Syphilitic Ulcers of the Anus

by R M Hollings FRCS FRACS (*London*)

This paper is based on the cases of syphilis affecting the anus seen in the Out-patient Department of St Mark's Hospital between 1932 and 1960. The objective in reviewing these cases is: (1) To illustrate some of the diagnostic features of anal syphilis. (2) To emphasize the importance of homosexuals as a reservoir of infection at a time when the overall incidence of the disease is falling (Ministry of Health 1960). (3) To add to the rather sparse literature on the subject. 'Discussion of primary ano-rectal syphilis as found in the literature is very meagre and incomplete and descriptions are inaccurate' (Martin & Kallet 1925). To some extent this criticism is applicable to 1960.

The most recent review of the subject to come from St Mark's Hospital is that of 55 cases seen at the hospital in the seven years 1882 – 1888 (Goodsall & Miles 1900) (Table 1). The majority of these are assumed to be secondary stages as Goodsall states elsewhere in his book that he had seen only one anal chancre at both St Mark's and the Gordon Hospital. Chancres of the anus were more commonly found in women (Lockhart-Mummery 1914). To-day the majority of cases are in men.

Table 1
Summary of 55 cases of anal syphilis (Goodsall & Miles 1900) St Mark's Hospital Out-patient Department 1882 to 1888

		Average age	*Range*
Males	37	31 years	18–57 years
Females	18	24 years	2–42 years
Principal clinical features:			*No. of cases*
Mucous patches in anal region			33
Ulceration in anal region			12
Syphilitic fissures			6
Primary anal chancre			1
Ulcer of rectum			1
Gumma of both sides of anus			1
Gumma of one side of anus with fistula			1
Secondary clinical features:			
Enlarged inguinal lymph nodes			43
Primary sore still present			29
Rash			15

This series is of a comparable number of cases spread over a longer period (Table 2). It is not possible to assess with accuracy the numbers of primary lesions as the clinical notes were frequently not explicit on this point, however it is certain that chancres form a majority of cases seen in recent years. The frequency of enlarged inguinal nodes, a watery discharge from the ulcer and the presence of a rash make these valuable diagnostic signs, as also noted in the earlier series.

Investigations carried out included dark ground microscopy and the Wassermann reaction. The

Table 2
Summary of 65 cases of ano-rectal syphilis (present series) St Mark's Hospital Out-patient Department 1932–1960

		Average age	*Range*
Males	57	31·6 years	17–62 years.
Females	8	31·5 years	20–50 years.
Principal clinical features:			*No. of cases*
Condyloma			29
Ulcer			31
Fissure			13
Associated clinical features:			
Enlarged inguinal lymph nodes			42
Watery discharge from anal lesion			21
Anal tags			11
Rash			9
Genital lesion present at some time			11
Presenting symptoms in current series:			
Pain on defæcation			24
Lump in the anal region			14
'Piles'			9
Irritation			7
Bleeding			6
Discharge			5
'Sore' on anus			3
Diarrhœa			1

former method was not employed in the earlier years of the survey and all 3 cases with a negative Wassermann reaction subsequently became positive. Where biopsy confirmed the diagnosis, it usually meant that the tag had been excised in the mistaken belief that it was a non-specific lesion.

It was rare for the general practitioner referring the patient to suspect the diagnosis. By contrast 58 out of the 65 cases were correctly diagnosed on their first visit to the clinic.

The occupations of the patients show a higher proportion of actors and musicians than this group would represent in the community (Nicol 1960).

The annual incidence of cases reflects the general level of syphilis in the community with its post-war peak and the rise in the last twelve months (Fig 1).

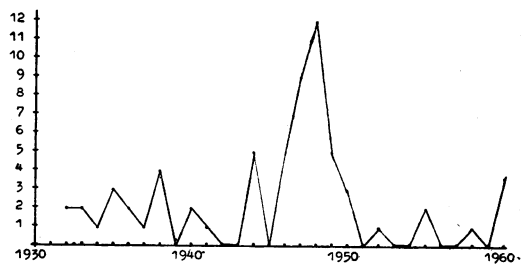

Fig 1 *Graph showing annual incidence of cases*

I am indebted to Dr W N Mascall of the St Paul's Hospital Clinic for his figures for 1960 to illustrate the problem as it relates to homosexuals. (Table 3). Despite the progressive fall in the incidence of syphilis, there does appear to be an increase in the disease among homosexuals who constitute a rising menace in the spread of infec-

tion. Extragenital lesions are being found in them in greater numbers (Degos 1958, Hecht 1957).

Table 3
Summary of 67 cases of syphilis at St Paul's Hospital, Endell Street Clinic (1960)

Homosexuals:	Active	17	53 (79% of total cases)
	Passive	31	
	Active and passive	5	
Lesions in homosexuals	Anal chancres		14
	Penile chancres		12
	Secondary syphilis		16
	Latent syphilis		11

A greater awareness of anal syphilis must precede earlier and more accurate diagnosis. This will lead to earlier and more effective therapy. Prevention can be achieved by better education of the public and careful follow up of contacts.

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Necrotizing Colitis

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Gangrene of the colon is a rare condition and was first described by Lauenstein in 1882 when he reported a case of infarction affecting the transverse colon. More common causes of gangrene affecting the large bowel are strangulation produced by intussusception, volvulus or hernia.

This paper introduces seven cases of a fulminating gangrene affecting the large bowel. A description has not been previously reported in the literature.

Clinical Features

The patients were admitted to the Central Middlesex, St Mark's, Westminster and Woolwich Memorial Hospitals between September 1957 and March 1960. There were 5 females and 2 males aged 56 to 78 years. Their illness was severe, causing the death of 3 patients.

Their symptoms began with a sudden onset of severe abdominal pain, usually accompanied by peripheral cyanosis and collapse. Abdominal distension was noted in 5, 4 were diagnosed as acute pancreatitis until the serum amylase estimations were carried out, 2 others were thought to have generalized peritonitis and one other, intestinal obstruction with strangulation.

Laparotomy

Laparotomy was undertaken soon after admission in all. On opening the peritoneal cavity a foul odour was noted. There were large amounts of turbid free fluid. The most striking feature was the presence of patches of green gangrene scattered over the surface of the large bowel. The situation of these areas varied considerably from case to case (see Fig 1). This gangrene was associated with an intense inflammation of the serosal surface accompanied by marked œdema in the bowel wall, mesentery and related retroperitoneal tissues.

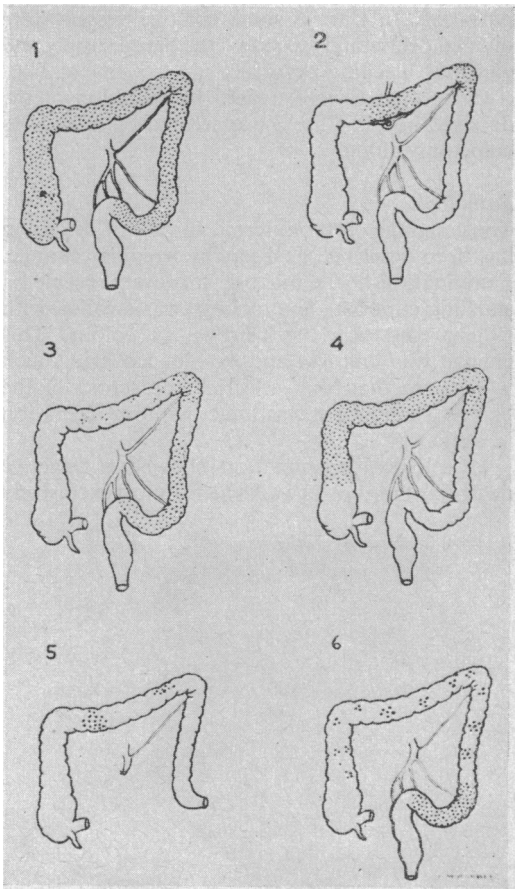

Fig 1 *The dotted areas show the distribution of the gangrene on the serosal aspect of the bowel in 6 of the 7 cases*