

ceased. Because of the earlier successful and uncomplicated use of the white Tegretol tablets, we speculated that a change in the production of the tablets was responsible for her unusual symptoms. We were able to provide the patient with a supply of the original, white Tegretol tablets. After starting at 100 mg/d, the dosage has been slowly increased to 200 mg three times a day with no untoward effects.

Comment.—The pattern of clinical response to the white, then pink, and, finally, white Tegretol tablets makes a compelling scientific argument for implicating some component of the new, pink Tegretol tablets in causing the toxicity. Anecdotal reports of altered clinical status associated with the introduction of the new Tegretol tablets have also recently appeared in the epilepsy lay press. Management in this woman may require the availability of the old, white Tegretol tablets or other, perhaps generic, preparations.

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Pontine Pure Motor Hemiparesis due to Meningovascular Syphilis in Human Immunodeficiency Virus-Positive Patients

To the Editor.—Johns et al¹ have called attention to the occurrence of a stroke syndrome of pure motor hemiparesis (PMH) in the setting of meningovascular neurosyphilis in patients with evidence of human immunodeficiency virus infection. Their two patients had magnetic resonance imaging documentation of infarction in the contralateral basis pontis as the mechanism of the PMH. These, and the following observation, suggest that this infectious central nervous system vasculitis may have a predilection for involvement of pontine branches of the basilar artery.

Report of a Case.—A 26-year-old homosexual man developed a penile chancre one year prior to admission. Three months later, he presented with a palmar erythematous rash, positive rapid plasma reagin test results (1:1024), and a positive (3+) serum fluorescent treponemal antibody test result. He was treated with two intramuscular doses of 2.4 million units of benzathine penicillin one week apart.

For two months prior to admission, he had daily frontal headaches, and the day before admission, he had the abrupt onset of left hemiparesis and vomiting. In addition to weakness, a feeling of "numbness" was also present in the left limbs. On examination, he was afebrile, normoten-



Fig 1.—Infarct in right basis pontis and tegmentum (arrow) on magnetic resonance imaging (spin echo, TE = 60; TR = 1500).

sive, with regular pulse and without carotid bruits or heart murmurs. He was alert and oriented, dysarthric, and fully aware of his left-sided deficit, which consisted of a moderate left hemiparesis affecting the face and arm more than the leg, with slight hyperreflexia and Babinski's sign. Sensation was intact to all modalities. Visual fields, extraocular movements, pupillary size and reactivity, palatal function, and tongue motility were all normal.

A computed tomographic scan of the head with contrast medium was normal. Cerebrospinal fluid analysis revealed the following: elevated protein (1.42 g/L [142 mg/dL]); normal glucose; pleocytosis of 210 white blood cells (0.13 [13%] polymorphonuclear cells, 0.76 [76%] lymphocytes, and 0.11 [11%] monocytes); reactive VDRL (1:4); and a markedly elevated IgG level (0.55 g/L [55 mg/dL]), with two oligoclonal bands detected. Serum fluorescent treponemal antibody absorbed test was reactive (3+), and the rapid plasma reagin test was positive (1:64). Serum human immunodeficiency virus antibody was reactive by enzyme-linked immunosorbent assay and Western blot techniques. Magnetic resonance imaging documented a high-signal abnormality in the right basis pontis, extending into the ventral tegmentum, consistent with acute infarction (Fig 1). Cerebral angiography showed "beading" of medium-sized distal intracranial arteries and irregular areas of focal spasm of more proximal trunks, especially in branches of the basilar artery (Fig 2). Prior to the onset of therapy, the left hemiparesis worsened to complete paralysis of the arm and severe paresis of the leg, and bilateral gaze-evoked nystagmus in horizontal gaze and mild right sixth-nerve palsy were documented. He was treated with aqueous penicillin, 2 million units administered intravenously, every two hours for three weeks, with resolution of the right sixth-nerve palsy and progressive improvement in his left hemiparesis and cerebrospinal fluid abnormalities (on day 21, the cell count was 14 lymphocytes, normal glucose



Fig 2.—Left vertebral angiogram, lateral view, with "beading" of distal small arteries (short arrow) and constriction of proximal segment of one superior cerebellar artery (long arrow).

level, and the protein level was 0.54 g/L [54 mg/dL]).

Comment.—This observation adds to previous reports of development of neurosyphilis after "adequate" therapy for primary or secondary infection,^{2,6} an occurrence that may be facilitated by concomitant human immunodeficiency virus infection.^{2,6} The vasculitis of this form of meningovascular syphilis may favor involvement of basilar artery branches, suggesting that PMH and other brainstem vascular syndromes may become a common stroke presentation in young patients affected by this infection.

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