THE "PRE-CONTEMPORARY" SYPHILITIC DEFAULTER*

BY

R. S. MORTON

Stockport and East Cheshire

Whatever path he chooses after qualification, no doctor is long in the world of patients before he finds himself saddened by a tragedy which is the direct result of the inadequate treatment, or the incomplete post-treatment surveillance, of a syphilitic.

Horne (1950, 1953), analysing contemporary defaulters in venereal diseases clinics in Edinburgh and Leeds, came to the conclusion that patients who default from anti-syphilitic treatment very rarely, thereafter, make regular attendances, and that this state was quite "unaffected by personal or other influences".

It would appear then that, if we are to accept this attitude of resignation to the problem, we have no more to do but sit back and await further tragedies.

This contribution gives details of an attempt made to persuade 268 patients, who defaulted during the years 1941-50, to re-attend. For inclusion in the series the minimum length of default was taken as one year (Table I).

TABLE I
YEARS OF DIAGNOSIS AND DEFAULT

Year	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	Total
Year of First Attendance	8	13	18	20	40	59	49	40	18	3	268
Year of Default	2	8	8	6	32	33	51	50	49	29	268

I have called such patients, for want of a better word, "pre-contemporary" defaulters.

Three clinics were concerned in the recall, which was completed between August, 1951, and May, 1952. Information is therefore available not only regarding the immediate condition of those who re-attended but also about the state of affairs after a further 2 years, where further surveillance and treatment were found necessary.

The series includes 109 females and 159 males, the average age being 31 years at the time of

diagnosis. All had been diagnosed as suffering from infectious or latent syphilis (Table II). 207 had defaulted while under treatment, and 61 while under post-treatment surveillance.

TABLE II
DIAGNOSIS, SEX, AND MARITAL STATUS

Diagnosis	Marital Status	Males	Females	Totals
Sero-negative Primary	Married	14	2	30
	Single	14	—	
Sero-positive Primary	Married	43	11	91
	Single	27	10	
Secondary ..	Married	27	33	92
	Single	14	18	
Latent	Married	12	27	55
	Single	8	8	
Totals ..	Married	96	73	268
	Single	63	36	

At the time when they would be classified as contemporary defaulters, 164 of these had been sent, between them, some 400 letters in an attempt to secure their re-attendance, but all these efforts had failed.

Clinical Condition at Default.—As regards treatment, the series of 268 patients could be divided roughly into four groups:

97 received arsenic and bismuth only.

113 received penicillin, arsenic, and bismuth.

53 received bismuth alone or penicillin or the two in combination.

5 defaulted before receiving any treatment at all.

(1) In the arsenic-bismuth group, if we take one standard course of ten injections of each drug as the minimum adequate treatment for sero-negative primary, three such courses for sero-positive primary and secondary, and five courses for latent syphilis, we find that only 21 (22 per cent.) in this group of 97 completed minimum adequate treatment.

(2) When penicillin, in doses of 4.8 to 6 mega units in 7 to 10 days, was combined with arsenic and bismuth, one such course being taken as the minimum for all infectious cases and two as the minimum for latent infections, we find that 88 (79 per cent.) of the group of 113 received minimum adequate treatment.

* Received for publication June 3, 1954.

(3) Where penicillin and bismuth were combined, one course of each being taken as the minimum for sero-negative primary, two courses for sero-positive primary and secondary, and three courses for latent syphilis, we find that only two patients in the group of 53 completed minimum adequate treatment.

Using these criteria, 112 (41 per cent.) of the whole series did not default till they had received minimum adequate treatment, though 207 defaulted before completing full treatment.

The benefit of penicillin is not unexpected, and it is of some interest to note that had the arsenic-bismuth group had this benefit the figure of 41 per cent. would have been raised to 63 per cent.

Method of Recall.—The method used was by letters to a maximum of three. Where these failed, visits, usually also to a maximum of three, followed. To ensure a degree of security for the patients, letters bore a non-committal letter-head, *i.e.* there was no mention of "venereal disease", "special clinic", or "venereologist". The first letter simply requested the patient to attend, and gave a list of the hours available. The second letter was much the same, but reminded the patient that he had failed to complete treatment or follow-up tests for "an infection". The third letter was a purely personal one, stating the plain facts of the diagnosis, together with the dangers to which the patient was exposing himself, and urging the earliest possible re-attendance. A clinic card showing the patient's number and the out-patient session hours, together with the publication "Do you know" was enclosed with each personal letter as a routine. All letters were sent in envelopes marked "strictly confidential", and each communication was placed in a second sealed envelope addressed for return if it did not reach the addressee.

Where there was no response to the three letters or where a letter was returned "unknown at this address" or "gone away", visits were instituted through the co-operation of the local Medical Officer of Health. As a general rule a maximum of three effective visits was made, an effective visit being one where the patient was actually seen and spoken to. All letters and/or visits followed each other at fortnightly intervals, this with a view to impressing upon the patients the importance of the matter, and demonstrating that an earnest interest was being taken in their individual problems. To this timing must be attributed such success in regaining attendance as was achieved.

The problems arising from this "long-range" default routine were no different from those found in dealing with contemporary defaulters. Only

in one case of the series was difficulty encountered. This concerned a personal letter to a young man whose father bore the same name. This third letter like the previous two was opened by the father, who promptly presented himself to say that the person concerned was certainly not himself, and could not possibly be his son, who had rejoined the services a year previously. With the excuse that a percentage of patients presenting at Venereal Diseases Clinics give false names and addresses the interview ended amicably, with honour satisfied on all sides.

As anticipated, by no means all the 268 patients could be contacted. Indeed 74 could not be located, and this in spite of visits when letters were returned. Eleven others were traced and written to with advice to attend their local clinic; recent inquiries have shown that only three took the advice and these have been included among those who are shown below as re-attending. Nineteen patients refused to attend, and twelve, although they promised to attend, did not present themselves. Eleven had died.

Results.—It will be seen that of the total series of 268 only 183 (68 per cent.) could be located, of which 144 (78 per cent.) attended. The response appeared to be best among those with default of 5 to 6 years' standing, but the numbers are too small to make it definite that this is the optimum time to recall "written-off" defaulters.

This total of 144 were found on analysis to be representative of the whole as regards age, sex, marital status, diagnosis, and treatment classification. No difference in the response was noted between those previously written to and those not previously written to.

Macfarlane (1954) notes that male contemporary defaulters respond more promptly to letters and females more promptly to visits. There was no marked difference in this series (Table III).

TABLE III
INCIDENT PROMPTING RE-ATTENDANCE

Sex	Letters			Visits			Total Letters	Total Visits	Grand Total
	1st	2nd	Personal	1st	2nd	3rd			
Male	34	12	11	14	3	3	57	20	77
Female	21	16	8	12	4	6	45	22	67
Total	55	28	19	26	7	9	102	42	144

Clinical re-evaluation of those who re-attended was undertaken using the criteria outlined above in conjunction with time and clinical factors. Where the patient had defaulted before completion of

treatment, and had not been seen for 2 years or more, but was clinically free from infection, and had a negative blood Wassermann reaction and Kahn test, and a normal cerebrospinal fluid, no further treatment was given. Such a patient passed to surveillance. Where less than 2 years had elapsed, and the patient had had inadequate treatment, further treatment was given. As regards surveillance before discharge as cured, 5 years from completion of treatment was the rule, except in sero-negative primary syphilis when 2 years was judged sufficient.

Using these criteria, the immediate disposal of the 144 was as follows :

- 61 discharged cured ;
- 51 further surveillance ;
- 32 further treatment or re-treatment.

The 83 asked to make further attendances had their individual clinical status explained to them. They were given as clear an idea as possible what tests and treatment were considered necessary, how long they would be required to attend, and how long it would take before they could be discharged as cured. At each visit (except when those requiring it attended for daily penicillin therapy) they were seen personally and encouraged to make further attendance. They were given every facility in regard to times of attendance and were assured of minimum waiting when they visited the clinic concerned.

Follow-up.—After a further 2 years the questions “How have these patients responded?” and “What is the up-to-date position?” can be answered as follows :

(1) Of the 51 requiring further surveillance, 34 have now been discharged as cured, mostly without further default, ten continue under surveillance, and seven are again persistent defaulters in spite of further efforts by letters and visits.

(2) Of the 32 requiring further treatment, 23 were straightforward cases of inadequate treatment, and in nearly all the Wassermann and Kahn tests were positive. Two patients, although clinically normal, had an active cerebrospinal fluid. Re-treatment was required by nine, who fell into the relapse/re-infection category, and two of these had asymptomatic neurosyphilis.

The attendance of this further treatment/re-

treatment group has been sufficiently good for 25 of the 32 to complete minimum adequate treatment, ten of these having completed full treatment and passed to surveillance. These ten attended without default or nearly so, while of the others one was lost sight of, one defaulted completely, and one died.

Of the other seven, as yet without minimum adequate treatment, three attend only sporadically, three are persistent and hopeless defaulters, and one has died.

As with those under surveillance, any defaulter from treatment promptly receives letters and, if necessary, visits to secure re-attendance. In the cases of surveillance a month's grace is given, and in cases of treatment 2 weeks' absence only prompts the despatch of the first recall letter.

The present position of the 144 who returned 2 years or more ago is now as follows :

- 95 discharged cured ;
- 20 under surveillance ;
- 15 under treatment ;
- 11 again persistent defaulters (seven from surveillance and four from treatment) ;
- 2 dead ;
- 1 lost to the series.

Summary and Conclusions

By recalling “pre-contemporary” syphilitic defaulters it has been possible to invade the no-man's land between default in early syphilis and the late syphilitic tragedy.

In spite of the fact that many were regarded as completely persistent defaulters the method used resulted in a high “yield” of those available.

Two years after completion of recall it can be stated that those required to make regular attendances have nearly all done so.

It is felt that this investigation has been worth while. It may be looked upon as a pilot study, as it is felt that similar work elsewhere would contribute further to the falling incidence of late syphilis in the country as a whole.

REFERENCES

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