Several authors, particularly Japanese (Koyanagi⁴, Komoto⁵), have noted a connection between uveitis, vitiligo and alopecia which is generally indistinguishable from alopecia syphilitica. This patient's skin condition was that of typical alopecia areata, also in the pigmentary disturbances which accompanied it; and the lapse of 20 years makes it extremely improbable that there is any factor common to his two diseases.

One disease, periphlebitis tuberculosa, is localised along the retinal veins in the manner mentioned; it is accompanied by vitreous haemorrhages and commonly leads to retinitis proliferans. This man, with his bad family history as regards tuberculosis, and with his positive reaction to tuberculin, may well have been the subject of a tuberculous periphlebitis which instead of taking its usual course and affecting the vitreous, has spread outwards towards the choroid; and this hypothesis is tentatively put forward as a possible explanation of the case.

I should like to express my thanks to Professor Roenne for his permission to publish this case. The accompanying sketch is also his work.

Summary

A case of retino-choroidal atrophy is described in which the atrophic areas are confined to the immediate proximity of the retinal veins. No similar case could be traced in the literature. One is compelled to conclude that it is a disease *sui generis*, for which the name retino-choroiditis radiata is suggested.

REFERENCES

1. de Schweinitz.—Ophthalmic Record, p. 23, 1909.
2. Gilbert's article in Schieck and Brückner's Kurzes Handbuch, Vol. 5, 1930.
3. Fuchs, E.—*Zentralb. f. Augenheilk.*, Vol. VIII, p. 100, 1923.
4. Koyanagi.—*Klin. Monatsbl. f. Augenheilk.*, Vol. LXXXII, p. 194, 1929.
5. Komoto.—*Klin. Monatsbl. f. Augenheilk.*, Vol. XLIX, pt. 1, 1911.

TARSITIS SYPHILITICA

BY

M. KHALIL

CAIRO

Introduction

(a) *Various syphilitic affections of the lid.*

Quoting from Connell and others: It may be said that all cases of syphilis of the eyelid are unusual, because this disease rarely manifests itself by a lesion in this location. Zeissl reported that of 40,000 cases of syphilis examined, only eight had lesions of the

eyelids. The lesions of all three stages have been reported. The chancre occurs on the skin of the lids and on the conjunctiva both palpebral and bulbar. Transmission is frequently by kissing. According to Fuchs, infection is conveyed to children by nurses, who sometimes moisten the agglutinated lids with saliva, and also by the practice of licking foreign bodies out of the conjunctival sac with the tongue.

"Secondary lesions of the lids have been reported in the form of papular syphilides and copper coloured patches."

(b) *Rarity of tertiary syphilitic affections of the lid.*

Tertiary lesions are the rarest of all, and to give an idea about this, I think, I cannot do better than quote Heckel and Beinhauer in an exhaustive article on the subject published in the "Archives of Ophthalmology," Vol. LIV.

A gumma, strictly confined to the eyelid, is a rare condition when one considers the frequency of syphilis and the frequency of gummata elsewhere in the body.

Max Joseph states that gummata of the eyelids are uncommonly met with. Bull reports, "Little is said of syphilis of the eyelids because lesions are better recognised and treated and are not common." Zeissl described 8 cases of syphilis of the eyelid in 40,000 cases of syphilis, reporting 2 cases from Arlt's ophthalmic clinic. He stated, "gummata of the eyelids are not common, but when involving the conjunctiva or tarsal cartilage are extremely rare. Clapp states that tertiary lesions are frequently seen as a general thickening—tarsitis—while the circumscribed tumefaction—gumma—is the rarest of all specified lesions." Hutchinson reports, "This is so rare that one, even in our large clinics, will see it seldom."

Narich reports a ratio of 1 in every 10,000 cases of syphilis showing a gummatus involvement of the eyelids. Dornig states the published cases of tertiary syphilis of the eyelids are very few and the same idea is held by Juliusberger. Bull remarks, "Such modern writers as Arlt, Zehender, Bader, Wells, Heisung, Graefe, Fuchs and Schweiggner make the rarest reference to it." de Schweinitz admits it is not a very frequent condition.

Vancea, describing his case of vegetative or polypoid type of tarsitis, in 1927, has estimated the cases of tarsitis reported up to that date to be 25 only.

Types

(c) *The four types of syphilitic tarsitis are :*

1.—*The Marginal*:—Characterised by ulceration, leading to deformity of the lid margin and partial or complete destruction of the lashes.

2.—*The Nodular* :—Characterised by circumscribed thickening at the site of which deep ulceration soon develops. When seen before necrosis takes place, gummata bear a very strong resemblance to chalazia, but nearly always progress towards the skin and leave the conjunctival surface normal.

3.—*The Diffusely Infiltrated* :—Diffuse swelling of the tarsus of one or more of the eyelids.

4.—*Vegetative or Polypoid* :—First described by Vancea in 1927 as a small rose-coloured, painless and slightly pedunculated tumour, arising from the conjunctival side of the tarsus and resembling a Meibomian epitheloma.

The marginal type, described by Morax under the varieties of tarsitis, is described by Poulard as a syphilitic ulcerative condition of the skin of the lid-margin unpreceded by indurations; Whiting denies that it affects the tarsal plate.

While syphilitic tarsitis is usually a painless condition, those reporting gummata have generally found it associated with considerable pain.

Fuchs, Parsons, Roemer, Poulard, de Schweinitz and other authorities consider tarsitis syphilitica as a gummatous infiltration of the tarsus, in a diffuse manner.

The diffusely infiltrated type to which my case belongs is usually described as follows, quoting from Bull :—

“ When diffuse, the whole lid is swollen and usually other symptoms of syphilis are present. When the tarsus appears infiltrated, the name ‘tarsitis syphilitica’ has been given. The infiltration is then chronic and indolent and is usually located in the upper lid. There is no pain or sensation. The tumour is hard, resisting, and is characterised by an induration of board-like consistency. The overlaying skin is of a reddish colour. The lid cannot be everted and ptosis is present. The swelling is homogeneous and the overlying skin is not usually involved.”

Age, Onset and Mode of Infection

As young as 2 to 3 months, patients were reported suffering from tarsitis, which got cured under anti-syphilitic treatment.

Whiting mentions in his article, that most of the cases described appear to have been in adults, and to have been the result of acquired syphilis, but several cases at an early age, from 2 to 9 months, were the result of hereditary syphilis.

Signs and Symptoms

To sum up, the signs and symptoms of tarsitis syphilitica are :—

1. Very gradual development.
2. Skin freely movable over tarsus; tense and reddened when condition has reached its acme.

3. Normal appearance of conjunctiva.
4. Absence of pain.
5. Ptosis usually well marked.
6. Tendency to falling out of eyelashes.
7. Tarsus enlarged, as could be verified upon palpation, of cartilaginous hardness and ungainly form.
8. Eversion of lid almost impossible, due to enlargement of tarsus.
9. The lymphatic gland in front of the ear of same side swells up.
10. Other signs in the globe, as old keratitis, iritis or peripheral disseminated choroiditis may be present.

Diagnosis

In pre-Wassermann days a histological examination of a fragment of the swelling revealing a round celled infiltration helped in the diagnosis which was confirmed by antisyphilitic treatment.

Nowadays a positive laboratory result makes the diagnosis easy. It should be borne in mind, however, that in the late tertiary stages the Wassermann reaction can be obtained only in about two-thirds of the positive cases. The tests for tubercle are not always reliable. Hence the importance of differential diagnosis based on clinical data. Signs of syphilis or tubercle accompanying the eye condition should be looked for.

The diagnosis of the nodular type, before it breaks down, has to be differentiated from that of any other nodular condition, *e.g.*, chalazia or styas and adenomata of the Meibomian glands. Some writers, *e.g.*, Whiting, consider the picture of the syphilitic type sufficiently characteristic to prevent confusion.

When ulceration has taken place the condition of epithelioma and tubercle has to be excluded. Ulceration from the conjunctival surface simulates tubercle of this membrane.

Pathology

If cut into, the cartilage is found transformed into a lardaceous tissue with scanty blood supply.

The histopathology of tarsitis syphilitica as described by Hugo Feilchenfeld in his case and confirmed by Greeff is as follows:—

“Histologically the epithelium shows itself almost normal. The site of the disease is the tarsus whose tissues are completely infiltrated with fresh small cells. These cells arrange themselves in two long parallel rows, which by separating the connective tissue fibres of the tarsus look like newly formed lymph vessels. The blood vessels are greatly increased, and seen to be dilated.

No change, worth mentioning, is noticed in the walls of the blood vessels. Media and intima are normal, only the adventitia seems to be greatly thickened in few small arteries.

" Besides this, more or less diffuse infiltration there appear two separate sharply defined infiltrations lying directly under the conjunctiva, that is, the most superficial part of the tarsus, which prove to be composed of densely arranged equally coloured cells with dark stained nuclei."

My Case

F.D., a female, aged 65 years, came to my section, at the Qalawoon Eye Hospital, on June 8, 1935.

Past History:—Patient suffered from enlargement of glands in the axilla for the past three years, for which she underwent a surgical operation; glandular enlargement all over the body followed the operation. When light treatment for three months with guarded prognosis was suggested she refused.

She had thickening of all four lids, with ptosis of both upper lids, the eversion of which was impossible.

Two photographs (one before treatment and another after), taken by Dr. M. O. El Rifaiy, our laboratory colleague, are reproduced.

Before treatment.

After treatment.

The blood report was positive + + + for syphilis.

There were no keratitis, iritis or choroiditis, as is sometimes reported to accompany the lid condition.

Prognosis

After the swelling has been, for weeks, maintained at the same height, if untreated it disappears very slowly, until the tarsus has reached its former volume, or has even, in consequence of atrophy, fallen somewhat below it. It takes several months for the disease to run through its course (Fuchs). Under specific treatment, however, the condition resolves itself very promptly.

Treatment

Potassium iodide and mercury inunctions in the treatment of syphilitic tarsitis were used in the cases reported.

Paton mentions the inefficiency of doses less than 30 grains, three times a day, and emphasises the importance of such liberal doses, as evidenced by him from a case of the nodular type in a young woman.

In my case the treatment was carried to a definite cure within a period of 2 months; 4.2 grams of neobismusalvan (Richter's bismuth preparation) and 6 ampoules of mercury cyanide amounting to 6 centigrams were given. Potassium iodide in the normal doses followed as a matter of routine.

BIBLIOGRAPHY

1863. Wecker, de.—*Traité theor. et pract. des Mal. des Yeux*. Paris, s. 180.
1864. Zeissl.—*Lehrbuch der const. Syphilis*.
1867. Magawly.—*Jahresbericht. Ueber Leistung und Fortschritter des gesammten Augenheilk.*, p. 502.
1873. Vogel.—*Inaugural dissertation*, Bonn (1 case).
1878. Fuchs.—*Klin. Monatsbl. f. Augenheilk.*, pp. 21-28.
1878. Hutchinson.—*Roy. Lond. Ophthal. Hosp. Repts.*, London.
1879. Vincentiis.—*Michel Nagel's Jahresbericht*, p. 367.
1883. Juliusberger.—*Vierteljahresschrift Dermatologie und Syphilis*, Wien, p. 100.
1899. Bull.—"Syphilis of the eye and its appendages." *Medical News*, New York, Vol. LXXIV, pp. 609-615.
1900. Basso.—*Ann. di Ottal.*
1903. Yamaguchi.—*Arch. f. Augenheilk.*, p. 51.
1906. Narich.—*Recueil d'ophtal.*, Paris, Vol. III, p. 554.
1906. Clapp.—*Ophthal. Record*, Vol. XXI, pp. 275-277.
- *Graefe-Saemisch Handbuch*, 2 Aufl., XI Bd., I. T., S. 750.
1907. Feilchenfeld, Hugo.—*Arch. f. Augenheilk.*, Vol. LVI, p. 350.
1909. Max, Joseph.—*Lehrbuch der Geschlechtskrankheiten*. Part 2.
1911. Fisher, J. H.—"Gummatous Tarsitis." *Trans. Ophthal. Soc. U.K.*, Vol. XXXI, p. 268.
1915. Alter, Francis W.—"Palpebral syphilis," a review with case report. *Transactions Seventieth Annual Meeting, American Academy of Ophthalmology and Oto-Laryngology*.
1920. Mancione, L.—"Gummatous Ulceration of Tarsus." *Arch. di Ottal.*, July-September.

1921. Sohby and Tewfik.—"Tarsitis due to Meibomian cysts." *Bull. Ophthalm. Soc., Egypt.*
1923. Poulard.—Tome I, p. 514.
1925. Heckel and Beinhauer.—*Arch. of Ophthalm.*, Vol. LIV, p. 352.
- "Syphilis of the eyelids." *Amer. Encyclo. of Ophthalm.*, Vol. VII, p. 5025.
- "Chancre of the eyelids." *Amer. Encyclo. of Ophthalm.*, Vol. LII, p. 2003.
1926. Connell, Evan S.—"Tertiary Syphilis of Eyelid." *Amer. J. of Ophthalm.*, p. 608.
1926. Le Roux, H.—"Sur un cas de tarsite syphilitique." *Arch. d'Ophthalm.*, September.
1927. Vancea, P.—"La tarsite syphilitique vegetante." *Arch. d'Ophthalm.*, October.
1932. Whiting, Maurice.—"Syphilitic Tarsitis." *Trans. Ophthalm. Soc. U.K.*, Vol. LII, p. 140.

TREATMENT OF HERPETIC KERATITIS WITH VITAMIN B

BY

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THE recent progress in the study of vitamins helps us to understand better the various aspects of slight or latent hypo-vitaminosis, which occur in association with the most different clinical manifestations, and positively influence their evolution.

Such cases appear to be much more frequent than was previously suspected, and their recognition becomes a question of great importance in our European countries, where the typical syndrome of avitaminosis is rarely met, and therefore the eventual manifestations of vitamin insufficiency can easily remain hidden and ignored.

This seems to be especially the case of vitamin B₁. Its recent synthesis, and the new possibilities of preparing it in sufficient amounts have promoted numerous essays of therapeutic trials. Different authors have studied its influence in various digestive syndromes, its active intervention in the troubles of carbohydrate metabolism (diabetes), etc.

Considering the rôle of vitamin B₁ in the causation and in the cure of beriberic polyneuritis, some authors, beginning with Minot, Strauss and Cobb, were lead to try its action in other nerve diseases of various aetiology.

In fact, encouraging results have already been obtained in the treatment of alcoholic polyneuritis (Strauss, Blankenhorn and Spies,