

SYPHILITIC NECROSIS OF THE INTERMAXILLARY BONE.*

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In a long clinical experience covering a period of thirty years I have seen the evidences of syphilitic infection of the upper air tract in almost every phase, stage and variety in which it is wont to appear in this region. The case which I shall describe this day, while being a tertiary necrosis and therefore not unusual in the life history of syphilis, presents several points of extreme interest—that is, the manner of its onset and the area of bone infected.

Mr. M. F., age twenty-six years, married, stock broker's clerk, consulted me first on April 16, 1917, on account of extreme pain in the lower third of the left nasal cavity. The family and general medical history as given by the patient seemed to have no bearing upon the case. The pain was described as being continuous, localized in the floor, over the lower portion of the inferior turbinate, and on the extreme lower portion of the septum near the floor. This symptom was present only in the left nasal chamber. The pain was so intense as to cause interference with sleep. The patient in no sense described the pain as greater at night. There was no alteration of function within the left nasal chamber. No symptoms other than pain and interference with sleep were complained of by the patient. The pain had already endured for several months. The young man had been under other special care before he came under my observation. He said that his former physician had stated that his condition was due to a spur of the septum, which was forthwith removed, without giving relief.

Physical Examination.—Investigation of the nasal chambers

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through anterior and posterior rhinoscopy revealed practically no deviation from the normal in the appearance of mucosa in either nasal cavity. Tenderness was especially marked in the lower anterior portion of the left nasal chamber, and particularly in the floor of the nasal chamber in this region. Careful examination of the incisor teeth demonstrated slight tenderness but no evident disease. Sinuses were transilluminated, special regard being paid to the left antrum, with negative results. The patient was referred to a roentgenologist for examination of the condition of the incisor teeth and the contiguous portion of maxillary bone. A negative report was received. As all other possible sources of such pain with negative objective symptoms had been eliminated, the patient was ordered to have a Wassermann made; with a double plus result. As the alveolar border over upper incision had become so intensely painful and so tender to the touch, I had these teeth extracted. The patient was immediately put upon salvarsan, but a little too late to spare him the destruction which had evidently started in before he came under my observation.

The destruction to which I refer was the complete necrosis of the intermaxillary bone on both sides. Shortly after removal of the teeth the evidence of necrosis began to be patent along the lower margin of the alveolar border in this region. In the course of several weeks, the whole mass of bone giving evidence of having separated, it was gently grasped with forceps and removed as one piece. By this time the patient had received three intervenous injections of salvarsan.

The important and salient feature in this case is, first, the severe, continuous pain for many weeks without any objective signs. Second, the severe necrosis, with the formation of complete sequestrum without any inflammatory swelling, and third, the complete limitation of the necrosis within distinct anatomic borders.