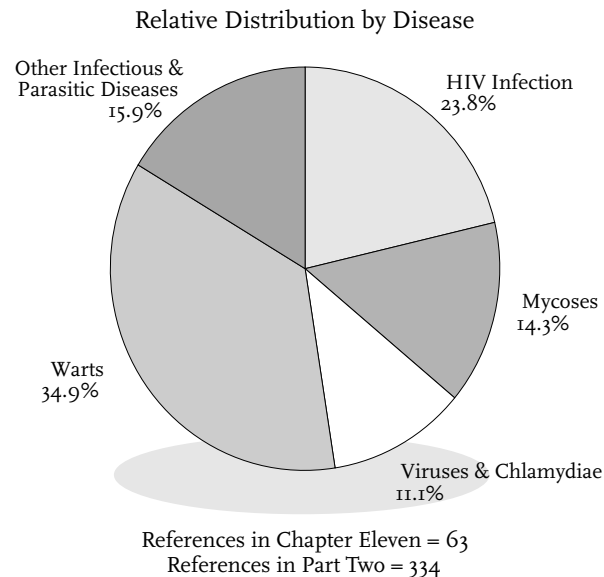


## II. Remission of Infectious and Parasitic Diseases



# Remission of Infectious and Parasitic Diseases



**I**nfectious and parasitic diseases include communicable or transmissible diseases caused by bacteria, fungi, rickettsia, chlamydia, viruses and parasites as well as diseases of unknown, but possibly infectious nature. These diseases can be borne by insects, birds, soil microorganisms, other humans or animals.

Examples of infectious and parasitic diseases include human immunodeficiency virus (HIV) infection; tuberculosis; typhoid fever; childhood infections such as diphtheria; whooping cough; measles; mumps; and chickenpox; polio; insect-borne diseases like malaria or encephalitis; viral hepatitis; venereal diseases; warts; intestinal parasitic infections; and the common cold. It can be seen that the diseases in this category cover a wide range. For some, such as many childhood infections and polio, vaccines have been developed that prevent these infections.

Many of these diseases, such as common bacterial or viral infections, run a natural course from inception to resolution and are not life-threatening. Other infectious diseases can be chronic and recur throughout the lifetime of the affected individual. Some diseases in this category, like HIV infections, are life-threatening and have no cure at present.

In the International Classification of Diseases 9th Revision (ICD-9-CM)\*, a volume created to provide a

consistent classification of all diseases, infectious and parasitic diseases has been assigned the code numbers 001-039.

In Chapter 11, spontaneous remission of a number of these diseases is presented. There are 63 references (18.9% of the 334 references in Part Two) in the chapter—39 annotated and 24 supplemental. Full text of 30 case reports is included. A summary of the chapter contents is presented in Table One.

Table One: References and Case Reports in Chapter Eleven †

Disease	References (number)	Cases (number)	Cases (%)
HIV (total)	15	12	10.0%
Serology	2	3	2.5%
Kaposi's Sarcoma	4	2	1.7%
Other Opportunistic Infections	9	7	5.8%
Mycoses (total)	9	7	5.8%
Sporotrichosis	3	2	1.7%
Other Mycoses	6	5	4.2%
Diseases Due to Viruses and Chlamydiae (total)	39	11	9.2%
Molluscum contagiosum	2	2	1.7%
Warts	22	7	5.8%
Helminthiases	5	0	0.0%
Other Infectious Diseases	10	2	1.7%
Totals	63	30	25.0%

† Total number of case reports in Part Two is 120.

\* Commission on Professional and Hospital Activities [Ann Arbor, Michigan: Edwards Brothers, Inc.], April 1986.

# Human Immune Deficiency Virus Infection

## REVERSAL OF POSITIVE SEROLOGY

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### Loss of Human Immunodeficiency Virus Type 1 (HIV-1) Antibodies with Evidence of Viral Infection in Asymptomatic Homosexual Men

*A Report from the Multicenter AIDS Cohort Study*

FARZADEGAN H; POLIS MA; WOLINSKY SM; RINALDO CR JR; SNINSKY JJ; KWOK S; GRIFFITH RL; KASLOW RA; PHAIR JP; POLK BF; SAAH AJ  
*Annals of Internal Medicine* 108 (6): Jun 1988; 785-790

#### *Extracted Summary*

Four asymptomatic homosexual men reverted from positive to negative serologic results for the human immunodeficiency virus, type 1 (HIV-1) over 2.5 years, as shown by enzyme-linked immunosorbent assay (ELISA) and Western blot. Antibody bands in the Western blot from three men were undetectable 6 to 12 months after being positive; gradual fading of the number and intensity of bands was seen in the other man. No HIV-1-p24 antigenemia was detected; cryopreserved peripheral blood mononuclear cells were negative for HIV-1 by standard culture assay. Polymerase chain reaction (gene amplification) assays were done on peripheral blood mononuclear cells and showed the HIV-1 provirus in all subjects 6 to 18 months after the last positive antibody test. Serum specimens from each participant were genetically identical. Polymerase chain reaction showed that peripheral blood mononuclear cells from one subject at different times matched by HLA DNA typing. Clinical and laboratory features of these four men were similar to those of other seronegative subjects. Rare, asymptomatic persons seropositive for HIV-1 may not remain seropositive, but may remain latently infected with HIV-1.

### Reversal of Positive Serology for Human Immunodeficiency Virus (HIV)

*Observation of Two Cases*

PERRIN LH; ZUBLER R; HIRSCHL B; MARTIN JL; SALOMON D; SAURAT JH; FRYC O  
*Schweizerische Medizinische Wochenschrift* 118(45): Nov 12 1988; 1641-1644

#### *Extracted Summary*

The medical history and laboratory data of two persons who have been in contact with HIV-1 positive carrier individuals are reported. The serologic data of successive serum samples collected from these persons were first negative, then positive (including antibodies directed against Gag and Env gene products), and finally negative for presence of anti-HIV-1 antibodies. Physical examination and other laboratory data, including absolute number of CD4 lymphocytes/mm<sup>3</sup>, were within the normal range in these two individuals, who presented a reversal of positive serology for HIV-1.

## SELECTED CASE REPORTS

**O**bservation 1 (Ms. X.): The blood donor was a 57-year-old single nurse in good health who stated she had never had a sexual relationship. Her medical history revealed that she took frequent care of an AIDS patient for a period of one month. This occurred three months before her blood donation and detection of the anti-HIV-1 antibodies. It was believed that the nurse had not ever been stuck with needles that were contaminated by the blood of the AIDS patient. Moreover, the nurse did not take particular precautions (gloves) and stated to have had frequent superficial lesions of mechanical origin in both of her hands. Clinical examination of the nurse was unremarkable.

**O**bservation 2 (Mr. Y.): The second observation is that of a single 34-year-old male in good health who reportedly engaged in bisexual behavior, and who spends several months a year in tropical regions. His medical history did not reveal other risk factors. At the beginning of his two latest trips, this subject presented to the Clinic of Dermatology for a check-up; he also asked to undergo a serologic test for HIV-1. Clinical examination of this patient was unremarkable.

**R**esults: Serologic tests were performed on successive blood serums of both Ms. X and Mr. Y. The tests presented in this table were performed at the time of request of these exams and then repeated before and after seroconversion with frozen serum samples (identical results). Moreover, the frozen serums were analyzed for an entire series of genetic markers (techniques utilized in legal medicine as a routine for paternity searches) within the limit of available serum. It was

therefore demonstrated that the successive serums of Ms. X came from the same individual with a probability of 99.99%, while the successive serums of Mr. Y came from the same individual with a probability of 98.24%.

It was demonstrated that both Ms. X and Mr. Y had an initial negative test for the presence of anti-HIV-1 antibodies. Following this, the test was positive and after a three-month interval reverted to negative. The two tests utilized Abbott EIA and Elavia and gave similar results. Moreover, the positivity of the tests was confirmed by immunoblot HIV-1; the two serums reacted with at least two well-defined components of HIV-1 that correspond to gene products found in the envelope (gp 160, gp 120) and in the virus (protein 24 and 17). In Ms. X, antibodies against the envelope antigens were brought to evidence by a second technique (Envacor). The serums of Ms. X and Mr. Y taken at the time of seroconversion both reacted with a 26 kilodalton antigen on immunoblot specific for HIV-2 virus. The antigen p 26 (p 26 for a protein of molecular weight equal to 26 kilodaltons) in HIV-2 corresponds to the p 24 viral antigen in HIV-1. These two antigens have several antigenic determinants in common, and cross-reacting antibody reactions involving the antigens can be frequently observed. Furthermore, the authors did not detect viral antigens circulating in the serums taken at the time of seroconversion and after its reversal.

The other laboratory exams performed in these two subjects were normal; among others, these were velocity of sedimentation, blood tests, absolute number of T4 lymphocytes greater than 1000/mm<sup>3</sup>, and transaminases. (Noetic Sciences translation)

## KAPOSI'S SARCOMA

# Spontaneously Healing Kaposi's Sarcoma In AIDS

JANIER M; VIGNON MD; COTTENOT F

*New England Journal of Medicine* 312(25): June 20 1985; 1638-1639

### Extracted Summary

Spontaneous healing has been described in classic Kaposi's sarcoma (KS) and may represent up to 10% of these forms. It has also been observed in recipients of renal allografts, the sarcoma sometimes disappearing when immunosuppression is corrected. However, we know of only one report of spontaneously healing KS in the acquired immunodeficiency syndrome (AIDS). A case of spontaneously regressing KS in a 25-year-old homosexual man is reported.

## SELECTED CASE REPORT

**W**e wish to report the case of spontaneously regressing Kaposi's sarcoma in a 25-year-old homosexual man who presented with a wast-

ing syndrome and cutaneous lesions evolving in three stages. The first stage consisted of purple pustular lesions on the legs, forearms, and hands. Biopsy specimens dis-

closed a polymorphous perivascular infiltrate of the superficial dermis with plump endothelial cells. A second stage was characterized by violaceous papules. Biopsy specimens showed marked capillary angiogenesis surrounded by a polymorphous inflammatory granuloma. In the third stage violaceous plaques appeared on the legs and forearms. Biopsy confirmed the clinical impression of Kaposi's sarcoma.

The course of these lesions was strikingly different from the usual Kaposi's sarcoma in AIDS. There was no extracutaneous involvement. Some of the lesions disappeared spontaneously after Stage 1 or 2; the others disappeared after Stage 3. At the same time, the immune status of the patient worsened, with the onset of severe pulmonary tuberculosis, *Pneumocystis carinii* pneumonia, and cerebral toxoplasmosis.

## Patients with Kaposi Sarcoma Who Opt for No Treatment

LEVY EM; BELDEKAS JC; BLACK PH; LERMAN RH; COTTRELL MC; KUSHI LH

*Lancet* 2: July 27 1985; 223

### *Extracted Summary*

The authors have been studying immune function in a group which includes 10 men with Kaposi's Sarcoma (KS) who have chosen not to enter conventional treatment protocols. These men seem to be surviving at least as well as patients who have been treated. These men may not be representative of KS patients in general. Their choice to forego conventional medical therapy may indicate a strong, independent psychological makeup which could enhance survival. They are all following a vegetarian (macrobiotic) diet and have a strong social support system.

## Spontaneous Regression of Kaposi's Sarcoma in Patients with AIDS

REAL FX; KROWN SE

*New England Journal of Medicine* 313(26): Dec 26 1985; 1659

### *Extracted Summary*

Spontaneous regression of AIDS-related Kaposi's sarcoma (KS) occurs in a low proportion of patients, and it may be an indication of better overall prognosis. Close observation without treatment directed at KS is a reasonable approach in this subgroup of patients. The authors report their observations of spontaneous regression of lesions of KS in patients with AIDS. Of 159 patients with AIDS and KS who were referred to the authors for treatment between April 1981 and June 1985, six had spontaneous regression of cutaneous KS lesions (3.8%).

## Spontaneous Remission of Kaposi's Sarcoma in an HTLV III-Negative Homosexual Man

BLAYNEY DW; ITO JI; JENSEN FC

*Cancer* 58(7): Oct 1 1986; 1583-1584

### *Extracted Summary*

Kaposi's sarcoma (KS) in homosexual men has been linked to the acquired immune deficiency syndrome (AIDS). We describe a 51-year-old homosexual man who developed extremity KS while taking corticosteroids. The KS resolved when the steroids were withdrawn. He did not have classically defined AIDS: no evidence of HTLV-III infection was found after serial ELISA and "Western blot" analysis of the patient's serum nor after co-cultivation of his peripheral blood lymphocytes. This clinical observation is consistent with the hypothesis that AIDS and KS may have different etiologic agents. Corticosteroids should be used with caution in patients at risk for KS (including homosexual men) and may be complicated by the development of KS without HTLV-III-induced immunosuppression.

#### SELECTED CASE REPORT

A 51-year-old white male homosexual developed jaundice, malaise, and fatigue in October 1984. Laboratory abnormalities included the following values: a bilirubin, 13.3; serum glutamic oxaloacetic transaminase (SGOT), 1,025; and serum glutamic pyruvic transaminase (SGPT), 1,275, and serum positivity for hepatitis B surface, core, and E antigens. Oral prednisone was prescribed for 6 weeks, and he had gradual resolution of his symptoms and liver function abnormalities. During his convalescence, he first noticed macular, nonpainful discolored lesions on his feet, and he was referred to our institution. He denied previous medical illness, fevers, weight loss, blood transfusion, or intravenous drug use. He was a sexually active, exclusively homosexual male with multiple sexual partners (including anonymous partners), until approximately four years prior to the development of illness, when he reduced his activity to

approximately one partner per month. He denied previous sexually transmitted diseases, including syphilis and gonorrhea.

The findings of the general physical examination were unremarkable save for three purplish, erythematous macular lesions on the sole of the right foot and two similar lesions on the lateral aspect of the left foot. There was no lymphadenopathy or oral thrush. Excisional biopsy of the largest lesion on the left foot was interpreted as Kaposi's sarcoma. Bone marrow examination and microbiologic culture were normal. No therapy was recommended. Two months later, gradual regression of the lesions was noted, which was complete by April 1985. An exacerbation of hepatitis was treated with bed rest; no further corticosteroids were prescribed and no antineoplastic therapy was given. The patient continued in remission when last seen in October 1985.

#### OTHER OPPORTUNISTIC INFECTIONS AND DISORDERS ASSOCIATED WITH HIV INFECTION

## Spontaneous Resolution of Cryptosporidiosis in a Child with Acquired Immunodeficiency Syndrome

BERKOWITZ CD; SEIDEL JS

*American Journal of Diseases of Children* 139(10): Oct 1985; 967

#### Extracted Summary

We report a child with acquired immunodeficiency syndrome (AIDS) who developed cryptosporidiosis that resolved before antimicrobial therapy was initiated.

#### SELECTED CASE REPORT

The patient, a male infant, was the 1,350 gram product of a 31-week gestation born to a non-drug-addicted mother (gravida 13/para 6/abortus 7). The neonatal period was complicated and the infant underwent two double volume exchange transfusions, three packed red blood cell transfusions, and one platelet transfusion.

At 8 months of age, he manifested failure to thrive, oral and cutaneous candidiasis unresponsive to nystatin, salmonellal gastroenteritis, recurrent otitis media, generalized lymphadenopathy, and hepatosplenomegaly. He was managed with prophylactic administration of trimethoprim/sulfamethoxazole and high caloric formula supplement. He has been followed up for two years. Candidiasis, lymphadenopathy, and hepatosplenomegaly have resolved, and he has had two isolated episodes of otitis media.

Significant laboratory tests at 33 months of age included: IgG, 3,300 mg/dL; IgM, 250 mg/dL; IgA, 64 mg/dL; IgD, not detected; cutaneous anergy to four intradermal skin tests; and mildly diminished in vitro response to pokeweed mitogen, phytohemagglutinin, and Concan-

valin A. The total lymphocyte count was 3,302/mm<sup>3</sup>; T<sub>4</sub> (helper) cells, 759/mm<sup>3</sup>; T<sub>8</sub> (suppressor) cells, 1,156/mm<sup>3</sup>; and T<sub>4</sub>/T<sub>8</sub>, 0.7. He demonstrated antibodies to human T-cell lymphotropic virus type III (HTLV-III), but not to cytomegalovirus, adenovirus, or herpes simplex. Chest x-ray film revealed a persistent, nodular interstitial pneumonia.

At 33 months of age the patient developed profuse, watery diarrhea (nine to ten stools per day) without blood or mucus. There was an 800 gram weight loss. Stool specimens for routine bacteriologic culture and ova and parasites were negative, but modified acid-fast stain of the stool revealed *Cryptosporidium*. The patient remained symptomatic for five weeks. He became febrile and developed herpetic gingivostomatitis, which subsided in six days. Coincidentally, the patient had a spontaneous cessation in his diarrhea. Four follow-up stool specimens examined over a one month period using acid-fast stain were all negative.

# Transient Remission after Viral Infection In Three Patients with Chronic Autoimmune Thrombocytopenia

TERTIAN G; DERYCKE M; DELFRAISSY JF; LAURIAN Y; TCHERNIA G  
*Nouvelle Revue Francaise D'Hematologie 28(1): 1986; 11-14*

## Extracted Summary

We describe three patients with chronic autoimmune thrombocytopenia who exhibited transient remission during viral infection (varicella, hepatitis B, and influenza virus pneumopathy). In two patients, a male homosexual and a hemophiliac, thrombocytopenia was associated with AIDS-related complex. The third patient had classic idiopathic thrombocytopenic purpura. The mechanism of these rare remissions is discussed.

## SELECTED CASE REPORT

**O**bservation 1: Mr. Ma..., a 29-year-old homosexual male, non-abuser of drugs, who had no previous history of disease, presented to the authors in April, 1984 for a thrombocytopenia discovered five months earlier. The clinical examination was normal except for a discrete purpura of the inferior limbs. The thrombocytopenia was advanced and isolated, without lymphocytopenia. The bone marrow was rich in megakaryocytes. Search for anti-nuclear factors, and direct red blood cell assay using Coombs' Test were both negative. Coombs' direct platelet assay was positive (5000 IgG/platelet). Electrophoresis of serum proteins demonstrated a polyclonal hypergammaglobulinemia (18.7 gm/l). The study of T lymphocyte subpopulations of the blood demonstrated a significant decrease of the T<sub>4</sub>/T<sub>8</sub> ratio without lymphocytopenia (lymphocytes = 2000/mm<sup>3</sup>, T<sub>3</sub> = 1200/mm<sup>3</sup>, T<sub>4</sub> = 320/mm<sup>3</sup>, T<sub>8</sub> = 700/mm<sup>3</sup>, giving a T<sub>4</sub>/T<sub>8</sub> ratio of 0.45 with a value of 1.85). The study of the proliferation of T lymphocytes in the presence of mitogens (phytohemagglutinin, Concanavaline A), demonstrated a moderate functional deficit with a sub-normal production in-vitro of interleukin 2. Multitest (copyright Merieux) for six out of the seven antigens tested (tetanus, diphtheria, streptococcus, tuberculin, trichophyton, candida) was slightly positive for the proteins. Serology of the LAV virus was positive. Search for an opportunistic infection, especially by alveolar wash, was negative. These results led to a

diagnosis of autoimmune thrombocytopenia in a patient with AIDS-related complex (ARC).

In June 1984, the patient was hospitalized on account of a severe case of varicella which was treated, because of the autoimmune deficit, with Acyclovir (15 mg/kg/day for five days). The evolution of the varicella had a favorable outcome. At the same time, a rapid correction of the thrombocytopenia took place seven days after the occurrence of the varicella, while Coombs' Test for platelets went from positive to negative. This improvement was transitory with re-occurrence of the thrombocytopenia three weeks later and a return of Coombs' Test for platelets to positive.

To eliminate the possibility that Acyclovir had a role in this remission, a second treatment was begun in July 1984, following the same modalities. No significant modification of the platelet count was observed and Coombs' Test remained positive. During the entire evolution and modification of the platelet count, the T<sub>4</sub>/T<sub>8</sub> ratio remained constantly low and unmodified.

Three months later, the patient underwent splenectomy after a five-day treatment with gammaglobulins (copyright Venioglobulines Merieux) at a dose of 0.4 gm/day i. v., which brought his platelet count up from  $3 \times 10^9/l$  to  $137 \times 10^9/l$  on the day of the operation. In the following months, the platelet count was made regularly and found to be normal. (Noetic Sciences translation)

# Unusual Remission of Pneumocystis carinii Pneumonia in a Patient with the Acquired Immune Deficiency Syndrome

HURLEY P; WEIKEL C; TEMELES D; ROSENBERG S; PEARSON R  
*American Journal of Medicine 82(3 Spec No): Mar 23 1987; 645-648*

## Extracted Summary

Pneumocystis carinii is a well-recognized cause of pneumonia in patients with immune deficiency, and, when untreated, mortality approaches 100%. Although rare cases suggesting spon-

taneous recovery (usually accompanied by resolving immune deficiency) have been reported, spontaneous resolution of *P. carinii* pneumonia in patients with the acquired immune deficiency syndrome (AIDS) has not been described. A patient with AIDS in whom *Pneumocystis* pneumonia developed and remitted without appropriate therapy is described. This case suggests that the immunologic defects of AIDS are not fixed and that fluctuations in the degree of immunocompetence may allow for clinical recovery from opportunistic infections associated with AIDS even without appropriate therapy.

#### SELECTED CASE REPORT

A 33-year-old black man had development of dysphagia in July 1984, diagnosed as pharyngeal candidiasis one month later. Despite treatment with nystatin oral suspension and penicillin VK, his symptoms persisted. Over the next two weeks, bilateral pleuritic chest pains and shortness of breath developed. Chest radiography on September 7, 1984, demonstrated bilateral pulmonary infiltrates, and treatment with cefaclor was initiated. Because his symptoms progressed, he was admitted to his local hospital two days later. Additional history of fevers, chills, weight loss over the previous two months was obtained. Physical examination revealed a temperature of 38.5°C, prominent candidal pharyngitis, and bilateral scattered rales on chest auscultation. His white blood cell count was 7,900/mm<sup>3</sup>, and the hematocrit was 35.8%. Blood cultures showed no growth. *Legionella* and *Mycoplasma* antibodies were undetectable. The patient was treated with erythromycin intravenously for eight days but his symptoms worsened, corresponding with progressive infiltrates on chest radiography. Bronchoscopy was performed, and a transbronchial biopsy specimen clearly demonstrated *P. carinii*. Subsequently, the patient acknowledged a six-month history of intravenous use of heroin and cocaine in New York City in 1982. He denied other risk factors associated with AIDS. The patient began to receive oral trimethoprim/sulfamethoxazole (160/800 mg) every six hours, but took only two doses before leaving the hospital against medical advice with no therapy. Dissatisfied with conventional therapy, the patient resorted to daily ingestions of fresh garlic and multivitamins. Over the next two weeks, the patient's chest pains, fevers, and shortness of breath resolved.

On October 5, 1984, the patient was evaluated at the University of Virginia Hospital. The patient was afebrile on physical examination. A small cotton-wool spot was

present in the left fundus. There were no oropharyngeal lesions, and results of chest auscultation were normal. The white blood cell count was 3,200/mm<sup>3</sup> with a lymphocyte count of 512/mm<sup>3</sup>. The hematocrit was 33.1%. A room air arterial blood gas study showed a pH of 7.43, carbon dioxide tension of 40 mmHg, and oxygen tension of 103 mmHg. Chest radiography demonstrated nearly complete clearing of infiltrates. Other serum studies showed a mild elevation of hepatic transaminase levels and the presence of IgG antibody to hepatitis B core antigen. The patient was anergic to *Candida*, *Trichophyton*, and tetanus antigens. Quantitative immunoglobulin study demonstrated mildly elevated IgG and IgA levels. The helper/suppressor T-cell ratio was 0.2. Results of testing for HTLV antibody were positive. Pulmonary function tests suggested restrictive pulmonary disease, and limited exercise oximetry testing demonstrated arterial desaturation with minimal exercise. He was discharged without therapy.

Six weeks later, the patient presented with a two-week history of progressive shortness of breath. An arterial blood gas study with the patient breathing room air showed a pH of 7.46, carbon dioxide tension of 35 mmHg, and oxygen tension of 66 mmHg. Chest radiography showed bilateral lower lobe infiltrates. Bronchoscopy with biopsy again demonstrated *P. carinii*. The patient was treated with trimethoprim/sulfamethoxazole and, subsequently, because of drug-related leukopenia, pentamidine isethionate for a total of 20 days. At the time of discharge, he was symptom free and his chest radiographic findings were completely normal. He remained well for four months until diarrhea, weight loss, and malaise developed. He was found to have adrenal insufficiency and improved with treatment. However, two weeks after returning home, he had a cardiopulmonary arrest and could not be resuscitated.

## Spontaneous Remission of Retinitis in a Case of Infection with Human Immunodeficiency Virus Type 1 (HIV-1)

NAHASS RG; ALCID D; GOCKE DJ

*Annals of Internal Medicine* 109(2): Jul 15 1988; 168

### Extracted Summary

A case of cytomegalovirus chorioretinitis in a 30-year-old male intravenous drug user with group 4 human immunodeficiency virus type 1 (HIV-1) infection is reported. The patient was



not given ganciclovir treatment and two months later the dark spots had resolved and did not recur in the subsequent 3 months. Spontaneous remission of cytomegalovirus retinitis has not been previously reported. (Permission to reproduce case report denied by publisher.)

## Prolonged Survival and Partial Recovery in AIDS-associated Progressive Multifocal Leukoencephalopathy

BERGER JR; MUCKE L

*Neurology* 38: Jul 1988; 1060-1065

### *Extracted Summary*

Two human immunodeficiency virus seropositive patients with progressive multifocal leukoencephalopathy (PML) exhibited a dramatic though incomplete recovery of neurologic function and have survived for more than 30 months since the onset of symptoms. PML was the initial manifestation of the acquired immune deficiency syndrome (AIDS) in both patients, though other opportunistic infections have subsequently supervened in one. Brain tissue from both patients obtained by stereotactic biopsy showed the typical features of PML, but was also characterized by an unusually prominent inflammatory response. Neurologic improvement did not appear to correlate with clinical or laboratory measurements of immunologic improvement. One patient continued to display neurologic recovery despite the development of other opportunistic infections. Though atypical, PML in AIDS may be associated with prolonged survival.

### SELECTED CASE REPORT

**C**ase 2. This 39-year-old homosexual man noted the onset of fatigue and depression in April 1985. In June 1985 memory difficulties and irritability developed gradually, followed shortly thereafter by clumsiness of the left leg, gait impairment, and throbbing headaches that were unaccompanied by nausea, vomiting, photophobia, or neck stiffness. His medical history was pertinent for infectious mononucleosis in his teens requiring splenectomy, syphilis in his twenties successfully treated with erythromycin, probable hepatitis B in 1983, and an uncomplicated pneumonia in 1985. He took no medications routinely and denied use of intravenous drugs. There was no history of other neurologic symptoms, recent weight loss, fevers, lymphadenopathy, or opportunistic infections.

Physical examination on July 22, 1985, revealed a chronically ill-appearing man with normal vital signs who was oriented to person, but not to time or place. He recalled only two of three objects over 5 minutes and calculated very poorly. His speech was mildly dysarthric. Inattention to objects in the left field of vision, saccadic visual pursuit, and difficulty in drawing maps and figures were observed. The left leg was weak; strength was graded (Medical Research Council 1976) as 3/5 for flexion of the hip, 4+/5 for knee extension, and 4/5 for knee flexion. His gait was affected out of proportion to the decrease in muscle strength, in that he was unable to stand or walk unassisted. Hyperreflexia and a Babinski sign were present on the left. Also noted in the left arm and leg were severely impaired position sense, extinction on double

simultaneous testing, markedly reduced graphesthesia, and astereognosis. There was an impressive pseudoathetosis of the left arm. Vibratory perception appeared unaffected. The remainder of the neurologic and general physical examination was unremarkable.

CT of the brain on July 23, 1985, showed an extensive area of low attenuation deep in the parasagittal white matter of the right dorsal parietal lobe with irregular marginal enhancement. There was also a slight midline shift to the left and effacement of sulci in the right hemisphere compatible with cerebral edema. An arteriogram on July 30, 1985, was normal except for prominent medullary veins in the deep aspect of the right parietal lobe.

An EEG revealed continuous generalized delta slowing more prominent on the right with greatest amplitude over the right parietotemporal region. The initial CSF examination on July 23, 1985, revealed an elevated protein of 72 mg% and 24 white blood cells, all mononuclear. HIV was cultured from the CSF (Dr. D. D. Ho, Massachusetts General Hospital). CSF glucose was normal and CSF VDRL, cryptococcal antigen, routine, fungal, and AFB cultures were all negative. The CBC showed 5,900 WBC with polymorphonuclear cells 39% and lymphocytes 37%. The patient showed no skin test reactivity to intermediate strength PPD, mumps, or candida antigen. Cytomegalovirus was isolated from his urine.

On August 1, 1985, a stereotactic biopsy of the right posterior parietal lobe was performed. The tissue obtained showed severe demyelination in association with many macrophages and enlarged astrocytes as well as

inclusion-bearing oligodendroglial nuclei that appeared dark and swollen. Enlarged astrocytes bearing mitotic figures were also observed. Histopathologic changes were similar to that seen in patient #1 and included a marked lymphocytic reaction, particularly in a perivascular distribution, numerous plasma cells, and a few eosinophils. Electron microscopy was suboptimal, but immunoperoxidase staining using monospecific sera against common papovavirus antigen (Dr. D. L. Walker, University of Wisconsin) showed that many of the abnormal oligodendroglial nuclei were strongly positive. Other microbiological studies, including specific stains for toxoplasmosis, were unrevealing.

An improvement in gait was noted on July 24, 1985, before the initiation of any therapy, in that the patient was able to walk unassisted for short distances, albeit unsteadily. After initiation of dexamethasone which the patient received for a total of 2 weeks his headaches subsided and his gait continued to improve. Because of the unusually prominent inflammatory reaction in the brain biopsy, the CT appearance of his lesion, and a low positive toxoplasmosis titer, the patient was treated empirically with sulfadiazine (taken for 17 days) and pyrimethamine (taken for approximately 6 weeks). On September 1, 1985, a repeat CT of the brain showed a significant decrease in marginal

enhancement in the lesion. His CSF at that time was completely normal. Slowly, the strength in his left arm and leg, his vision, memory, and other mental faculties improved. Interval CTs of the brain were obtained on October 20, 1985, and April 24, 1986.

On July 9, 1986, examination revealed him to be alert and normally oriented. Calculations were normal. He recalled three of five objects over 5 minutes with distraction. His speech was not dysarthric. Visual fields were full. Optokinetic nystagmus was somewhat diminished with the stimulus moving from left to right. A very slight left spastic hemiparesis was apparent. Muscle stretch reflexes were slightly brisker on the left and no Babinski sign could be elicited. Position sense was normal. Gait was remarkable for favoring the left leg and a diminished left arm swing, but was otherwise performed well. MRI of the brain on July 23, 1986, revealed increased signal intensity in the white matter of the right parieto-occipital lobe on T<sub>2</sub> weighted image. CSF examination on July 29, 1986, revealed 23 mononuclear cells, glucose of 53 mg% (serum 96 mg%), and protein 60 mg%. CT performed on March 20, 1987, appeared to show some improvement radiographically, as did a repeat MRI from May 22, 1987. As of November 1987, he has remained neurologically stable.

## Acute Regressive Myelopathy in Infection with Human Immunodeficiency Type 1 Virus

VERSTICHEL P; GRATEAU G; MAS JL; LINDER F; SERENI D  
*La Presse Medicale* 17(32): Sep 24 1988; 1653

### Extracted Summary

Among HIV positive patients (human immunodeficiency virus), only medullary syndromes arising after primary infection have been described as spontaneously regressive. The authors report one case of medullary syndrome with a favorable evolution arising independently of the primary infection.

### SELECTED CASE REPORT

A 27-year-old Lebanese drug abuser was found to be HIV-1 seropositive in 1986. One year later, the patient suffered a motor dysfunction of the lower left limb that became total three weeks later, and that was accompanied by an inflammation of spinal root Th10 and by dysuria.

Clinical examination revealed the existence of a pyramidal syndrome of the inferior limbs, with a minor left paralysis, a slight inflammation of the posterior right (cordonnale) and left spinal thalamic regions. The patient had no fever, no sensitive region, and no spinal syndrome. An epidural or intramedullary tumor was shown to have disappeared by myelography, scanography, and MRI, all of which were normal.

The study of cerebrospinal fluid (CSF) showed 37

cells/mm<sup>3</sup>, spinal proteins 0.70 gm/l with oligoclonal increase of the gammaglobulins to 21%. The search for parasites, and bacterial and viral cultures, was negative. The search for antibodies in the CSF against syphilis, toxoplasmosis, cytomegalovirus, and herpes was negative. The search for anti HIV-1 antibodies was positive in the serum (Western blot) and in the CSF. T<sub>4</sub> lymphocytes were 945, T<sub>8</sub> were 1,137/mm<sup>3</sup>. Cerebral scanography, evoked potentials (visual and somesthetic), as well as electromyogram of the inferior limbs were normal.

Two months after the start of clinical symptoms, the authors observed a motor and sensory recovery that became complete two months later.

(Noetic Sciences translation)

# Thrombocytopenia and Human Immunodeficiency Virus in Children

ELLAURIE M; BURNS ER; BERNSTEIN LJ; SHAH K; RUBINSTEIN A  
*Pediatrics* 82(6): Dec 1988; 905-908

## Extracted Summary

Thrombocytopenia occurs in 13% of children with symptomatic human immunodeficiency virus (HIV) infection. The clinical and laboratory course of 19 children infected with HIV with thrombocytopenia is described. Bone marrow aspirates showed normal to increased numbers of megakaryocytes. Levels of antiplatelet antibodies were increased in 80% of the children and circulating immune complexes were found in 74%. Clinically significant hemorrhage leading to anemia occurred in five patients, and CNS bleeding led to a fatal outcome in an additional three children. Spontaneous remission of thrombocytopenia occurred in three of the 19 subjects. High-dose IV gamma globulin was effective in increasing the platelet counts of six of 15 patients (40%) but resulted in a sustained remission in only one subject. Oral prednisone was effective in increasing the platelet count of two thirds of those whose platelet counts could not be controlled by IV gamma globulin. Bleeding manifestations were eliminated in all patients whose platelet counts increased significantly. Of the 11 children whose counts increased either spontaneously or as a result of therapy, eight remain alive (72%). In contrast, all of the eight patients whose platelet counts did not improve have died.

Thrombocytopenia in children with HIV disease is engendered by immune mechanisms and is a major cause of morbidity and mortality. High-dose IV gamma globulin and/or corticosteroids are temporarily effective in increasing the platelet count and reducing bleeding in about half of thrombocytopenic patients and are recommended for use. The ability to respond to therapy correlates with improved survival.

During the course of the study, three patients (16%) had significant spontaneous increases in platelet counts and required no therapy for thrombocytopenia. Detailed data is presented. In this group, the platelet-associated IgG and C1q levels were not predictive of the spontaneous increase.

## Spontaneous Resolution of Endobronchial Mycobacterium Avium-intracellulare Infection in a Patient with AIDS

CORDASCO EM JR; KEYS T; MEHTA AC; MEHLE ME; LONGWORTH DL  
*Chest* 98(6): Dec 1990; 1540-1542

## Extracted Summary

The authors report what they believe is the first case in the English literature of spontaneous resolution of endobronchial Mycobacterium avium-intracellulare (MAI) infection in the lung of a patient with AIDS. The authors comment that none of the medications the patient received for hemoptysis or parenchymal lung disease have been reported to have a bactericidal activity against MAI in-vivo, and suggest that either parenchymal MAI is self-limiting or that the spontaneous resolution may indicate immunologic reconstitution, perhaps aided by zidovudine and gamma globulin.

### SELECTED CASE REPORT

We previously reported a case of endobronchial Mycobacterium avium-intracellulare infection (MAI) in a patient with AIDS whom we evaluated for massive hemoptysis. (Mehle ME et al., *Chest* 96

(1989), 199-201) Bronchoscopic examination initially disclosed no specific abnormality with the exception of a fresh clot in the posterior segment of the right upper lobe bronchus. A second bronchoscopy performed for evalua-

tion of recurrent massive hemoptysis revealed a clot in the same location. Bronchial artery embolization of the corresponding vessels was therefore performed to control bleeding. One month later a third bronchoscopy performed as a follow-up evaluation disclosed multiple, partially obstructing, polypoid endobronchial lesions. Endobronchial biopsies were performed. Histologic examination revealed necrotizing and non-necrotizing granulomas, and the tissue cultures ultimately grew MAI. Five months later, recurrent hemoptysis, fever, and a chest radiograph typical of bronchiectasis necessitated endobronchial examination. Polypoid masses occluding multiple bronchial segments were partially removed using biopsy forceps, which allowed drainage of purulent material from the distal airways. During the next nine months, the patient's clinical course was dominated by recurrent maxillary sinusitis resistant to multiple courses of antibiotics (amoxicillin-clavulanate, ciprofloxacin); progressive bilateral, interstitial lower lobe infiltrates; and progressive CMV retinitis. Intravenous DHPG and prophylactic therapy with aerosolized pentamidine and oral zidovudine in addition to cyclic antibiotics (erythromycin, tetracycline, cefadroxil) and monthly gamma globulin injections for control of lower

airway infection were utilized over the same period. Bronchoscopy performed for evaluation of the lower lobe interstitial infiltrates 14 months after the initial airway examination demonstrating endobronchial lesions revealed absence of polypoid airway masses. Transbronchial biopsies were unremarkable for infectious organisms or a specific pathologic abnormality. Cytomegalic virus was recovered from bronchoalveolar lavage fluid cultures, but cultures for MAI organisms were negative. The patient continued to experience frequent bouts of sinusitis and minor episodes of hemoptysis. During September 1989 his sputum cultures again turned positive for MAI. However, bronchoscopy performed on October 10, 1989, revealed no bleeding source or evidence of recurrence of endobronchial MAI.

To the best of our knowledge this is the first report in the English literature of spontaneous resolution of endobronchial MAI in a patient with AIDS. None of the medications the patient received during the time of evaluation for hemoptysis and parenchymal lung disease have demonstrated clinical bactericidal activity against MAI, although ciprofloxacin in combination with imipenem and amikacin has demonstrated in vitro activity against MAI.

## Spontaneous Regression of Cardiomyopathy in a Patient with the Acquired Immunodeficiency Syndrome

HAKAS JF JR; GENERALOVICH T  
*Chest* 99(3): Mar 1991; 770-772

### Extracted Summary

Cardiac involvement is common in patients with the acquired immunodeficiency syndrome (AIDS) and, when symptomatic, it portends a poor prognosis. We present a case of marked spontaneous regression of cardiomyopathy in a patient with AIDS. To our knowledge, this is the first reported case of spontaneous recovery of ventricular function in an AIDS patient.

### SELECTED CASE REPORT

A 32-year-old woman was found to have human immunodeficiency virus (HIV) infection (Walter-Reed stage 5, CDC group IV-B) in November 1987 when she developed Guillain-Barré syndrome. A history of intravenous cocaine and heroin abuse was obtained. Echocardiography was normal. Her clinical course was stable until June 1988, when she presented with onset of peripheral edema, abdominal fullness, and dyspnea. Her only medication was methadone.

Physical examination revealed a thin woman, afebrile, with normal vital signs. Marked jugular venous distention with prominent V waves was noted without pulsus paradoxus. The lungs were clear. Cardiac examination revealed a right ventricular heave, summation gallop, and a grade 2/6 pansystolic murmur over the xyphoid with inspiratory augmentation. Pulsatile hepatomegaly and 2+ bipedal edema were present.

Laboratory data at the time of hospital admission showed hemoglobin of 11.4 gm/dl, WBC count of 4,600/mm<sup>3</sup> (normal differential), and normal creatinine. Room air arterial oxygen saturation was 92%. Chest roentgenography showed clear lung fields with a markedly increased cardiac silhouette. Electrocardiography demonstrated sinus tachycardia with left atrial abnormality, decreased voltage, and diffuse T-wave flattening.

Echocardiography showed biventricular dilation with generalized hypokinesis, paradoxical septal motion, and small pericardial effusion. Doppler studies demonstrated pulmonic and tricuspid insufficiency. Gated radionuclide ventriculography revealed a left ventricular ejection fraction (VEF) of 36%; right VEF was 37% by first pass technique. Gallium and perfusion lung scan results were normal. All cultures, antibody titers, rheumatologic studies, and endocrine studies were normal.

Following routine treatment of congestive heart failure, right heart catheterization with endomyocardial biopsy was performed. Findings included left ventricular dysfunction, pulmonary hypertension, and low cardiac output. Biopsy specimens of the right ventricle were subjected to the following: staining and culture for bacteria, fungi, and mycobacterium; HIV culture; and histologic study and electron microscopy. All were normal.

The patient was discharged from the hospital on a regimen of vasodilators, diuretics, and digitalis. Nuclear ventriculography in October 1988 demonstrated further diminution in right and left VEF to 28% and 26%, respectively. Zidovudine (azidothymidine [AZT]) therapy was prescribed, but it was discontinued in December 1988 due to neutropenia. From January through March 1989, the

patient was incarcerated in another state where treatment with all medication was discontinued.

In March 1989, the patient returned to our institution without complaints. Physical examination revealed resolution of the abnormal cardiopulmonary findings and roentgenographic cardiomegaly. Echocardiography demonstrated improvement in biventricular wall motion with resolution of the valvular insufficiencies. Right and left VEF by radionuclide ventriculography were now 33% and 45%, respectively. Repeated cardiac catheterization showed normal coronary arteries and only mild inferior hypokinesis. Cardiac output and pulmonary and systemic hypertension had markedly improved. The patient continued to do well clinically with no medications.

# Mycoses

## SPOROTRICHOSIS

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### Sporotrichosis of the Nose with Spontaneous Cure

BARGMAN HB

*Canadian Medical Association Journal* 124(8): Apr 15 1981; 1027

#### *Extracted Summary*

Sporotrichosis is a chronic skin infection caused by the demorphic fungus *Sporothrix schenckii*. I have been unable to find a documented case of sporotrichosis that underwent spontaneous cure and, therefore, am reporting the following case of sporotrichosis of the nose that spontaneously resolved.

#### SELECTED CASE REPORT

A 39-year-old painter had had an asymptomatic lesion on the right side of the nose for 1 month. He stated that the lesion had begun as a "pimple", and after he squeezed it, it started enlarging. He did not recall any prior trauma to the area.

Grouped scaly papules were noted over the right side of the nose. There were no abnormalities of the surrounding skin or of the regional lymphatics and lymph nodes. A specimen 2 mm in diameter obtained by punch biopsy showed marked hyperkeratosis, irregular acanthosis and a dense infiltrate of plasma cells, lymphocytes and multi-

nucleated, foreign body type giant cells in the upper dermis. Periodic acid-Schiff and Ziehl-Neelsen stains revealed no organisms, but *S. schenckii* was cultured and its identity confirmed by morphologic studies. A chest roentgenogram was normal.

After 1 month the patient returned. No treatment had been given, pending a laboratory diagnosis, but his lesion was smaller. He returned again after 3 weeks and the lesion had nearly disappeared. Eleven weeks after the initial visit all that remained was a slightly depressed scar, which was not the result of a biopsy.

# Sporotrichosis of the Skin with Spontaneous Cure

## Report of a Second Case

BARGMAN HB

*Journal of the American Academy of Dermatology* 8(2): Feb 1983; 261-262

### Extracted Summary

Sporotrichosis is caused by *Sporothrix schenckii*. The organism has worldwide distribution and can be found on both living and dead organic material, especially soil, moss, hay, and wood. The usual clinical picture is one of a suppurative abscess, often with lymphangiectatic spread. Iodides constitute the mainstay of treatment, but in certain situations amphotericin B, surgery, or thermotherapy is indicated. Spontaneous resolution has only been documented once but has been alluded to but not documented in another report. I wish to report the spontaneous resolution of cutaneous sporotrichosis in a young girl.

### SELECTED CASE REPORT

The patient was an 8-year-old white girl who presented in the office on March 3, 1981. She had developed a lesion on the upper right portion of the back in December, 1980. It started as a "pimple" and increased in size. Treatment by another physician with a course of oral penicillin and topical gentian violet was of no benefit. Her past history was noncontributory. A 4 millimeter punch skin biopsy was taken, and samples were sent for histopathologic examination and culture.

Pathologic examination revealed granuloma formation with local areas of polymorphonuclear leukocytes and giant cells of the foreign body type. Periodic acid-Schiff stain revealed a few fragments of suspected fungal hyphae. Cultures for bacteria and atypical mycobacteria were negative. Chest x-ray, VDRL, rheumatoid factor, and urinalysis were negative or within normal limits. An antinuclear factor screening test was weakly positive to a titer of

1:20. The hemoglobin was 13.6 grams, and the white blood cell count was slightly elevated at 11,400/mm<sup>3</sup> with a normal differential. Fungal culture grew *S. schenckii*.

When the patient returned for follow-up on April 2, there was evidence of resolution which consisted of decrease in size of the lesion with shrinkage and early peripheral scar formation. Further history at that time revealed that the patient's mother ran a flower shop and regularly worked with moss. The patient frequently played in the shop and often asked her mother to scratch her back while there. After careful deliberation, it was decided to withhold iodides and to start hot compresses. These were performed on an irregular basis, one to two times per day and for never more than three or four minutes at a time. They were carried on for only 3 to 4 weeks.

When the patient was last seen on June 4, 1981, the lesion was completely healed with scar formation.

### SUPPLEMENTAL REFERENCE SPOROTRICHOSIS

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#### Spontaneous Remission of Extensive Pulmonary Sporotrichosis

PUERINGER RJ; IBER C; DEIKE MA; DAVIES SF

*Annals of Internal Medicine* 104(3): March 1986; 366-7

## Spontaneous Regression of Oral Histoplasmosis

YOUNG SK; ROHRER MD; TWESME AT

*Oral Surgery, Oral Medicine, and Oral Pathology* 52(3): Sept 1981; 267-270

### Extracted Summary

A case of histoplasmosis with an unusual clinical presentation and subsequent disease course was diagnosed when a tooth extraction site failed to heal. Culture, biopsy, and serologic study confirmed the presence of *Histoplasma capsulatum*. Radiographs and sputum culture established pulmonary involvement. Oral and pulmonary lesions regressed without treatment. This case is presented to raise the question of whether all cases of histoplasmosis with oral involvement should be assumed to be disseminated disease requiring treatment with amphotericin B.

### SELECTED CASE REPORT

A 51-year-old Caucasian man was referred to the Oral Surgery Clinic at the Oklahoma City Veterans Administration Hospital on September 9, 1977, because of an "abscessed lower tooth" which had been symptomatic for several weeks. The mandibular left central incisor was mobile and painful and was extracted.

Twenty-one days later the patient returned complaining of continued pain in the extraction site. The area had not healed but was radiographically unremarkable. The patient was placed on penicillin V therapy, 500 milligrams, four times a day.

On October 5 and October 12, 1977, the area appeared to be healing satisfactorily and was asymptomatic. When the patient returned on October 22, 1977, the extraction site had not yet healed and the surrounding tissue was edematous and erythematous, suggesting the possibility of squamous cell carcinoma. The lesion was biopsied and cultured.

Microscopic findings: Two pieces of alveolar mucosa, each measuring approximately 0.5 by 0.3 by 0.3 centimeters, were submitted from the labial and lingual area in the region of the lower left central and lateral incisors. Microscopically, sections of tissue from both biopsy specimens were composed of fibrous connective tissue surfaced in part by parakeratotic stratified squamous epithelium. Portions of the mucosal surface were ulcerated. Within the submucosa was a diffuse, chronic inflammatory cell infiltrate composed predominantly of histiocytes with variable numbers of plasma cells and lymphocytes. Microorganisms, which were round to oval and varied in diameter from 2 to 4 microns, were present within the cytoplasm of the histiocytes. The organisms had a small eosinophilic core surrounded by a clear halo. Grocott's methenamine silver stain disclosed the presence of numerous organisms,

some of which showed single budding. The diagnosis was histoplasmosis.

Work-up: The patient was referred to the Infectious Disease Clinic for work-up of disseminated disease. Pertinent findings in the medical history were treatment of alcoholism since 1975, a productive cough of several years' duration, and the smoking of two packs of cigarettes per day for many years. The patient's history revealed that he had cleaned chicken houses in the 1940s. Physical examination, complete blood count, and blood chemistry were unremarkable. A chest radiograph revealed a 1.0 centimeter irregular nodule overlying the anterior portion of the left third rib, which was not present in 1975. Responses to the histoplasmin skin test and histoplasma serologic tests were positive. One month following the biopsy cultures of gingival tissue and sputum were reported as positive for *Histoplasma capsulatum*.

Clinical course: Approximately 2 months after the biopsy, the gingival lesion had healed but was still erythematous and periodically tender to palpation. Physical examination, blood chemistry, and complete blood count continued to remain within normal limits, and the histoplasma agglutination titers were stabilized. It was decided that no treatment would be instituted unless there was a change in the patient's physical or serologic findings.

Follow-up: The patient has been followed for 2 years, with no evidence of active histoplasmosis. The gingiva has remained normal in the affected area and chest radiographs since November 1977, have shown no evidence of active histoplasmosis. Histoplasma titers converted to negative in January 1979. The patient continues to be followed at regular intervals for any evidence of active disease.

# Spontaneous Recovery Phenomenon in the Presumed Ocular Histoplasmosis Syndrome

ORLANDO RG; DAVIDORF FH

*International Ophthalmology Clinics* 23(2): 1983; 137-149

## Extracted Summary

The presumed ocular histoplasmosis syndrome (POHS) is an important cause of legal blindness in the eastern half of the United States. It is characterized by a prolonged clinical course during which the lesion may show continued activity both ophthalmoscopically and angiographically for 1 1/2 to 2 years. The prognosis for these patients has remained poor, despite the many treatment modalities. In a small percentage of patients (9% or 13 patients), we have seen a remarkable return of vision (to 20/100 or better) in an eye with a long-standing macular scar secondary to histoplasmic choroiditis. Perhaps as many as 9 to 10% of patients can recover useful macular function that previously was lost. In fact, 1 patient in this series experienced a return of 20/20 vision in an eye that had deteriorated to 20/400.

Six hundred seventy-five cases of POHS were reviewed. Of these, 144 contained complete follow-up information documented by visual acuity evaluations, fundus photography, and fluorescein angiography.

Of the 144 patients originally studied, 13 were identified as having undergone a spontaneous recovery, defined as improvement in visual acuity of at least three lines on the Snellen chart from the patient's worst visual acuity after the lesion had become inactive. Patient histories, ophthalmoscopy, fluorescein angiography, and fundus photography of all 13 patients were examined and compared to identify any clinical or demographic characteristics common to patients exhibiting the spontaneous recovery phenomenon.

## SELECTED CASE REPORTS

**A** 53-year-old woman (Patient 3) who had lost central vision in her right eye 8 years previously presented with metamorphopsia and decreased vision in the left eye. Her visual acuity was 20/300 in both eyes. Ophthalmoscopic examination showed an atrophic chorioretinal scar in the macula of the right eye. There was an active choroiditis with subretinal blood and a subretinal neovascular membrane with the FAZ of the left eye. Corticosteroid therapy was begun. The lesion became inactive and remained so for 2 years, at which time the patient again experienced a decrease in vision. Examination showed recurrent subretinal hemorrhage beneath the macula of the left eye, and the neovascular membrane again was demonstrable on fluorescein angiography. Visual acuity remained 20/300 in both eyes and failed to improve with corticosteroid therapy. Two years later, the patient noticed a sudden improvement of vision in both eyes; visual acuity had improved to 20/40. The macular scars of each eye, however, were unchanged from those seen 2 and 4 years previously.

**A**t age 30, this woman (Patient 9) lost central vision in the left eye owing to POHS. Thirteen years later, she presented with symptoms of metamorphopsia and decreased vision in the right eye. Acuities at this time were 20/400 in the right eye and 20/200 in the left. An area of subretinal edema was seen in the right macula, and an old pigmented chorioretinal scar was located in the left macula. Histoplasmosis desensitization was tried

initially, but her vision decreased to counting fingers within 1 month. The subretinal fluid had increased, a subtenial injection of steroids was started along with parenteral corticosteroids. On ophthalmoscopy, the subretinal fluid had reabsorbed, and the lesion had become inactive. Still, visual acuity remained at 20/400 for 18 months, after which time the patient's vision suddenly improved to 20/60 from finger counting in the opposite eye, without ophthalmoscopical changes in the macula.

**A** 38-year-old woman (Patient 11) presented with central choroiditis due to POHS in her right eye. Despite treatment, her vision decreased to finger counting. At age 41, vision of the left eye also worsened. Visual acuity at this time was counting fingers in the right eye and 20/400 in the left eye. A dense fibrous macular scar was found on examination of the right eye, and an edematous, hemorrhagic choroidal lesion, typical of POHS, was seen in the left macula. She was started on corticosteroid therapy, which resulted in slow resolution of the central hemorrhage and exudate. Subsequently, the left choroidal lesion became inactive. However, visual improvement did not coincide with resolution of the inflammation but remained at the 20/400 level for 1 year. During this period, examinations failed to detect any obvious change in the macular lesion. After 1 year, the patient experienced a dramatic return of vision to 20/20 in the left eye.



# Spontaneous Regression of Pulmonary Paracoccidioidomycosis

## Report of a Case

LOPEZ RC; RESTREPO AM

*Mycopathologia* 83(3): Nov 25 1983; 187-189

### Extracted Summary

A case of pulmonary paracoccidioidomycosis with spontaneous regression of the roentgenologic lesions is reported. Regression of lesions took place within ten weeks, with the original infiltrates being replaced by fibrotic lines. The implication of this finding in the pathogenesis of paracoccidioidomycosis is analyzed.

### SELECTED CASE REPORT

A 37-year-old man has been ill for the last 10 days. He was seen by his doctor on April 16, 1982, and productive cough, fever (37.8°C.), chills, chest pain and anorexia were recorded. Auscultation revealed rales and ronchii, more pronounced in the right pulmonary fields. He received a prescription for penicillin and cough relievers. The past medical record showed no relevant data. Therapy failed and a new consultation took place on April 29, 1982. The symptoms were now more pronounced and subclavicular pain has developed. Also, the patient has lost some weight and experienced slight dyspnea. Auscultation showed generalized hypoventilation of both lungs. A chest x-ray film revealed extensive, bilateral infiltrates and some confluent nodules in the central and lower portions of lung fields. Hilar adenopathies also appeared to be present. These signs were considered compatible with either tuberculosis or mycoses and laboratory studies were conducted to confirm the former diagnosis. Acid-fast bacilli were not observed in the serial sputum samples but a PPD (2UI) skin test gave a 20 millimeter indurated reaction. While waiting for the results of mycobacterial cultures, non-specific therapy was initiated. On July 27, these cultures were reported as negative and this patient was referred to a pneumologist. At this consultation, the patient had improved somewhat although the cough and

the general malaise were still present. Clinical examination revealed a patient in good condition, non-febrile, with persistent dry cough and slight dyspnea. The only abnormalities were in the chest, where auscultation discovered rales, located towards the right scapulovertebral region and in the lower fields. Laboratory examinations for fungi and a new x-ray film were ordered. Direct examination of one sputum sample revealed scarce *P. brasiliensis* cells and the patient's sera was reactive on the serological tests, with 2 bands of precipitate and a complement fixation (CF) titer of 1:512, both with a yeast filtrate paracoccidioidin. The patient's skin test with this fungal product was also reactive (12 mm induration). However, the fungus was not isolated in culture. The new chest film did show important changes in comparison with the one taken 10 weeks previously, namely, the infiltrates had disappeared and fibrotic lesions became apparent. Likewise, the serological test had diminished (1 band of precipitate and CF titer of 1:32).

It must be stated that during this time the patient did not receive antimycotic drugs or sulfonamides. In spite of marked lung clearance, ketoconazole therapy was initiated on August 16, 1982, as there were some symptoms and we were afraid that later on, the patient might have had developed progressive disseminated disease.

### SUPPLEMENTAL REFERENCES OTHER MYCOSES

Histoplasmosis: Long-Term Remission Following Treatment With Low Dose Amphotericin-B  
ERAVELLY J; RAMANATHAN K; EAPEN JS  
*Medical Journal of Malaysia* 30(1): Sep 1975; 59-62

A Case of Primary Pulmonary Cryptococcosis Involving Several Lobes with Spontaneous Recovery  
KUTSUZAWA T; TAKASAKI Y; YAMABAYASHI H  
*Respiratory Research* 1(2): 1982; 262-265

Cryptococcal Hygroma of the Elbow: Spontaneous Mycological Remission (letter) (Hygroma Cryptococcique du Coude: Guérison Mycologique Spontanée)

POIROT JL; ROUX P; MARTEAU-MILTGEN M; LESAGE D; BORELLI D; DUPONT B  
*La Presse Medicale* 17(2): Jan 23 1988; 81-82

# Diseases Due to Viruses and Chlamydiae

## MOLLUSCUM CONTAGIOSUM

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### Spontaneous Disappearance of Molluscum Contagiosum: Report of a Case

STEFFEN C; MARKMAN J

*Archives of Dermatology* 116(8): Aug 1980; 923-924

#### *Extracted Summary*

We report herein a case of molluscum contagiosum that healed spontaneously. The molluscum papules did not involute simultaneously, but became inflamed and disappeared individually over a period of months. Biopsy specimens were taken at various stages of inflammation and regression. The histopathology was consistent with a cell-mediated rejection reaction.

#### SELECTED CASE REPORT

Papules developed on the chest of one of the authors of this report (C. S.). He was, otherwise, in good health. He had had a planar wart disappear from his foot after it had been present for 20 years. Other than this, he had had no skin diseases. His son had molluscum contagiosum and, presumably, was the source of infection.

Physical examination indicated that, scattered over the right side of the chest, there were approximately 50 tiny pearly papules each with a central dell. The lesions were typical of molluscum contagiosum.

It was thought that the disease might disappear spontaneously, so no therapy was undertaken. Within three weeks after the appearance of the lesions, one papule became inflamed and exquisitely tender. The inflammation and tenderness subsided within a week, leaving a normal appearing skin site. During the next three months, multiple individual papules became inflamed and then healed. Gradually, all of the papules disappeared; whether all became inflamed prior to healing was impossible to determine. The lesions left no scars. Three years after apparent cure, there had been no recurrence.

Five biopsy specimens were taken during the course of the disease. At the time of onset, a biopsy of a noninflamed papule, which had the typical histologic appearance of molluscum contagiosum, was done. The histopathological appearance at an early stage of inflammation showed that the molluscum contagiosum architecture remains intact, but an inflammatory infiltrate is present. The infiltrate hugs the infected epidermis and is composed almost entirely of lymphocytes and histiocytes. The basal cells have become vacuolated. A few inflammatory cells have infiltrated between the infected epidermal cells.

At a later stage of inflammation, a superficial ulcer develops, and a nest of degenerated cells containing molluscum bodies is extruded with the epidermal scale. The inflammatory reaction infiltrate is composed of mononuclear cells. At a still later stage, the scale loses any readily identifiable cells containing molluscum bodies, although clumps of large glassy epidermal cells, which may be infected, are present. The epidermis is regenerated and there is an initial reduction in the inflammatory cell infiltrate.

### Spontaneous Regression of Generalized Molluscum Contagiosum Turning Black

OGINO A; ISHIDA H

*Acta Dermato-Venereologica* 64(1): 1984; 83-86

#### *Extracted Summary*

In this report, the unusual case of an infant with extensive eruptive molluscum contagiosum (MC) scattered over the back and buttocks that became inflammatory with blackening and

subsequently healed spontaneously over a short period of time is described. To our knowledge, the blackening of spontaneous regressing MC has not yet been described. The mechanism involved in the phenomenon of spontaneous resolution of the inflammatory MC with blackening is discussed.

#### SELECTED CASE REPORT

A 15-month-old male infant was referred to the Division of Dermatology of the Kyoto National Hospital on September 25, 1981, for evaluation of numerous eruptive papules. Eight months prior to the initial visit, he developed a few papules on the back, gradually increasing in number and size. The infant had suffered from mild atopic dermatitis on the trunk, extremities and postauricular regions.

Physical examination indicated that scattering over the back and buttocks, there were approximately 650 tiny pearly papules with a central delle. The papular lesions were clinically diagnosed as MC. Due to his young age and such widespread distribution of the lesions, it was impossible to remove all of the papules with forceps. Therefore, no special therapy was given except for the application of 5% sulfadiazine pasta. One month later, these papular lesions progressively enlarged and individually became inflammatory with an erythematous halo. During the next two months, these inflammatory papules gradually increased in number and turned black in the

central delle. During a few weeks, each of the inflamed papules with blackening flattened or was destroyed spontaneously, eventually undergoing involution. Four months after the patient's initial visit, almost all of the papules regressed and healed with a slightly elevated scar.

Histological examination of a biopsy specimen from an inflammatory large papule with a central black crust on the back revealed molluscum lobules surrounded by dense infiltrates of a mixture of lymphocytes, histiocytes and polymorphonuclear leukocytes and diffuse epidermal necrosis. The cellular infiltrates were extending into a damaged overlying epidermis showing degeneration and necrosis. The stratum corneum and degenerated Malpighian layer had focal areas of clotted blood and hemorrhage. Laboratory studies disclosed that the level of serum immunoglobulin IgA decreased to 19 mg/dl (normal: 26 to 74 mg/dl) while serum IgG, M, and E were within normal limits. Indirect immunofluorescent study showed that a circulating IgG antibody against molluscum bodies was positive at a titer of 1:32 (dilution).

#### WARTS

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## Hygiogenesis of Warts Disappearing Without Topical Medication

ZWICK KG

*Archives of Dermatology and Syphilology* 25: 1932; 508-521

#### *Extracted Summary*

In this paper the author summarizes some of the salient observations concerning the disappearance of warts: (1) As the methods of magic treatment for warts are identical in principle with the methods of treatment by suggestion, their results are also identical. (2) Magic treatment fortifies and supplements "suggestion" by employing mechanical manipulations causing trauma, which alone may cause the disappearance of warts. (3) Autohemotherapy is useful in the treatment for warts, even though it is not uniformly successful. (4) The disappearance of warts following the treatment by magic, by suggestion, by injection of the patient's blood or of foreign protein derived from other sources, as well as the so-called spontaneous disappearance of warts, are causatively linked with a change in the host of the warts. (5) Unless the host overcomes all the invaders, the warts return sooner or later.

# Treatment of Warts by Suggestion

VOLLMER H

*Psychosomatic Medicine* 8: Mar 1946; 138-142

## *Extracted Summary*

Warts in children can be cured by suggestion more easily than in adults and verrucae planae juveniles respond to treatment by suggestion in a higher percentage of cases and within a shorter time than verrucae vulgares. Children below three years of age and feeble-minded individuals are not suited for this treatment.

Warts have a tendency to heal spontaneously. However, the average duration of untreated warts is more than ten times longer than that of warts treated by suggestion. The great number of other methods which have been recommended in the literature for the treatment of warts are probably unspecific, and, with the exception of radiotherapy and surgery, act mainly as disguised suggestion. It is assumed that cure by suggestion and spontaneous healing are similar processes, and that successful suggestion merely accelerates the spontaneous healing of warts by causing hyperemia in the surrounding tissues.

## Verruca Plana of the Face Treated by Posthypnotic Suggestion

OBERMAYER ME

*Archives of Dermatology and Syphilology* 60: 1949; 1222-1224

## *Extracted Summary*

This paper presents a case history of a woman whose flat warts were cured by suggestion. Since a preliminary interview revealed no psychoneurotic features, the psychiatrist expressed the belief that while the treatment could produce no ill-effects, its chance of success was small. At the end of the first interview, the patient was told to imagine for a few minutes before bedtime each night that her face was covered by cold compresses and was beginning to itch and tingle. At her second visit, she gave the encouraging report that she had had the sensation of itching. An attempt at hypnosis was followed only by a state of deep relaxation without sleep, during which it was suggested that her face would feel cold, her skin would itch and the warts would begin to fall off. The patient began the third and last consultation by stating that the warts had commenced to become scaly. Once more hypnosis was attempted, and a state of light sleep was produced. It was then suggested that her face would feel cold and turn pale and that the lesions would itch and fall off within two weeks. The patient was awakened and told that no further interviews were contemplated because her warts would shortly disappear. Two weeks later her skin was clear of all lesions.

### SELECTED CASE REPORT

A 21-year-old unmarried woman, D. P., noticed the appearance of a group of flat warts on the right side of her chin two years ago. The dermatologist who was treating her at that time with fractional doses of roentgen rays for acne vulgaris intimated that the warts would probably disappear with continuation of treatment. However, the verrucae spread rapidly, and when the course of roentgen therapy had been completed they involved most of the face. Various dermatologists removed the ordinary warts which appeared on the fingers of the right hand by means of electrodesiccation. Injections of bismuth subsalicylate in oil, given over a period of eight months, as well as subsequent applications of peeling ointments and solid carbon dioxide and the use of lotions in combination

with ultraviolet irradiation, had no effect on the verrucae planae of the face.

When I saw the patient for the first time, on December 5, 1946, her face was studded with verrucae of the flat juvenile type and lesions were also present on the forehead, the anterior portion of the scalp and the sides of the neck. Most of the right side of the face and neck was covered with confluent plaques, while the lesions on the left side were more scattered.

When it became clear that the oral administration of bismuth (sobisminol mass) and the local use of a 20% solution of podophyllin in acetone had failed to benefit the patient, her mother was told that I had no other therapeutic suggestions, and the irrational behavior of warts was

discussed and illustrated by an account of Dr. Bloch's experiments in Zurich. A few days after this discussion, the mother suggested that arrangements be made for treatment by posthypnotic suggestion. I agreed. In order to complete my record of the case, biopsy of a lesion was performed. The section showed the features typical of verruca plana juvenilis.

The patient was then referred to Dr. Ralph R. Greenson, certified by the American Board of Psychiatry. She saw Dr. Greenson only three times, at weekly intervals. Two weeks after the last consultation, in accordance with a suggestion made during light hypnotic sleep, all verrucae had disappeared.

The skin today reveals no trace of the lesions.

## Evaluation of Treatment of Warts by Hypnosis

SINCLAIR-GIEBEN AHC; CHALMERS D

*Lancet* 2: Oct 3 1959; 480-482

### *Extracted Summary*

Fourteen cases of warts were treated by hypnosis. It was suggested to the patient that the warts on one side of the body (the worst affected) would disappear. The other side served as a perfectly matched control. In 9 of the 10 patients in whom deep or moderate hypnosis was achieved, the warts on the treated side disappeared while those on the control side remained unchanged. This treatment was effective in all cases where the patient was hypnotised deeply enough to perform, on awakening, some action that had been suggested to him.

## On the Psyche and Warts I

### *Suggestion and Warts: A Review and Comment*

ULLMAN M

*Psychosomatic Medicine* 21(6): 1959; 437-488

### *Extracted Summary*

The literature on the suggestion therapy of warts has been reviewed and the areas of general agreement among the various investigators have been noted. With due consideration to the rate of spontaneous recoveries (as near as this can be determined by studying large groups of patients with warts), the cure of warts can be brought about by psychological means generally associated with the term suggestion. Some authors go so far as to imply that this is the most important factor underlying the successful treatment of warts by x-ray, drugs, and even surgery. All agree that in one way or another an affective response must be set up in the patient.

An attempt was made to reconsider the work of earlier investigators from the viewpoint of the nature and goal of the personal relationships established. For the most part, they represented a heightening of the authoritarian relationship between doctor and patient in an effort to reproduce clinically some of the psychological factors which obtain in lay healing, e.g., the combination of submission and helplessness on the part of the subject and the aura of omnipotence and infallibility on the part of the healer or healer-symbol. The ritual involved in the various lay approaches and the procedures employed in the medical techniques to effect a cure by suggestion both result in the temporary suspension of the discriminative, critical, and evaluative faculties of the patient in favor of certain emotional reactions engendered by the situation. These reactions are as yet not very clearly defined. The considerations here presented warrant the further exploratory use of hypnosis as a procedure incorporating many of the elements that appear to be involved in the various accounts of the cure of warts by suggestion.

# A Critical Assessment of the Cure of Warts by Suggestion

STANKLER L

*Practitioner* 198: May 1967; 690-694

## *Extracted Summary*

An attempt has been made to induce unilateral disappearance of common warts by using two forms of suggestion under controlled conditions. Twenty-four of the original 91 patients defaulted without trace after three months; 22 of the remaining 67 lost their warts, but all did so on both sides. No case of unilateral disappearance was seen. It is suggested that these results show that this attempt to charm warts failed and that the 'cures' depended upon spontaneous resolution. With the possible exception of Sinclair-Gieben and Chalmers (1959) who used hypnosis (not simple charming) I know of no convincing evidence that charming works.

## Hypnotic Treatment of a Child with Warts

SURMAN OS; GOTTLIEB SK; HACKETT TP

*American Journal of Clinical Hypnosis* 15(1): July 1972; 12-14

## *Extracted Summary*

The present case report describes a nine-year-old girl with multiple common warts. The lesions were refractory to routine dermatologic treatment but appeared to respond dramatically to hypnotherapy. The patient's schoolwork concomitantly improved. The authors present a brief discussion of the literature and indicate some problems for future study.

### SELECTED CASE REPORT

Holly, a nine-year-old fourth grader, began to develop multiple common warts during her first year in grammar school. The lesions began on her left thumb and subsequently spread to both hands and to the face. For the fifteen months prior to her first visit with us the lesions increased in number and size much to her consternation. On three occasions she was treated with unknown topical medication without improvement. Five weeks prior to the onset of hypnotherapy, she was treated unsuccessfully in the dermatology clinic of the Massachusetts General Hospital with acetylsalicylic acid plaster.

When first seen for hypnosis Holly presented with 31 warts. These included the following: two of filiform type, one on each eyelid, five of the planar type at each corner of the mouth, three large lesions on the right hand, and eighteen, varying in size, on the left hand. Her past medical history was unremarkable, as were the milestones of growth and development.

Holly was attractive, intelligent and engaging. She gave no evidence of being anxious or depressed. The only child of a divorced couple, she was fluent in speech and open in expressing her feelings. She was cooperative and separated with ease from her mother who accompanied her in the clinic visits. She was described as a well-adjusted and contented girl, who had always performed well in school except during the past year when her grades had plummeted. She expressed a great deal of

concern about her skin lesions since she was frequently teased by her classmates who called her "warty hand, warty face." It was for this reason that her interest in school work declined. In response to our comment that she was very pretty, she responded with a shrug of disbelief.

Holly readily agreed to participate in hypnotherapy, which was presented as "a kind of game." She was informed that people treated in this fashion frequently lost their warts and that we were seeing her along with other patients in an attempt to understand why the warts go away without the use of medicine. We then told her we would treat first one side for five sessions (she chose the left hand and left side of her face) and that if the warts went away we would then treat the other side after a period of three months.

Hypnosis was readily induced using eye closure and simulated stair descent. Hand levitation was suggested and promptly occurred. Holly was then told that she would feel a tingling sensation in all the warts on the left side. After she felt the tingling, she was told that the warts on that side would begin to go away. It might take a week or possibly longer, but they would soon be gone. It was then suggested that she would have a pleasant dream. Upon awakening Holly reported both of the suggested sensations. There was no amnesia. She said that hypnosis was fun and immediately left the office to tell her mother of the experience.

Subsequent sessions were conducted in the same fashion with the exception that in place of a dream Holly was invited to envision fantasy material with her eyes open. In the ensuing visits she hallucinated in turn a circus and a series of animals. She at no time experienced amnesia, but her activity in trance was altogether in keeping with her verbal report. For example, in the third session she played actively with a hallucinated dog. On another occasion she was asked to note that one of the authors was sitting to her right. She was then instructed to see "another Dr. Gottlieb" sitting to her left. She was able to do so readily and to converse with him while directing her gaze toward an empty chair. At the end of each trance period, Holly excitedly ran to her mother to report her experience. Throughout the sessions Holly became more a partner in her treatment than a passive recipient.

The lesions began to resolve after the first session. On the second visit she reported that the filiform wart over her right eyelid had fallen off. She stated that during the week she had "concentrated" on the warts on her left thumb but that when they failed to disappear she shifted attention to her face. The following week a snowstorm prevented her

attendance. Her mother reported that the wart over her left eyelid had fallen off shortly after our last session leaving a spot of blood. In the third visit there were eight lesions on her left hand, three on the right hand, four at the left side of her mouth and one on the right side of the mouth. In the fourth session there were seven lesions on her left hand, three on the right hand, three at the left side of her mouth and only residua on the right side of the mouth. By the fifth visit Holly had lost a total of 26 warts. Two remained on her left hand, and the original three remained on the right hand, but her face was entirely clear. Her mother reported that schoolwork was improving.

Three months following the start of therapy we requested that Holly return for follow-up as planned. Of the 31 presenting lesions, two small warts remained on her left hand. She reported that she was no longer teased at school and her mother stated that Holly was scoring "hundreds" on her schoolwork. Her appetite had increased and the teacher reported an improvement in general interest. Holly handled the termination quite well and gayly offered to hypnotize one of the authors to help him stop smoking.

## Hypnosis in the Treatment of Warts

SURMAN OS; GOTTLIEB SK; HACKETT TP; SILVERBERG EL

*Archives of General Psychiatry* 28: 1973; 439-441 (also *Advances* 1:19-26;1983)

### *Extracted Summary*

This study was designed to test the hypothesis that warts are treatable by hypnotherapy. Seventeen experimental patients with bilateral common or flat warts were hypnotized weekly for five sessions and were told that the warts would disappear on one side only. They were reexamined three months from the time of the first hypnotic session. Seven patients who were untreated were also reexamined at the end of three months.

Fifty-three percent of the experimental group improved. No improvement was observed among untreated controls. These findings support the hypothesis that warts respond to hypnotherapy. Whereas specific lesions could not be influenced selectively, the findings suggest that hypnosis has a general effect on host response to the causative virus.

## Hypnosis in the Treatment of Warts in Immunodeficient Children

TASINI MF; HACKETT TP

*American Journal of Clinical Hypnosis* 19(3): Jan 1977; 152-154

### *Extracted Summary*

Three patients (12- and 14-year-old females and a 12-year-old male) with an immunologic deficit developed multiple warts which proved refractory to all therapy. The warts disappeared in response to hypnosis in all 3 cases, and there was no recurrence after 8 months of follow-up.

### SELECTED CASE REPORTS

**C**ase 1: A 12-year-old boy presented with Hodgkin's disease. He was treated with radiotherapy in October 1970 for 31 days with a total dose of 4,000

roentgens. He tolerated the therapy well and remained in good health except for the appearance of numerous warts on his hands and face, shortly after radiotherapy was ter-

minated. There was no prior personal or family history of warts. He had been repeatedly treated with liquid nitrogen and chloroacetic acid since 1971 but the warts continued to proliferate.

In November 1973, prior to his first hypnotic session, he had 20 warts of varying sizes on his left hand and 45 on his right, several large warts on his arms as well as multiple ones on his face. Parental consent was obtained and a hypnotic induction was done. The patient found the experience pleasurable and was always eager to return.

Two weeks after the first session, many small warts around his eyes and on his hands had fallen off. The larger warts (3 millimeters and above), had a rough surface and showed multiple thrombi and erythema at the bases. The patient failed to keep his next appointment and was not seen until February 3, 1974. At that time he had lost many of his warts. The sites of these could still be identified by depigmentation in the underlying skin. There were no new lesions. For the first time in eighteen months the warts ceased to proliferate. On April 19, 1974, three solitary regressing warts were still present on his right hand. He was wart free when he returned on May 14, 1974, after five sessions. The follow up examination four months later revealed no new lesions.

**C**ase 2: A 12-year-old girl had been treated with prednisone since age six, (1968) when a diagnosis of juvenile rheumatoid arthritis was made. She was maintained on prednisone 15 milligrams daily until 1970 when an attempt to change to prednisone 30 milligrams every other day resulted in an exacerbation of the rheumatoid arthritis. Since then she has received 12.5 milligrams daily. Any reduction of this level precipitated new inflammatory changes. During the second year of her treatment she began to develop warts on her hands, legs and face. Since 1972 she was treated unsuccessfully with topical liquid nitrogen, trichloroacetic acid and electrocauterization.

She was first seen for hypnosis on February 7, 1974. She was a "moon-faced" child who was very distressed because of the many warts on her face. One of these irritated her eyelid whenever she blinked. This wart was surgically removed under hypnosis during the first visit. The standard suggestion was made during this hypnosis experience for the warts to disappear. She experienced no pain during the surgical procedure and was totally amnesic postoperatively. Regression in all her lesions was noted during a second visit one month later. Three months after the first hypnotic session she was wart free for the first time in four years. There was no recurrence of warts at the eight-month follow-up examination.

**C**ase 3: A 14-year-old girl with congenital hypoparathyroidism and adreno-cortical insufficiency has been maintained on replacement therapy since age 5 when her condition was diagnosed. She has been receiving prednisone 5 milligrams in A.M., prednisone 25 milligrams in P.M., Florinef 200mcg, Vitamin D 100,000 daily until 1969 when the prednisone was changed to cortisone 25 milligrams in A.M., cortisone 12 milligrams in P.M. She has been well and displayed normal growth and development (present height 64"), except for multiple peri-ungual warts. These warts proliferated unremittingly despite topical therapy and eventually involved both hands to the point where she became fearful of exposing them in public. For this reason she was referred to hypnotherapy in April 1974. She was seen for hypnosis three times. One month after the first hypnotic session the warts were indurated and erythematous. Cracking of the warts was observed six weeks after the first session during her third visit. Total regression occurred four weeks later and she still was wart free at eight-months follow-up.

## Spontaneous Regression of Plane Warts After Inflammation

### *Clinical and Histological Studies in 25 Cases*

TAGAMI H; TAKIGAWA M; OGINO A; IMAMURA S; OFUGI S  
*Archives of Dermatology* 113(9): Sept 1977; 1209-1213

#### *Extracted Summary*

Based on clinical and histological studies in 25 patients, we have confirmed that plane warts show a characteristic phenomenon of spontaneous regression totally distinct from that described in common warts. This regression developed during various treatments in nine cases, and, in 16 cases, it occurred spontaneously. In all the patients, there was a sudden and systemic onset of inflammation in every flat wart. Within two to six weeks, all the warts completely involuted.

Histologically, there were variable degrees of epidermal changes depending on the stage of inflammation. However, a mononuclear cell infiltration with epidermal invasion was demonstrated in every biopsy specimen. This evidence further supports the earlier concept that this regressive phenomenon of plane warts is mediated by cellular immunity. It represents a natural experimental model of rejection of tumors induced by papovavirus in humans.



# Influence of Psychosocial Factors on Wart Remission

SHEEHAN DV

*American Journal of Clinical Hypnosis* 20(3): Jan 1978; 160-164

## *Extracted Summary*

The effects of psychosocial events on the natural history of warts and the physiological mechanisms that mediate them are observed in 2 case studies. Psychosocial factors not only accelerate the remission of warts but may also reinforce their presence and proliferation as in case 1. In that case, a 14-year-old girl believed that a beloved grandfather had given her warts as a secret life bond between them. When the grandfather died, the warts underwent natural extinction. Vasomotor changes during and following nonspecific hypnotic suggestions in case 2 involving a 25-year-old man lend confirmation to earlier speculations and hypotheses on the nature of one mediating physiological mechanism in wart remission. The merits of an operant conditioning paradigm of so-called "hypnotic" behaviors are discussed.

## SELECTED CASE REPORT

Kelly, an attractive, very intelligent and articulate 14-year-old girl, was referred by her dermatologist for hypnotherapeutic treatment of warts. They had proliferated rapidly beyond his capacity to remove them without a risk of scarring. At an age when she and her school friends were becoming cosmetically conscious, she expressed a wish to be rid of her "unsightly" warts. This concern was reinforced particularly by her mother who accompanied her to the appointment.

Her first wart had appeared at age 9 on the third finger of the right hand in the area of the proximal interphalangeal joint. The large wart that grew in this area was "burnt" off. However, over the next two years, a wart grew back in exactly the same area and multiple warts then spread over both hands and feet. Both one year and again one month before the hypnotherapy sessions, her warts had again proliferated suddenly for no apparent reason. She had tried many treatments including cryotherapy, electrodesiccation and keratolytic acids, and a variety of popular home remedies and topical medication. Two years previously her younger sister who had warts had responded to one such placebo treatment.

At the time of our first session she had over 50 warts on her hands of both the filiform and planar types (*verrucae vulgaris* and *verrucae planar*). They were on the anterior and posterior aspects of both hands with the highest concentration on the dorsum of the right third and fourth fingers where the warts had first appeared. There were four additional warts on the soles of her feet and a small cluster on the left tibial tuberosity. Otherwise she was in good general medical health with no history of significant medical illnesses or hospitalization. A mental status exam did not uncover any evidence of anxiety, depression, or other gross psychopathology. Her family background had been stable, and she appeared cheerful, pleasant, and well adjusted.

Following hypnotic induction, she responded only

partially to the usual challenges like arm levitation, but positively hallucinated paraesthesias in her hands and feet. These paraesthesias were used as part of the sensory imagery suggestions to facilitate wart remission. She was instructed in a simple self-hypnotic technique to elicit the paraesthesias and focus them into the areas of the warts.

Two weeks later on the second appointment no significant changes were found although she used self-hypnosis daily. She was rehypnotised. On the third session (three weeks after the first) again no significant change was noted and she was again rehypnotised and other techniques used. On the fourth session (six weeks after the first) still no significant change had occurred. Indeed, in the previous week she had become discouraged and stopped practicing her nightly self-hypnosis and a few new warts had appeared. The point of diminishing returns appeared to have passed. I expressed puzzlement that the warts had failed to remit in spite of our combined efforts and wondered if the warts might have any special meaning for her or if there might be some good reason for them not to go away. She became silent, her head lowered, and the quiet tears that crossed her cheeks gave the first hint of a story behind the warts.

To my surprise, she suggested that perhaps the reason her warts had not gone away was that her grandfather had given them to her. When I asked for further clarification, she explained that the warts first began when her grandfather burnt her fingers with a cigarette. She was his favorite grandchild. They had a little game they frequently played together, where he would tease her by pretending to burn her with the cigarette. On one occasion five years ago he had accidentally caused a minor burn on the dorsum of her right third finger. Two weeks later a wart grew at this site, and hence forth she saw the warts as a gift from grandfather, a life bond and a secret between them. Since that time her grandfather's health had progressively deteriorated.

One year before our first contact her grandfather suffered a severe thrombophlebitis and was hospitalized. This coincided with the first rapid proliferation of her warts. One month before our first session, at the time of her most recent wart proliferation, grandfather suffered a severe recurrence; his diabetes mellitus became difficult to control and he had an amputation of his leg. Since then, he had been in a nursing home in the next state, and his health was rapidly deteriorating because of "gangrene" and chronic inflammatory changes in his legs. He was not expected to live more than two months. She was distressed that she might never see him again and explained that no one she had ever loved had died. Since she associated the warts so closely with her grandfather, she said she felt that by keeping them "alive" she could keep grandfather alive longer. She described lying awake most nights crying and worrying about his health and if she would ever see him again and what she might be able to do to help him recover. By the same token, she feared that if she "gave up" the warts now, her grandfather by magical association

might die and she would feel responsible and guilty.

She spontaneously conceded that this was a superstitious and childish way of thinking and she was ashamed to admit it, but she would prefer to keep her warts until her grandfather's condition had resolved itself one way or another. She felt that if he died "there would be no more reason to have warts" and that she would probably lose them rapidly then. No attempt was made to disrupt these defenses, but rather I tried to be a supportive and sympathetic ear since she felt these thoughts were too private and was embarrassed about discussing them with anyone. Arrangements were made to have her visit her grandfather before he died. She was re-hypnotised and suggestions were made that she would lose her warts rapidly after her grandfather died or, if he survived, when his health was stable again. Six weeks later she reported that grandfather had died three weeks before and within a week the warts had begun to remit. Now they were gone completely. She excitedly told me about her new dog "Papi".

## Recalcitrant Warts on the Hand Cured by Hypnosis

DREAPER R

*Practitioner 220: Feb 1978; 305-310*

### *Extracted Summary*

Whatever the pros and cons of antibody and cell-mediated immunity, it would seem difficult to accept that either of the above mechanisms could cause the geographically selective destruction of warts as happened in the case of Mrs. M. Is it conceivable that the cure under hypnosis (or indeed with wart charming) may lie in some neurogenic mechanism? This would seem to offer the only explanation of selectivity. Take, for instance, the one wart left on Mrs. M.'s ring finger. What nervous mechanism could be involved? The sympathetic nervous system which would therefore implicate the sweat glands? Under hypnosis patients can be made to produce anatomically localized sympathetic effects such as vasodilation and sweating in one hand or one side of the face. It is noticeable how many people with warts have hot sweaty hands and feet.

A leading article (British Medical Journal, 1961) commented that there have been no satisfactory trials on the effect of internal medication on warts and suggested that attention to the sweating of soles and palms might be worthwhile.

However, a trial of the sweat-diminishing agent propantheline, which blocks the cholinergic sympathetic nervous supply to the sweat glands, was found to be disappointing, a fact that I have confirmed on 25 of my own patients. However, one fact of importance merits further research. A localized tumour that is virus-induced can be caused by hypnosis to regress completely while a nearby similar tumour remains. If the precise reason for this regression could be determined the findings might have significance in the wider field of cancer research, as well as affording a clue to the more efficient cure of warts.

### SELECTED CASE REPORT

**I**n March 1971, Mrs M. first came under treatment for her severe warts in the department of dermatology, the Royal South Hants. Hospital, Southampton. She was then 56 years of age and had already had the warts for about a year. At that time, also, she had been taking enteric coated prednisolone tablets, 2.5 milligrams four times a day for about four years on account of a diagnosis

of systemic lupus erythematosus (SLE), the main clinical findings of which having been swollen joints. The warts were large, ugly, numerous and mainly on the dorsal aspect of both hands, with a few on the palmar surfaces.

It is of interest that Johansson and his colleagues (1977) reported that 25 out of 56 patients with definite or probable SLE had warts which were most usually seen

among the elderly. They found an inverse correlation between the occurrence of warts and rheumatoid factor activity, suggesting that rheumatoid factor might interfere with resistance to warts. Mrs. M. had a negative rheumatoid factor test.

Treatment was started along routine lines with local applications of liquid nitrogen every three or four weeks. After three months two of the largest warts were curetted and cauterized with the electric cautery. Treatment was continued with monthly liquid nitrogen, and varying applications of Salactol, Callusolve, and Posalfilin for another 1 1/2 years with, if anything, deterioration rather than improvement. In spite of this Mrs. M. elected to continue with monthly applications of liquid nitrogen and daily applications of Salactol but in July 1974, after 3 1/4 years of treatment her condition was essentially the same as when she started. So, in desperation, a trial of hypnosis was suggested, since the steroids were being continued for her SLE.

The patient proved to be a good subject, reaching a somnambulistic state after four sessions. The simple suggestion was given that the warts would gradually shrivel up. After about six sessions the patient volunteered the fact that the warts felt as if they were gently burning for

a few days after hypnosis. Accordingly this sensation was suggested as a reinforcement to hypnosis. The treatment was given weekly at first and then fortnightly, each session lasting about ten minutes. Within three months the warts were less fleshy and possibly smaller.

As the sessions continued the warts started to shrink and one or two of the smaller ones regressed completely after about six months' treatment. Following the concept put forward by Sinclair-Grieben and Chalmers (1959) the suggestion was introduced that after all the other warts had disappeared one would remain as a control. This was to counter the objection that any form of attentive treatment will get the credit for curing warts that were disappearing spontaneously.

In May 1975, after ten months' treatment the only wart remaining was the suggested one on the ring finger. The deformed nail was due to coincidental paronychia, a sliver of nail was removed under hypnosis without any need for local anaesthetic and without remembrance of the operation. After another two months the remaining wart had gone, following appropriate hypnotic suggestion, a total of one year of hypnosis and 36 sessions. Two years later there have been no recurrences and steroid treatment has continued.

## The Phenomenon of Spontaneous Regression of Numerous Flat Warts: Immunohistological Studies

TAGAMI H; OGUCHI M; OFUJI S  
*Cancer* 45(10): May 15 1980; 2557-2563

### *Extracted Summary*

The phenomenon of systemic regression of numerous flat warts took place within one month after the sudden onset of spontaneous inflammation in them. In other types of warts, we have never observed such a dramatic regression. We performed a histological study in a total of 51 cases showing this spontaneous inflammation in their flat warts and found a massive mononuclear cell infiltration in all. In 9 cases, a histological study for basophils was carried out but failed to show them among the infiltrating cells despite the strong histological resemblance to contact allergy. An immunofluorescence technique performed in 16 cases demonstrated no specific deposits of immunoglobulins and complement in such inflamed wart tissues except for those which appear to be only a secondary event to inflammation per se. These immunopathological findings further substantiate the concept that cell-mediated mechanisms rather than humoral immunity play a major role in this phenomenon of sudden regression of numerous flat warts.

# Immunohistologic Analysis of the Phenomenon of Spontaneous Regression of Numerous Flat Warts

AIBA S; ROKUGO M; TAGAMI H  
*Cancer* 58(6): Sep 15 1986; 1246-1251

## Extracted Summary

Among various tumors induced by human papilloma virus (HPV), flat warts are unique in that they show a systemic regression phenomenon after sudden occurrence of inflammation in all the tumors, leaving permanent immunity to flat warts in the host. When studied immunohistochemically, the presence of HPV antigen using papilloma virus genus-specific antiserum in 31 cases of regressing flat warts was not found, whereas it was demonstrated in the nuclei of upper epidermal cells of ordinary flat warts in 12 of 19 cases (63%). T-cell phenotype assessment in nine regressing flat warts using monoclonal antibodies showed that helper/inducer subsets constituted a major peritumoral dermal infiltrate with a moderate number of intermingling OKT6+ cells. In contrast, the tumoral epidermis was invaded by almost equal number of suppressor/cytotoxic T-cells and helper/inducer T-cells, where at least some keratinocytes also expressed HLA-DR antigen in addition to Langerhans cells. Most T-cells expressed HLA-DR antigen, a marker of activation, but only a small number of them were Tac antigen+, i.e., bearing interleukin 2 receptors. Leu 7+ natural killer cells were seldom found in the infiltrate. These data provide evidence that T-cell-mediated immune attack against tumor cells, and not against intranuclear HPV antigen, induces the systemic spontaneous regression of numerous flat warts in humans.

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## Spontaneous Remission of Chyluria

OHYAMA C; SAITA H; MIYASATO N  
*Journal of Urology* 121(3): March 1979; 316-317

### Extracted Summary

The natural history of chyluria is not well known. We have followed 72 patients with chyluria who have not had treatment and the condition has disappeared in 36 cases (50%). In these cases the duration of chyluria varied from 3 days to 20 years, with an average of 44.3 months, but it was less than 6 months in about half of the cases.

### SUPPLEMENTAL REFERENCES HELMINTHIASES

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## Other Infectious and Parasitic Diseases

### Spontaneous Regeneration of the Parotid Salivary Gland Following Juvenile Recurrent Parotitis

GALILI D; MARMARY Y  
*Oral Surgery, Oral Medicine, and Oral Pathology* 60(6): Dec 1985; 605-607

### Extracted Summary

Sialograms of an 18-year-old female patient known to suffer from juvenile recurrent parotitis (JRP) disclosed the destructive glandular changes typical of the disease. During the 10 years subsequent to the sialographic examination, the patient did not experience any further attacks of JRP. Sialograms carried out when the patient was 28 years of age demonstrated a normal gland. This case illustrates that a damaged parotid gland is capable of regeneration following JRP.

#### SELECTED CASE REPORT

At the age of 4 years the patient, who was otherwise healthy, suffered her first episode of swelling and pain in the right parotid gland. The attacks recurred at different intervals throughout childhood and puberty, each time involving the same gland. The attacks, which lasted for 4 or 5 days, were accompanied by pain, redness of the overlying skin, high fever, and difficulty in eating. Treatment consisted of antibiotics only. During an attack when the patient was 18 years old the manifestations were so severe that hospitalization became mandatory. Again, she received antibiotics only. This time, however, a sialographic examination was performed soon after the symptoms had subsided. The sialogram demonstrated an extremely atrophied right parotid gland. Many of the ducts

were absent, and those that remained were severely narrowed. No glandular tissue was discernible. Numerous spherical areas, 1 to 2 millimeter in diameter, containing opaque medium were scattered throughout the glandular area (sialectasis). The clinical and radiographic findings were compatible with juvenile recurrent parotitis (JRP).

During the subsequent 10 years, the patient was free of attacks of JRP. A follow-up examination at the age of 28 years revealed no clinical symptoms of the disease, and salivation was normal. The sialogram demonstrated completely normal gland anatomy, including the secretory components and ductal system. Clearance of the opaque medium was consistent with normal gland function.

## Spontaneous Disappearance of Tuberculous Psoas Abscess Calcification

WHITAKER SC; PRESTON BJ; MCKIM-THOMAS H

*British Journal of Radiology* 63(748): Apr 1990; 303-304

#### Extracted Summary

Calcified psoas abscesses are a characteristic feature of tuberculosis of the thoracolumbar spine. We present a case in which well-established calcification has almost completely disappeared, several years after any antituberculous treatment. A review of the English literature has revealed no previous report of this finding.

#### SELECTED CASE REPORT

The patient, now a 48-year-old woman, first presented at the age of 6 with back pain and radiographic features of spinal tuberculosis at T12/L1. Bilateral calcified psoas abscesses developed over the next few months. Management was first by bed rest and later, at the age of 12, by postero-lateral drainage with spinal fusion. By this time abscess calcification was well established. The patient then remained relatively well until the age of 33, when she developed girdle pain due to further vertebral destruction at a higher level (T8-T12).

This new focus was drained via a trans-thoracic approach and a small abscess cavity was found which did not communicate with the original psoas abscesses.

Tubercle bacilli were cultured. Radiographs of the lumbar spine at this time still showed a large calcified psoas abscess on the right side and a small one on the left. Appropriate antibiotic cover was given for 2 years until 1975 when it was noted that the calcification in the left psoas abscess had decreased. Routine follow-up radiographs in 1981 still showed calcification in both psoas abscesses but subsequent films have shown a dramatic reduction in calcification at a time when the patient had not received any anti-tuberculous treatment for many years. During this time, the patient remained well, apart from symptoms due to the menopause, for which she was given a short course of hormone replacement therapy.

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JESUDASAN K; CHRISTIAN M

*Indian Journal of Medical Research* 81: Feb 1985; 119-122

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