on admission, 1/8 two weeks later, and 1/256 seven weeks after the onset of her illness. Her husband's titre was 1/64, and he had had a severe influenza-like illness soon after his shop opened in December 1974.

Discussion

Our patient's neurological presentation was consistent with a diagnosis of encephalitis, and this was reported in only two of 156 cases in 1972.[1] Clearly reliance cannot be placed on an early negative CF test for psittacosis to exclude the disease in an unusual presentation, and in addition the administration of tetracycline may delay the appearance of a rising titre for several weeks.

From September 1974 to July 1975 10 cases of psittacosis were documented at the Public Health Laboratory in Leicester. Together with two other cases[2] all had some connection with a particular pet shop dealer in Leicestershire, who himself developed a respiratory illness in 1974 after importing some Bolivian parrots. One patient merely helped in moving an aviarist and his birds to a new house, and, of the others, our patient and her husband stocked their shop from this dealer, one bought directly from him, and two were wives of bird enthusiasts who also bought from the dealer.

Since the ban on importation of psittacines was lifted[3] unknown numbers of birds infected with *Chlamydia psittaci* have entered Britain. The practice by dealers of giving tetracycline reduces the high mortality in recently imported infected birds, but partially treated birds may survive to excrete organisms for months. Repeated warnings about this zoonosis have been given,[4] and we were surprised to find that many pet shop owners and private aviarists were still unaware of the importance of the disease. A quarantine for imported parrots and other birds was reintroduced on 1 March 1976.[5]

We are greateful to Professor R Kilpatrick for permission to report a patient under his care.

[1] *British Medical Journal*, 1973, **3**, 704.
[2] Walker, C W M, *State Veterinary Journal*, 1975, **30**, 206.
[3] Parrots and Miscellaneous Birds (Prohibition of Importation Revocation) Order, 1966.
[4] Keymer, I S, *Lancet*, 1973, **2**, 1437.
[5] Importation of Captive Birds Order, 1976.

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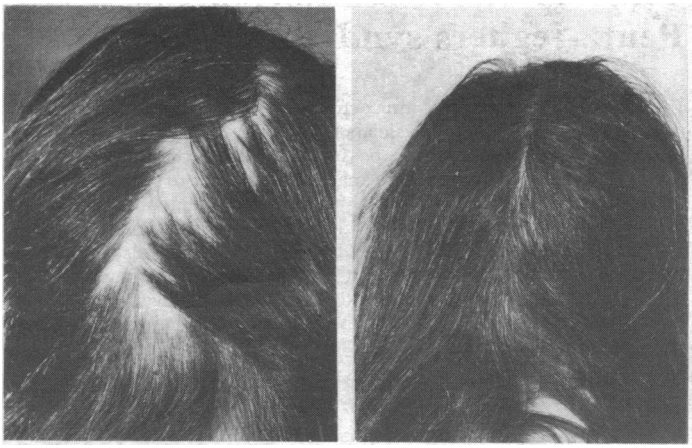
Syphilis presenting as hair loss

The diagnosis of syphilis may be considerably delayed when the manifestations are unusual, single, or modified by inadequate treatment[1]: and even when in retrospect they are typical.[2] The two cases reported here were referred to a dermatology department solely on account of hair loss. They were shown to have syphilis, the treatment of which resulted in regrowth of hair.

Case reports

Case 1—A 24-year-old woman had noted progressive loss of scalp hair for three months. At the beginning of this time she had had a sore throat, cough, and headache, but at no stage did she have a rash. Eight weeks before beginning to lose hair she had had sexual intercourse with a stranger while on holiday in Greece. On initial examination she had slightly uneven thinning of scalp hair, but no abnormalities of the hairshafts or scalp (figure). The results of skin, mucous membranes, body hair, and general examination were normal. The results of investigations were Venereal Diseases Research Laboratory test: positive 1:4; fluorescent treponemal antibody absorption and treponemal haemagglutination: positive; telogen count: top of scalp 35%, side 61% (samples about 80 hairs, normal less than 30%). Histopathology of scalp showed sparse chronic inflammatory cell infiltrate in the upper dermis. She was treated with procaine penicillin 600 000 U daily for 10 days, and her hair began to regrow six weeks from the onset of treatment (figure). The telogen counts returned to normal.



Case 1. Uneven hair loss (left) and regrowth two months after treatment (right).

Case 2—A 25-year-old homosexual man presented because of thinning of scalp hair for four months. Two months before this he had a slightly itchy rash consisting of small macules and papules mainly on the trunk, which had cleared after three weeks. At no time had he felt ill. He had no relevant medical history, and a routine serological check for syphilis had given a negative result 18 months earlier. There was widespread thinning of scalp hair, although, as in case 1, the decreased density was not uniform. Hair elsewhere was unaffected, and the results of clinical examination, including proctoscopy, were otherwise normal. The results of investigations were VDRL: positive 1:32; FTA-ABS: strongly positive; TPHA positive. In the cerebrospinal fluid both the VDRL and TPHA were positive. Telogen count: top 43%, side 14%. Histopathology of the skin showed a sparse lymphocytic infiltrate around the superficial aspects of several hair follicles. Because of the positive serological reactions in the spinal fluid he was treated with procaine penicillin, 600 000 U for 21 days. His hair began to regrow four weeks after starting treatment.

Discussion

Both these patients had their alopoecia reversed by effective treatment of the syphilis. Both had self-limited conditions which may have been part of their illness: upper respiratory symptoms in case 1 and a rash in case 2. Nevertheless, in neither case did these episodes suggest syphilis. These cases differ in that case 1 was at the secondary stage, and case 2 had asymptomatic neurosyphilis, although the clinical and histological features of their alopoecia were similar.

Could the alopoecia be unrelated to syphilis? The hair loss was less dramatic than the "moth eaten" appearance illustrated in many textbooks, but nevertheless patchy. Histologically the changes were not typical of syphilitic alopecia,[3] although consistent with both this and alopoecia areata.[4] Nevertheless, alopoecia areata seems unlikely in view of the response to treatment. Despite the high telogen count, the patchy hair loss and presence of inflammation are against a diagnosis of telogen effluvium. Hence it would seem prudent to consider syphilis in patients with non-scarring alopoecia which cannot otherwise be readily explained.

I am grateful to Dr S C Gold for permission to report case 1, Dr A G Knight for permission to report case 2, and Dr R C Catterall, Director of James Pringle House, Middlesex Hospital, where both cases were referred for treatment.

[1] *British Medical Journal*, 1972, **3**, 66.
[2] *British Medical Journal*, 1975, **2**, 460.
[3] Wile, U J, and Belofe, G H, *Archives of Dermatology and Syphilology*, 1926, **13**, 495.
[4] Van Scott, E J, *Annals of the New York Academy of Science*, 1959, **83**, 480.

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