V

A LETTER FROM THE UNITED STATES OF AMERICA DEALING WITH VENEREAL DISEASES

I

A movement of great significance in the campaign against the venereal diseases in the United States was inaugurated with the formation of the American Neisserian Medical Society last June. A month previously, a committee of sponsors, including the leading venereologists of the country, headed by Dr. Edward L. Keyes, issued an invitation to physicians interested in the venereal diseases to meet at Cleveland, Ohio, during the annual meeting at that place of the American Medical Association. Twenty-one physicians were present, and excuses were received from several others. A permanent organisation was effected with Dr. J. Dellinger Barney, of Boston, as President, and Dr. Oscar F. Cox, Jr., of Boston, as Secretary-Treasurer.

This Association is an outgrowth of the Neisserian Medical Society, of Boston, which was organised in 1930, with Dr. Barney as its first president. Dr. Walter Clarke, of the American Social Hygiene Association, suggested to a group of physicians that a similar organisation on a national basis deserved serious consideration. A committee of twenty-two sponsors, with Dr. Keyes at its head, took the leadership in the movement, which resulted in the formation of the permanent organisation. The committee of sponsors is as follows: Drs. J. Dellinger Barney (Boston), Emily D. Barringer (New York), W. D. Bieberbach (Worcester), W. H. Cary (New York), A. L. Clark (Oklahoma City), Walter Clarke (New York), Arthur Curtis (Chicago), M. J. Exner (New York), F. W. Lynch (San Francisco), E. L. Merritt (Fall River), C. Jeff Miller (New Orleans), N. A. Nelson (Boston), C. C. Norris (Philadelphia), A. H. Peacock (Seattle), P. S. Pelouze (Philadelphia), Marion Craig Potter (Rochester), Stella Q. Root (Stamford), W. F. Snow (New York), W. E. Stevens
LETTER FROM UNITED STATES OF AMERICA
(San Francisco), R. A. Vonderlehr (Washington) and A. L. Wolbarst (New York).

The Neisserian Society has these objectives in view:—
(1) An intensive effort to reduce the incidence of gonorrhoea; (2) research in the medical and social pathology of this disease; and (3) the improvement in and standardisation of the treatment of the disease and its complications in both the male and female. This is essentially the programme of the parent Boston society, which studied plan and scope for three years before work was started.

Dr. Cox, in taking the Chair, stated among other things that, although the past history of gonorrhoea in medicine might be something to blush about, the fact that competent physicians in good standing are willing to gather together to discuss the management of gonorrhoea foretells the day when the physician will be able to admit that he treats gonorrhoea without blushing. In this connection, he emphasised the importance of exercising extreme care in selecting the membership of the new Society if the Society is to command the respect and attention of the medical profession.

Dr. N. A. Nelson, of the Massachusetts Department of Health, was introduced by Dr. Cox as the father of the Massachusetts Society. He reviewed the incidents which led to the formation of that Society, and declared that the subsequent meetings demonstrated clearly that, while there was a good deal of difference of opinion, it was nevertheless possible to gather together a large group of reputable physicians for the discussion and study of gonorrhoea and syphilis. He hoped that the day would come when even the matter of informing the public as to what it should know about gonorrhoea should be in the hands of Neisserian Medical Societies.

An executive committee, to be appointed by the President, was directed to draw up the constitution so as to permit the formation of local societies. It was the unanimous opinion of those present that this new society would become an important factor in the conquest of gonorrhoea.

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In a discussion of the treatment of chronic endocervicitis of gonorrhoeal origin by surgical diathermy,
BRITISH JOURNAL OF VENEREAL DISEASES

Dr. J. R. Waugh, A.A. Surgeon, United States Public Health Service Clinic, Hot Springs, Ark., declared that it is futile to treat patients with chronic endocervicitis by means of topical applications, medicated tampons, and douches, especially when the endocervicitis is characterised by a tenacious, mucoid, or muco-purulent discharge. In his clinic he has noted any improvement in patients of this type so treated.

Surgical diathermy (the high-frequency current, or fulguration), was instituted as treatment about three years ago. He has had excellent end-results in 69 per cent., fair end-results in 23 per cent., and poor results in 8 per cent. of a series of patients treated by this method. Treatment consisted of a single fulguration. It is believed that a second fulguration would have improved the end-results in this series as it has done in other cases. Complications have occurred, such as bleeding in 9·9 per cent. of the cases, chronic salpingitis in 4·3 per cent., and monoarticular arthritis in 1·4 per cent., the responsibility for which must be placed upon the surgical diathermy, although 50 per cent. of the patients with chronic salpingitis as a complication had had diseased tubes before. This procedure cannot be considered entirely free from danger; it is similar to any other operative procedure in the presence of infection.

In his summary, he said it was advisable to select patients in whom the endocervicitis is of at least six months’ duration, with cervical smears negative for gonococci. Treatment by fulguration should be done about four days after completion of the menstrual period. Stricture of the cervix was not observed as a complication in a single case, although fulguration with the high-frequency current has been mentioned as a cause of stricture.

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For a number of years, the United States Public Health Service has been interested in determining the incidence of the venereal diseases, and the most accurate figures have been obtained from estimates based on surveys to determine the number of early or acute cases of the venereal diseases under treatment on a given day in a selected area. In all, areas embracing about one-fourth of the population of the United States have been surveyed.
LETTER FROM UNITED STATES OF AMERICA

by this method, and estimates indicate that each year approximately 1,100,000 patients with fresh venereal infections seek treatment in the United States; that is, about 423,000 persons with early syphilis and 679,000 persons with acute gonorrhoea seek treatment annually. This estimate of the incidence of syphilis and gonorrhoea is obviously the minimum, because at least one-half of the infected individuals fail to seek treatment until after their infection reaches the late or chronic stage, and there is an unknown but large group of individuals who never seek authorised medical care; neither of these groups is included.

In spite of these figures, during the fiscal year ended June 30th, 1933, only 149,527 new cases of gonorrhoea and 234,647 new cases of syphilis, or 384,174 new cases in all, were reported to the State health authorities. This would indicate that but one case in three is reported. It is the duty of every physician to regard the venereal diseases as being of equal importance with other communicable diseases. Unless syphilis and gonorrhoea are reported, the vast problem which they present cannot be fully appreciated, and efforts to cope with them will be seriously handicapped. Every new case of gonorrhoea and syphilis should be reported to the proper health authority. This is a matter worthy of the attention of all directors of clinics, hospitals and other institutions entrusted with the care of venereally diseased patients as well as of the practising physician.—(Official Report, U.S. Public Health Service.)

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An insurance company had issued a policy of life and sick benefit insurance which provided that the insurer should not be liable for benefits on account of "any venereal disease or disease of venereal origin." The plaintiff had syphilis, which he claimed had not been acquired through sexual intercourse, and so was not a venereal disease. He therefore sought to obtain benefits under the policy. The appellate court of Louisiana (Orleans), held that the term venereal disease as used to-day means a disease caused by a certain organism. A venereal disease, whether it originates from sexual intercourse or from shaking the hand of an infected friend, is, nevertheless, a venereal disease.
BRITISH JOURNAL OF VENEREAL DISEASES

Dr. W. W. Brandes reports a case of gonococcal endocarditis in an infant ten days old, with gonorrhœal conjunctivitis. The conjunctivitis appeared three days after birth. Smears of the discharge from the infant's eyes and from the mother's vagina showed gram-negative intracellular and extracellular diplococci. Post-mortem examination showed a large vegetation (6 x 12 mm.) attached to the posterior leaflet of the tricuspid valve. Gram-negative diplococci were found in widely scattered areas in the vegetation. No other organisms were seen. The evidence that this was a case of gonococcal endocarditis secondary to the conjunctivitis seems sufficient, though no cultures were made. The large size of the vegetation suggests the possibility of an intrauterine infection through the placenta, but there were no evidences in the mother of a blood stream infection. Furthermore, endocardial involvement by one route and conjunctival involvement by another would be unusual. The localisation of the lesion may have been associated with the widely patent ductus arteriosus.

This child is the youngest patient with bacterial endocarditis, and the youngest with gonococcal endocarditis reported in the literature. No case of endocarditis secondary to conjunctivitis could be found.

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Practical methods of controlling the spread of venereal disease are discussed by Drs. B. H. Regenburg and R. A. Durfee, based on their work in the Public Health Institute, Chicago. Good results have been obtained in tracing the source of infection by asking the patient for the name of his partner, and then urging him to see that she is properly treated. This the patient is often reluctant to do, but many are convinced that the examination of the girl is of vital importance not only to herself but to the community, and co-operate with the clinic in seeing that she is given treatment either in the women's department of the institute or by a private physician. If the patient is unwilling or unable to convince his partner of the need of an examination, a letter is sent to her. If this fails she is reported to the health authorities.

The greatest response has been obtained from clandestine prostitutes. Little attempt has been made to have professional prostitutes examined; experience has proved
LETTER FROM UNITED STATES OF AMERICA

that for several reasons it is useless to do so. Wives present the most difficult problem. If the patient is in the early stages of syphilis, the examination of the wife is so important that almost any method is justifiable to obtain the examination. With ingenuity and tact the social worker may often arrange for an examination of the wife without her suspecting what the examination is for.

Among 500 patients with gonorrhoea, 304 contracted their infection from clandestine prostitutes. Ninety-five of these women were placed under treatment, seventy-three were taken by the man to a private physician, fourteen were brought to the clinic and eight were reported to the health department.
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*Br J Vener Dis* 1934 10: 268-273
doi: 10.1136/sti.10.4.268

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