DIFFICULTIES IN THE SUCCESSFUL TREATMENT OF THE VENEREAL DISEASE PATIENT*

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In considering our difficulties at the present time, we should perhaps reflect on the response of the venereal diseases to treatment during the last thirty years, for this has gradually brought about a complete change of outlook. The old “it’s incurable” attitude has given place to optimism, as chemotherapy has been developed and facilities for treatment improved. It is unfortunate that the stigma of these diseases persists, for this factor is undoubtedly responsible for some of the remaining difficulties in treatment. It is unlikely that many of our problems will be overcome until we have achieved an enlightened public opinion, but, with the medicaments now available, it is possible to do much that was impossible even a few years ago.

The aim of the Venereal Diseases Scheme in Great Britain is to make proper treatment available to all persons suffering from venereal diseases, to render the patient non-contagious rapidly and also to prevent the onset of the later crippling manifestations of uncured disease, with all their economic implications.

There are few diseases in Medicine for which medicaments of such potential curative value are available. We can however expect too much of a drug; to rely on a highly effective remedy may lead to a casual approach to treatment. It is generally agreed that the successful treatment of a case requires cooperation between the doctor and the patient. The advances in treatment have promised much, but experience has shown that a considerable proportion of cases do not obtain uncomplicated cures.

The object of this paper is to consider briefly some possible explanations of the difficulties and failures which are encountered and to stimulate discussion, in the hope that an exchange of opinion may be of benefit to all concerned with this important branch of public health work.

Regular attendance of patients

Treatment and case observation have hitherto necessarily been prolonged and one of the essential criteria in case management has been continuity of treatment. A major problem in maintaining the regular attendance of a patient for the completion of treatment depends upon the rapidity with which the outward manifestations of disease clear up. Some of the patients are of an unreliable type but, even if we discount these, we find that patients in general readily accept a false security. In their ignorance of the possibility of relapse if treatment is discontinued prematurely, they tend to default when the signs which brought them for advice have cleared up. Even when they have been warned of this possibility, the inconvenience of prolonged treatment and the social problems involved may lead them, for the sake of their reputation, to take the risk of default. Some authorities consider that notification—and compulsory treatment if necessary—might overcome this important problem in case control. They have compared the venereal disease position with that of other contagious diseases which are notifiable. We must, however, recognize that the conditions are not strictly comparable; the present stigma of venereal disease would be an unfair taint on a person who has perhaps done no

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more than have some of his more fortunate friends. The course of most contagious diseases, on the whole, is short and calls for little cooperation on the part of the patient. It is debatable to what extent a compulsorily attending patient would cooperate in the treatment; his personal reaction might easily be one of resentment and he might even adopt the attitude, "you've notified me, now you cure me".

Generally speaking, the non-cooperative patient does not respond well to our specific remedies. At present, in civil life at least, we have to depend upon his taking tablets regularly as an out-patient, or upon his attendance with absolute regularity for injections. It seems that notification would require the admission of every infected person as a hospital in-patient for efficient compulsory treatment. This has not hitherto been practicable, but, if the recent introduction of modified intensive arsenotherapy and of penicillin treatment for syphilis and gonorrhoea should prove to be effective, it might perhaps be a solution which would lead to the rapid control of the venereal diseases and justify compulsory measures. The admission of a patient to hospital would indeed lead to new domestic problems, and inquisitive neighbours and work-mates would need to be pacified.

In the present scheme of treatment, regular attendance frequently causes anxiety to patients lest they be seen entering or leaving a venereal diseases clinic; this is especially true of the smaller provincial clinics, at which attendance often has to be on a special day each week; apparently it is difficult for workers to get "time off" in order to make the necessary visit without divulging the reason to employers or work-mates. Many such patients, prepared to adopt a reasonable and enlightened attitude to the problems, have been penalized or lost their jobs. Their employers have either been unable to pacify other workers, or have not realized that a regularly attending patient is no risk to them, whereas disease suppressed and untreated—through fear of the stigma and consequences—may lead to a serious problem in a factory. Patients are sometimes discharged from the Forces to continue their necessary treatment at a civilian treatment centre without full recognition of these difficulties and they tend to be especially serious for a man coming back to a new routine in civil life. These problems must be tackled, and there must be a control of continuity between Service and civil centres if a major problem on demobilization is to be avoided.

For various reasons some of the treatment centres now hold insufficient sessions, with the result that considerable overcrowding occurs. The standard of work may then be inferior, either because the medical officer has to rush through the cases on account of his other commitments, or because the overcrowding may cause the patients to lose much time in waiting and demand long extensions of the doctor's hours. In either case the situation is unsatisfactory and must reflect adversely on the work of these clinics.

Special difficulties of the small clinic

There are special difficulties in maintaining a high standard of work at some of the smaller clinics. Often these are open on only one day each week. I have referred above to some of the social problems likely to be encountered under such conditions. Furthermore, the equipment of a small clinic is sometimes inadequate. Clinical specimens have often to be sent to a county laboratory for examination, with the result that at least one week elapses before a diagnosis can be confirmed and treatment commenced. I know of clinics where a microscope is not available, and of many that do not have the apparatus necessary for dark-ground examinations. Local authorities which provide central laboratory facilities do not always recognize the importance of immediate diagnosis, which is so desirable in the once-a-week clinic. These clinics seldom have laboratory facilities available close at hand. Thus, diagnosis by culture is for all practical purposes useless; in female cases this leads to doubt as to the safety of accepting repeated negative tests on cases sent up as contacts for examination, because there is a general agreement that the film diagnosis of gonorrhoea in the female patient is at best a precarious matter.

The admission as in-patients of those who need special treatment may be
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difficult to arrange, especially when smaller clinics are not situated at the local hospital, and often when beds are found facilities are not available for these cases to remain in the care of a recognized venereologist. The smaller clinics which open for a single session once a week may provide intermediate treatments, but there is then no supervision by the medical officer; consequently complications which may develop receive no immediate attention, and the delay not infrequently leads to the spread of infection and greater difficulties in the subsequent management of the case. There is an urgent need for an adjustment of the facilities in order to bring these smaller clinics into line with the service and standard of work now available at the larger clinics. It may seem that all these matters are of little direct concern to the doctor; nevertheless they are of great importance to the proper administration of the Venereal Diseases Scheme.

Psychological factors in maintaining attendance

It is probable that the regular attendance of a patient depends to some extent upon the atmosphere of the clinic and the attainment of a sympathetic understanding of the patient and his problems. Nurses, orderlies, health workers and doctors need to be carefully selected, both for their ability and training and for their undivided interest in venereal diseases work. The part-time worker in venereal diseases tends to be pre-occupied and his patients soon recognize the lack of interest, which naturally is reciprocated. Similarly the "militant" attitude, still occasionally persisting, works adversely in emphasizing to the patient his moral lapse rather than his medical problem; the result is that he will escape at the earliest opportunity.

Efficient medication

When we have found an adequate solution to all these problems in the individual patient and have obtained his cooperation and regular attendance, we shall be faced still with the problem of the efficient use of the medicaments at our disposal. We must recognize that successful treatment requires more than a knowledge of the compounds in common use. A knowledge of the dangers of overdosage and underdosage and an appreciation of the prodromal symptoms of intolerance will go far towards a control of the infection, but we must adapt this knowledge to the individual problems of each patient. No doubt the specialist is better able to administer these remedies and fulfil these requirements than is the most competent and reliable general practitioner, who may see an occasional case only; at present there is indeed evidence of a lamentable ignorance on the part of some practitioners, due to lack of opportunity in recent years to keep themselves proficient in diagnosis and treatment. Even among specialists there is a wide divergence of opinion as to the best method of treatment; many schemes are capable of producing good results, but only by constant observation can we assess the limitations of each.

Problems in the treatment of gonorrhoea

It is unfortunate that many a case of gonorrhoea has on first attendance already received an inadequate dose of sulphonamide, which has failed to effect a cure and has rendered the patient tolerant of or resistant to sulphonamides. Failure to recognize that sulphonamides are bacteriostatic and not bacteriocidal is equally liable to cause failure, if large doses are employed over too short a period. It is probable that the infection is then not controlled for a long enough period to allow the natural defences of the body to complete the destruction of the organisms. Furthermore, the inefficient penetration of pus by these chemotherapeutic agents will lead to failure if drainage of infected follicles and aggregations of pus is not assured; it is becoming rapidly apparent that the importance of this factor applies as much to penicillin treatment as it does to treatment with the sulphonamides.

A suggested course of treatment

In case I am accused of destructive criticism, let me diverge for a moment in
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order to mention the standard treatment which I have found to be effective for the control of the majority of cases of gonorrhoea.

Immediate diagnosis is made by means of a stained film of the discharge, but further tests are necessary in obscure cases; the treatment for gonorrhoea should not be undertaken until investigations have confirmed the clinical diagnosis. The patient is then supplied with 45 tablets of sulphathiazole and carefully instructed to take 3 tablets at 8-hourly intervals day and night for 5 days. In many cases treatment with the proper total dose fails if regular administration is not continued day and night. The actual timing of doses must be regulated to the patient’s individual routine and this is discussed with each patient. For example, the manual labourer usually finds it convenient to take his 3 tablets at 6 a.m., 2 p.m. and 10 p.m., or, if on night work, say, at 7 p.m., 3 a.m., and 11 a.m. The clerk prefers 8 a.m., 4 p.m., and 12 midnight, and I suppose that the Mayfair playboy might choose 12 noon, 8 p.m., and 4 a.m! The first dose is given immediately, and the patient is instructed to take the next dose at the next time in the agreed time-table. The patient is warned of the risk of resistance to treatment if the spacing is irregular or if even a single dose is missed; such irregularity may allow the sulphonamide blood level to fall below that which is necessary for constant control of the infection. The patient is warned also of the possibility of relapse, with the likelihood of sulphonamide resistance, if, because the discharge has stopped, he ceases to take the tablets before the end of the 5 days’ treatment. In my opinion it is quite useless to hand over the correct number of tablets without impressing these details on every patient.

A large number of reports from many authorities have been published, in which the writers state their preferences for varying doses and spacing and differing durations of treatment. Williams, King and Nicol have ably summarized in the Journal their experiences with differing schemes of treatment. Their best results approximated to the dosage which I have mentioned and which I have used in my clinics for several years. The five-day period has reduced evidence of sensitization to a negligible factor, and the total dosage of 22½ grammes in that five-day period is adequate for the majority of new and untreated cases and does not cause appreciable symptoms of intolerance. I prefer sulphathiazole to sulphapyridine for that reason, and in dealing with out-patients, who usually must remain at essential work, the choice of compound is a matter of some importance. Unpleasant subjective symptoms may make it necessary for a patient to abandon his treatment in favour of his work, which will probably result in the development of sulphonamide resistance.

I have found that urethral irrigations for male cases and local dry swabbing for female cases are an essential adjuvant to treatment in order to achieve rapidly a high standard of cure. Relapses, or a subsequent non-specific urethritis, which are not uncommon when irrigations have been dispensed with, appear to be due to the presence of residual foci of infection located under folds of mucous membrane or in obstructed local gland ducts.

Two-day or three-day courses of treatment have been advocated; in these a slightly higher daily dosage is employed, for instance 20 grammes in 3 days. From my observation of the subsequent history of some of these cases, I do not think that the shorter courses are wholly satisfactory. Many patients continue to have a slight morning discharge or threads in the urine; the possible complications of a secondary infection and of stricture from a long-continued, even if mild, infection cannot be ignored, quite apart from the psychological effect which persisting symptoms may have on the patient. To render a patient gonococcus-free and leave a non-specific urethritis, is to add to the difficulties of ultimate treatment; it occurs less commonly in the five-day treatment which I have described and which I therefore prefer.

Refractory gonococcal infections

Sulphonamide-tolerant patients who have not obtained cure by a single course, whether of adequate or of inadequate dosage, are not often cured by further
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Immediate treatment with the same or an alternative sulphonamide compound, even if the daily dosage is increased. There appears to be some evidence, both clinical and experimental, that a true sulphonamide-resistant gonococcal strain exists or can be induced, as, for example, by the injudicious use of sulphonamide prophylaxis, but the majority of apparently resistant cases are only temporarily so resistant. It is my practice in the latter type of case to give preliminary treatment with increasing doses of gonococcal vaccine intradermally; I give also daily urethral irrigations with potassium permanganate solution, together with alkalis by the mouth, for a period of 10 days. Then an alternative sulphonamide compound (sulphadiazine or sulphapyridine) is administered, with all the precautions and advice outlined above, and a successful result is finally achieved in all but a small proportion of these cases.

Harkness and other authors have described the good results which can be obtained in these residual cases with Aolan (milk protein) injections or with typhoid-paratyphoid vaccine fever therapy, and penicillin is now being used more generally and with considerable success for these refractory cases. Usually, some undrained foci can be discovered in the remaining failures; attention to these foci, with methods to promote drainage, assisted by local treatment with short-wave diathermy, will produce a favourable result in many cases. A final course of chemotherapy is generally administered when adequate drainage has been established, but the association of trichomonas vaginitis, or of a superimposed non-specific urethritis, may call for appropriate additional treatment in certain cases.

Sulphonamide sensitivity

Constitutional sensitivity to sulphonamides may interfere with the routine treatment of a case of gonorrhoea. On the first occasion on which sulphonamides are administered to a patient this reaction is unlikely to occur before the eighth day, so that, in treatments limited to 5 or 7 days, the difficulty seldom arises; a patient who has not responded to treatment at this stage is in any case unlikely to benefit by a prolongation of the sulphonamide administration. If the reaction does occur, immediate steps should be taken to desensitize the patient; otherwise the recovery is delayed and patients may retain for long periods a latent sensitivity, which may preclude the administration of sulphonamides in some grave emergency at a later date. On the assumption of sensitization, I have long advocated a continuation of sulphonamide administration if sulphonamide dermatitis develops (Erskine); drug retention must however first be excluded by means of a urinary test with Werner's solution (3 per cent P-dimethylaminobenzaldehyde in 7 per cent sulphuric acid). Tate and Klorfajn have recently described their successful desensitization of persons suffering from sulphonamide dermatitis by means of small but increasing doses of the drug, even when a recrudescence of the reactions had occurred, and Park has even treated cases of sulphonamide granulocytosis with the continued administration of sulphonamide.

The control of a sensitized state can be achieved when reactions are noted during treatment if sulphonamide therapy is continued; the urinary excretion must be confirmed and, although at first this therapeutic procedure seems alarming it may prevent much more difficult situations at a later date. For a patient already found to be sensitized at the outset of treatment, it would probably be wiser to employ penicillin therapy than to embark on the difficult and prolonged process of desensitization, but this possible alternative does not absolve us from the responsibility of freeing the patient from sensitivity if the reaction develops as a result of our treatment. How much this allergic state is bound up with resistance, or with sulphonamide tolerance, is unknown as yet, but evidence now coming to light suggests the possibility of some antigenic quality being acquired by the sulphonamide, alone or in combination with a tissue protein.

Prevention of resistance and of toxic reactions

The dangers of resistant infections and of sulphonamide toxicity can be minimized by the careful administration of an adequate dose of an effective sulphon-
mide for an optimum period. To give 1 tablet, 2 or 3 times a day, for 2 or 3 weeks, not only fails to control the infection but exposes the patient to the dangers of sulphonamide treatment and to the risk of the development of chronic or resistant gonorrhoea. So also does the immediate administration of a full second course of a sulphonamide if a first course has failed. There is seldom any benefit and often much harm; these two errors, therefore, cannot be stressed too strongly or avoided too carefully.

Non-specific urethritis and vaginitis

A consideration of non-specific urethritis may seem to be beyond the scope of this paper, but the apparently increasing incidence of the condition calls for its brief recognition.

Non-specific urethritis and vaginitis may be of venereal or of non-venereal origin but more commonly the onset of symptoms appears to be related to sexual intercourse; very often the conditions may be ascribed to the injudicious use of an antiseptic or of certain contraceptives, to which the individual may be abnormally sensitive. Sometimes the condition results from the reactivation of a quiescent focus persisting after a previous attack of gonorrhoea.

The conditions may exist with concomitant syphilis or gonorrhoea; this is especially important in female patients, in whom trichomonas vaginitis may mask an underlying gonococcal infection. Observation of treated cases should be as prolonged as for gonorrhoea, in order to exclude the risk of unrecognized double infections. Although the conditions are not recognized in the Ministry of Health's classification of venereal conditions, the treatment of these cases is a public health problem and should be the responsibility of the Venereal Diseases Service; the majority of cases are of venereal origin and seldom are full facilities available elsewhere.

When the history and examination do not reveal a simple cause calling for some minor adjustment, treatment with large doses of alkalis or a routine course of a sulphonamide compound may be effective. It has been recognized that sulphonamides are beneficial only occasionally in these conditions, but their careful use offers a rapid improvement to the fortunate few. Resistant cases may respond to the administration of large doses of ascorbic acid, to weak acriflavine or oxycyanide of mercury irrigations, or to mild protein shock or fever therapy; penicillin is not usually indicated. In male cases it is frequently found on examination that urethral folliculitis or an old prostatic focus is an associated factor, and appropriate treatment for these foci may be attended with the relief of symptoms. In female cases an abnormal vaginal flora or cervical erosion may be implicated. Efforts should be made to control the condition and to overcome the potential risk of permanent damage if a discharge is left untreated. There is no evidence that the condition is contagious, but it does appear to be related to the state of nutrition in a certain number of cases.

Problems in the treatment of syphilis

Pitfalls in diagnosis.—Provided that strong antiseptics have not been used injudiciously within a few hours of an examination for Spirochaetapallida, the diagnosis of recently acquired syphilis is seldom difficult; in all cases thorough cleansing must precede the collection of the exudate expressed from the deeper parts of the lesion. The occasional co-existence of scabies and syphilis in the same patient may result in a chancre being overlooked, if the possible association of these two conditions is not in mind at the time of examination; it is essential, too, to recognize the possibility of the development of a syphilitic lesion in a soft chancre. A differential diagnosis made by means of a therapeutic test alone is unacceptable, unless the circumstances are exceptional. Lydon and Scott Cowe have drawn attention to the possible masking of syphilis which might be developing in a patient treated for gonorrhoea with penicillin.

I consider that the widely advertised recommendation of intravenous noradrenochrome for throat ulcerations due to Vincent's organisms (Fusiform dentium
and *Borrelia vincentii* is a dangerous procedure, unless it is stressed that blood must be collected for a Wassermann test at the time of injection. An incorrect diagnosis can lead to the masking of syphilis with the probability of a serious recurrence at a later date. In this connexion it may be emphasized that the mere demonstration of Vincent’s organisms in a smear from such an ulcer does not confirm the diagnosis; these organisms are "opportunists", often found in healthy mouths, so that their occasional presence in syphilitic ulcers is not surprising.

**Syphilis and pregnancy.**—There is much doubt as to the type of treatment indicated for a pregnant woman who is found to be suffering from latent syphilis, and about the assessment of inherited infection in a child born of such a woman who has received some treatment during pregnancy. Most authorities consider that a woman who is known to have had syphilis and to have received full treatment should be given at least one course of treatment during any subsequent pregnancy. When syphilis has been discovered during pregnancy the woman must receive full treatment; tolaration is usually very satisfactory. A child born of a woman in either of these conditions will show serological reactions similar to those of the mother at the end of pregnancy, and, in the absence of clinical signs of active disease, should be left untreated until the age of from 3 to 6 months, when a proper assessment of its own blood reactions can be made.

**Positive serological tests.**—Greater difficulty is caused by the discovery of a strongly positive Wassermann and Kahn reaction in the routine testing of the blood. We have all met these cases in the testing for cure of gonorrhoea or at antenatal examinations, and they are constantly occurring in the testing of blood donors. Certain conditions are indeed recognized as causes of temporary false reactions but, if the tests are confirmed on repetition, the verification tests which are being carried out now at the Ministry of Health’s laboratory may help to clarify the case. In the absence of any significant history or clinical signs, it is debatable whether or not treatment should be instituted, even for those cases in which positive tests have been verified. Much will depend upon the age of the patient and every case will need individual consideration. Wassermann-fastness after apparently regular and adequate treatment may sometimes indicate an uncured focus, for example, a latent neurosyphilis; a thorough clinical examination, together with testing of the cerebrospinal fluid and x-ray films of the heart and the great blood vessels or of the bones, may help to solve the problem. We should recognize, however, that a positive Wassermann or other serological test is not evidence of active syphilis, either in the primary or the later stages of the disease, but is a blood change which may be associated with the disease and which in some instances can exist without active disease. Like all laboratory tests, it should be used as a guide to clinical judgment and not as a dictator of policy.

**Treatment and the individual.**—The prolonged treatment of a syphilitic patient is absolutely essential to the expectation of a permanent cure. We need not at the moment consider modern intensive arsenotherapy and penicillin treatments, which require much more controlled observations before being adopted for general use. If these treatments are proved to be successful, they may set our moralists a new problem, but a recent report by Ross, Nelson, Lourie and Collier already casts some doubt upon the high expectations from penicillin alone.

I have already referred to the difficulty of case holding during the many months of attendance which are necessary in order to complete the established approved schemes of treatment. There are, in addition, many problems associated with toleration and with the toxicity of the remedies which we generally employ. In spite of full approved courses of treatment, in occasional cases what appear to be genuine muco-cutaneous relapses have been found to develop; it appears, therefore, that the cure of syphilis requires not only the recognized standard of treatment but also some factor related to the patient’s own resistance. It is probable that the full toleration of the compounds is also dependent upon the patient’s health and metabolism.
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Jaundice during arsenotherapy

Beattie and Marshall demonstrated recently that the onset of jaundice, which so often interferes with routine treatment, could be delayed by feeding their patients with certain amino-acids. It was hoped in this way to achieve adequate antisyphilitic treatment before the onset of contra-indicating toxic reactions. It is doubtful, however, whether or not the method is practicable or the slight delay achieved adequate. The work of these authors does, on the other hand, suggest a possible explanation of the variable incidence of jaundice in groups of patients under observation.

Neoarsphenamine is commonly implicated in the onset of jaundice during antisyphilitic treatment, and various theories have been advanced in explanation of the complication. Bigger suggests that the transmission of a virus may be responsible, but I find it difficult to accept this view. In one of my clinics which deals with male and female patients from the Forces and from civil life, and in which 6 syringes only are used, the bulk of the jaundice has occurred in male army patients; I cannot see why such selection should have occurred if transmission of a virus by means of syringes is the simple explanation.

Some authorities have advocated the use of arsenoxide (mapharside or mapharsen) as an alternative arsenical, less likely to cause unsatisfactory reactions; it appears to be the more satisfactory compound for intensive treatments, but the recent modifications in treatment and the toxic reactions need to be investigated further and case observation must be prolonged before this form of treatment can be widely adopted. Arsenoxide has been employed also as a substitute for neoarsphenamine in the routine prolonged schemes of treatment, but the dosage generally employed has been based on the assumption that 1/10 gramme of arsenoxide is equivalent to 1 gramme of neoarsphenamine. Experimental work with animals suggests the equivalent dose for the cure of syphilis to be in the nature of 1/10 gramme, so that it is doubtful how successful arsenoxide will ultimately prove to be in this method of treatment; in larger and equivalent doses it is certainly no less toxic than is neoarsphenamine. The compound has not found general favour as an alternative medicament for use in the routine prolonged schemes of treatment; it does not reduce toxicity to the liver noticeably and in the treatment of difficult cases it does little that an alternative brand of neoarsphenamine will not do. If at the same time it does not seem likely to be a safe cure of syphilis, there can be little to say for it.

The occurrence of jaundice and of other reactions in antisyphilitic treatment constitutes a hazard which must, at present, be accepted in the interests of the cure of syphilis. To jeopardise the chance of cure by utilizing any modified course, if it does not eliminate the risk of jaundice and, at the same time, leaves some doubt as to the adequacy of the treatment, is a practice which cannot be too strongly deprecated.

Careful preparation of the solution in fresh sterile distilled water, immediately prior to each individual injection, will minimize the incidence of untoward reactions. The preparation of bulk solutions, for use in a busy clinic, inevitably leads to oxidation and toxicity and may account for the great incidence of intolerance in at least one centre known to me. Careful observation of the patient, with leading questions at each treatment, will often produce evidence of prodromal symptoms such as nausea, pains in the limbs and back or skin irritation, and, if appropriate steps are taken to modify the treatment, objective evidence of toxicity can sometimes be averted. Withholding treatment for a few weeks may be all that is necessary, and the time lost in the cure of syphilis by such a procedure is justified by the later toleration of full treatment. The solution of the neoarsphenamine in sodium thiosulphate for a few injections may be effective for patients who experience mild symptoms.

If jaundice or dermatitis occurs, active methods ought to be adopted in order to overcome the complication as rapidly as possible. If this is done, residual damage and permanent intolerance are less likely to be encountered. I have used intravenous injections of sodium thiosulphate or calcium thiosulphate daily,
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together with a similar mixture and compound vitamin tablets orally, and my impression is that the patients concerned have improved more satisfactorily than have others for whom, for some reason, no corrective treatment has been employed. The control of syphilis during the period in which arsenic is contra-indicated can be ensured by continuing the treatment with injections of bismuth. Forbes has recently confirmed the opinion that this procedure does not adversely affect the cure of the hepatic derangement.

Bismuth intolerance

Bismuth will itself sometimes be responsible for difficulty in treatment. Proper oral hygiene is of the utmost importance during antisyphilitic treatment, and bismuth gingivitis can be prevented in a properly cared-for mouth; but bismuth ulceration is apt to develop round the molar teeth in neglected cases; this happens perhaps more frequently when adequate massage of the injection site has not been practised as a routine, but is used only after the later injections. Treatment may be similar to that of Vincent's angina, which sometimes occurs during neoarsphenamine treatment. Provided that the blood picture excludes the possibility of agranulocytosis, the administration of 1 gramme of sulphapyridine 8-hourly for 5 days, with hydrogen peroxide or sulphur mouth washes, is usually effective.

Conclusions

Venereology has for too long been regarded by the medical profession as the Cinderella of specialities, because it is supposed to be a simple branch which anybody is able to practise. In the uneventful case, with the patient faithfully following the routine and producing no problems, this may be true, but the practice of venereology does produce problems in such a large majority of cases. In order to discharge his duties properly the venereologist must have a thorough clinical appreciation and a "public health" outlook. The problems call for a sympathetic understanding of all the difficulties which develop during the patient's adjustment to his misfortune and the attendant restrictions on personal liberties.

We are now in the fortunate position of having effective medicaments available for treatment and, armed with these, we are justified in looking towards the ultimate eradication of the diseases. The apparent simplicity, however, cloaks a host of difficulties, and I contend that at present our greatest need is to ponder on these difficulties and endeavour to find a solution to the many problems. Only thus can we succeed in developing a fully efficient service with a reliable standard of treatment. Propaganda and education will in due course give the public an enlightened outlook on sex matters and venereal diseases, and already we are aware of a greater freedom of discussion. The greater the knowledge possessed by the public, the more certainly must we be able to administer a cure and discharge our responsibilities under the Venereal Diseases Scheme. Can we overcome the hypocrisy and stigma which have for so long surrounded these diseases, or should we abandon the specialized clinic and undertake treatment at health centres dealing with many other conditions inimical to public health?

REFERENCES

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