord. Many infarctive lesions leave the child mentally backward. Early hydrocephalus, retarded psychomotor development, failure to thrive, defective mental and physical growth are other features(3). Behavioral abnormalities like irritability, agitation and outbursts, are also known. Besides seizures, peculiar chorieform movements, twitches and action tremors are frequent(3). The tendon reflexes are hyperactive and plantar reflexes are extensor(3,4). Fixed pupils, loss of accommodation reaction, optic atrophy and chorioretinitis are known occular abnormalities(3).

Cutaneous manifestations in early congenital syphilis most commonly appear during the third week of life or rarely three months after birth(5). The skin lesions seen even at one year of age were classically like the lesions described in the first few weeks or early congenital syphilis. Prolonged persistance of such cutaneous lesions is rare.

Buphthalmos or congenital glaucoma is infrequent but is known to occur in syphilis. Osseous lesions were not detected in this child even at 1 year age. Osseous involvement in early congenital syphilis can vary from 25%(6) to 90%(7) and if the infant survives, the bones heal completely(8).

The clinical course of early onset congenital syphilis depends upon the time at which infection was contracted by the fetus. The disease tends to be more severe with infection in the first trimester, resulting in fetal loss and tends to be less severe if the exposure occurs in late pregnancy(7). It can be speculated that since the mother had given birth to two healthy children and developed genital ulcers during the later part of this pregnancy, most probably the infection was acquired by this child in late pregnancy and this may be the reason for prolonged cutaneous manifestations.

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Spontaneous Aortic Thrombosis in a Neonate

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In childhood, the incidence of thrombotic disease, both spontaneous and catheter-induced, is highest in the neonatal period(l). A case of spontaneous aortic thrombosis following acute gastroenteritis and severe dehydration in a neonate is presented.

Case Report

A 2.5 kg, full-term female baby was delivered by emergency LSCS (for non-progress of labor) to a second gravida mother with Apgar scores of 9,10 and 10. There were no maternal antenatal high risk factors. Postnatally, the child was being bottle fed with cow's milk.

At 70 h of age, the neonate presented with diarrhea. Examination revealed an active infant with normal hydration. Investigations revealed: hemoglobin 17 g/dl; TLC 8,300/mm^3 (60% polymorphs, 40% lymphocytes and band to total neutrophil count ratio of 0.33); micro ESR 1 mm/lst hour. Stool miscroscopy revealed numerous polymorphs. Blood culture was sterile and stool culture grew *Escherichia coli* sensitive to gentamicin and nalidixic acid.

The infant was started on septran and gentamicin parenterally and nalidixic acid orally. Bottle feeds were continued and half-strength WHO-ORS advised as additional feeds for replacing ongoing diarrheal fluid losses.

At 84 hours of age, the infant was in a state of shock. Anterior fontanelle was depressed and skin turgor was lost. Resuscitation with appropriate fluid replacement was carried out. Following resuscitation it was observed that while both radial pulses were palpable and the upper extremities were pink, the lower limbs from inguinal region downward (anteriorly) and sacral region downward (posteriorly) were cyanosed with both femoral pulses still unpalpable. Heart

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