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SYPHILLITIC ARREST. M Ison, K Mihara, M Donohoe, Department of General Internal Medicine, Oregon Health Sciences University, Portland, Oregon.

LEARNING OBJECTIVES: 1. To recognize, diagnose, and treat neurosyphilis; 2. To address the controversy surrounding screening prisoners and those with new psychiatric diagnoses for syphilis.

CASE PRESENTATION: A 47 year-old male with no known history of sexually transmitted diseases became increasingly forgetful and disoriented over a three month period. His behavior became manic and aggressive. On the day of admission, he broke all of his mother's dishes; she called the police who took the patient to our psychiatric department. His physical examination was significant for bizarre behavior, hyperreflexic deep tendon reflexes, and bilateral clonus. His erythrocyte sedimentation rate was 56 seconds while his routine labs were normal. He was treated with lithium and thorazine for presumed bipolar disorder, but he failed to improve. A head MRI revealed no focal abnormalities. Lumbar punctureshowed 24 WBCs (95% lymphocytes), 4 RBCs, total protein 151, and glucose 64; cultures were negative; CSF VDRL was positive. Serum HIV and ANA were both negative; RPR was positive. He was treated with Penicillin G 3 million units Q4 hours IV for ten days for generalized paresis variant of neurosyphilis. He has improved back to baseline and maintained a negative CSF VDRL to date.

DISCUSSION: Syphilis often goes unrecognized and/or untreated in its early stages. One-third of untreated individuals may developed tertiary neurosyphilis over 10-20 years. Tertiary neurosyphilis encompasses both generalized paresis and tabes dorsalis. Generalized paresis presents as changes in personality, affect and intellectual ability, delusional states, psychosis, and hyperreflexia. Tabes dorsalis is characterized by Argyll Robertson pupils, sensory ataxia, a wide based gait, areflexia, impotence, urinary disturbances, and other signs of dorsal column dysfunction. Neurosyphilis is diagnosed when the above signs and symptoms are accompanied by a positive CSF VDRL and serum RPR. Treatment includes penicillin G 2-4 million units IV Q 4° for 10-14 days with follow-up CSF VDRLs to assess treatment success. The degree of improvement following treatment is difficult to predict and is related to the degree of pre-treatment CNS destruction.

The prevalence of syphilis in jails ranges from 1-3% and is higher in women and African Americans. Most of these patients have unrecognized syphilis and poor access to health care pre- and post-internment and may benefit from screening and treatment to prevent neurosyphilis. Furthermore, the utility of screening inmates and adults with new psychiatric symptoms or bizarre behavior for neurosyphilis should be considered. Since the positive predictive value of the serum RPR is low, physicians should maintain a high index of suspicion with a low threshold for lumbar puncture.

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