

IV.

GUMMA IN FOSSA OF ROSENMUELLER CAUSING DEAFNESS.*

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Mrs. H., aged forty-one years, married, called October 25, 1916, complaining of deafness in the left ear. This had been growing progressively worse for three weeks, and the sense of fullness was most annoying. She denied all knowledge of any initial lesion, was the mother of three normal children, and aside of a seven months' stillborn child between the first and second children, there was nothing to suggest a luetic infection.

Examination of left ear showed a decided retraction of the drum, but no adhesions. Right ear, normal to hearing tests. Left ear, conversation, twelve feet; whisper, eight feet; acoumeter and watch, five feet; Weber to left; Rinné, positive; Schwabach, normal; large C and small C⁴ forks heard, but not so well as on the right side.

The nose and mouth were negative. With the postnasal mirror, however, a mass was readily made out in the left side of the nasopharynx. It extended from the posterior wall forward to the palate, precluding a view of the lower and middle turbinates. At the site of the eustachian tube was a slight dimple or depression. Passing a catheter into this failed to inflate the ear. No undue force was used, as the diagnosis was not fixed, and I did not want to cause any trauma which might result in cicatricial contraction of the tubal orifice. This mass was about the size of a hickory nut. Surface was more or less covered with a false membrane, interspersed with smaller areas of reddish tissue. It seemed quite firm to touch

*Read before the New York Academy of Medicine, Section on Otol-ogy, December 8, 1916.

of the catheter, did not bleed, and was not tender on pressure. Tumor was even better seen through the nasopharyngoscope of Holmes.

The diagnosis lay between a malignant growth and a gumma, with a decided leaning toward the latter, despite the negative history. Tuberculosis was ruled out because of the single growth, lack of erosion, healthy appearance of surrounding tissues, and absence of larynx and lung involvement. There was no glandular enlargement. A competent pathologist reported a four plus Wassermann.

On November 3d and 10th I injected neosalvarsan gram 0.45, and on November 23d, gram 0.60, intravenously. She was likewise put on a fifty per cent solution of sodium iodid with mercury inunctions. Reaction was prompt. After the first injection the mass was reduced by one-half; after the second, the tube could be catheterized, while after the third, hearing was equal to that of the right ear and Rosenmüller's fossa was free.

Examination of the literature shows this form of solitary tertiary lesion to be quite uncommon. Mucous patches of the secondary stage throughout the mouth and pharynx are frequently seen. Likewise a gumma of the soft palate with perforation and cicatricial contraction is often encountered. The interesting point in the case cited is the total freedom from symptoms referable to syphilis. If she had not noticed a disturbance in hearing, she would have sought no medical advice until sloughing of the palate had occurred.

Gerber reports a similar case, where, however, there was a clear history of primary infection some six years previous. In his atlas he shows an excellent reproduction of this condition, but there is an added involvement of the uvula. Gerber concludes by maintaining that tertiary syphilis can be present and concealed in the nasopharynx without any other manifestation of the disease elsewhere about the body. This is quite important to remember, since such a neglected case would surely be followed by ulceration of the soft palate or tubal opening, and more or less stenosis be the result. A small lesion is readily overlooked, especially where posterior rhinoscopy is difficult or impossible. It is here that the electric nasopharyngoscope of Holmes is of distinct value, and it should

always be used where the otoscopic findings do not fully account for the disturbances of hearing.

A negative specific history should never mislead one in his conclusions, for with improved technic in serodiagnosis, cases of mild, overlooked syphilitic infection are yearly becoming more frequent. To illustrate, let me give briefly a hitherto unpublished case related to me by Dr. A. Rostenberg:

A married woman came to him with a diffuse papular eruption scattered about the body. It looked suspiciously like a secondary syphilide. Possibility of a primary lesion was denied. On close examination he discovered a scar the size of a dime on the sternum just below the clavicle. She stated this to be the site of a sore some five weeks before. He consulted the physician then in attendance, who said it was a hard indolent ulcer, yielding slowly to aseptic treatment, and lasted about four weeks. Because of its unusual location, he gave no thought to syphilis. Further investigation brought to light the fact there was a boarder in her house who had had a chancre, and that the patient took care of his linen. Contaminated finger nails and a scratch on the breast completed the chain of evidence. Subsequent Wassermann was strongly positive.

If this woman had disregarded her rash, which was of mild degree and apparently unimportant, she would have been totally innocent of the source of infection. Some years later, seeking relief from a tertiary lesion, she would have indignantly denied the possibility of lues.

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