IMPRESSIONS OF POSTGRADUATE TEACHING ON VENEREOLGY IN PARIS

GONORRHOEA

BY

GEORGES FAYNER

With the advent of the sulphonamides and of penicillin the treatment of gonorrhœa has again entered into the routine work of the general practitioner who in the past era of "grands lavages" was rather reluctant to undertake it. The problems encountered in this field by practitioners and venereologists and the methods of dealing with them formed one of the subjects of a postgraduate course of instruction on gonorrhœa recently held at the St. Lazare Hospital and University Clinics in Paris under the auspices of Dr. P. Durel.

A Cyclical Disease

It was emphasized that gonorrhœa is a cyclical disease and that its evolution, if not interrupted earlier by adequate treatment, comprises, *grosso modo*, three successive stages.

Stage I : Diffuse Suppuration.—In this period the symptoms are acute urethritis of recent origin in the male and female, acute vulvo-vaginitis in children and more rarely in adults, simple purulent cervicitis (for example, in multipara) acute rectitis, peritonitis, etc. In a man it is at this stage that the diagnosis is generally made, but this is seldom in women, in whom the symptoms are usually much milder and not so obvious, and thus they seek medical advice at a later stage. General treatment (antibiotics, sulphonamides) is mainly applicable to this stage as, in the past, extensive local treatment (lavages) was used for the same purpose. It is, therefore, frequently inappropriate to use "grands lavages"—as some general practitioners still do—when penicillin and/or sulphonamides have failed, since the former are much less potent than the latter.

Stage II : Localized Foci.—Symptoms in this period are litritis, diverticulitis, prostatic cavernula, vesiculitis, female urethro-skenitis, bartholinitis,

cystic cervicitis, and hydro- or pyosalpingitis. These foci are sometimes recognized during the first consultation, but more usually in cases of relapse in men or on suspicion of contamination in a female contact. In this connexion emphasis is laid on the special instances of relapse in men, so called "urétrites de réensemencement." By this is meant not the simple relapse due to the revival of local latent infection, but the reinoculation of urethral mucosa from a reopened focus. The individualization of this kind of relapse has important value from a therapeutical point of view.

The difference in the course of gonorrhœa in men and women accounts for the fact that general treatment is given to the former in the first period, that is, in the most favourable stage, with highly satisfactory results, whereas in the latter it is frequently administered in the second period, where it appears to be insufficient when used alone and should be accompanied by appropriate local treatment. This is why the general practitioner is so often puzzled by his female cases. Although by means of general treatment he is able for a short time to dry the urethra and cervix, relapses usually occur over and over again, and only local treatment applied by a specialist can put an end to this. Until the general practitioner realizes this fact, his achievement will be quite illusive.

These first two periods are contagious and therefore much more important from the point of view of social hygiene than the third.

Stage III : Obturations.—After many attacks of urethritis or salpingitis there is obturation or stricture of affected ducts. Urethral stricture in the male is at present very rare, but tubal obturations are much more frequent. Treatment is specialized, mostly mechanical (dilatations, insufflations) or softening (electrolysis).

Drug-Resistance

This brief scheme makes it clear that to speak of the failure of the general treatment, when applied to the patients in the second period, as of sulphonamide or penicillin-resistance, is an error of judgment, because such remedies are not indicated at this stage of the disease. The resistance in this instance does not depend on a given drug, but on the doctor who has overlooked a focus (called a focus of resistance). It is only fair to admit that the fault does not always lie with the practitioner. It sometimes happens that the course of gonorrhoea does not follow the above scheme strictly and that the acute diffuse suppuration is complicated by a *litttritis* "d'emblée." When this is so the processes belonging to two successive stages occur simultaneously, and it is only natural that the failure of treatment is in this case attributed by a not too perspicacious practitioner to drug-resistance, whereas the focus (the cause of resistance) is easily overlooked. We are dealing here with a false drug resistance. It is legitimate to speak of true drug-resistance only when we are quite sure that we are dealing with the first stage, that is, diffuse suppuration. True penicillin resistance scarcely exists at present, as against sulphonamide-resistance which occurs in 50 per cent. of cases even with big doses (6 to 8 g. per day for four days).

There is some apprehension about the occurrence of this penicillin-resistance in the near future as happened, unfortunately, with the sulphonamides through natural selection of sulphonamide-resistant strains. In order to obviate this the doubling of the usual dose is recommended. This is especially important in regard to oral penicillin, concerning which it is advocated that if tablets are to be sold they should contain not less than 1,000,000 units (five tablets at 200,000 units) as a single dose.

Penicillin-oil-wax (Romansky's formula), 300,000 units in one injection, is given and repeated after twelve hours. There is a preference for the new "penicillin-retard," a solution of penicillin in a 25 per cent. watery solution of polyvinyl-pyrrolidone. Subtosan is given twice at eight-hour intervals in 200,000 unit doses. Results are very satisfactory and are attributed to the prolonged penicillinemia of this preparation and to the initial high peak of its penicillinemia curve, which Dr. Durel considers essential.

It is pointed out that penicillin does not dry the urethra as quickly as the sulphonamides used to in their happier days. One should not be over-anxious about a milky, aseptic discharge frequently following penicillin treatment and lasting for twelve to fifteen days. The usual tests for cure should be delayed until this period is over.

The usual hygienic restrictions (abstention from alcohol, beer, aerated water) are as obligatory with penicillin as with old-fashioned lavages.

Localized Foci

For localized foci local treatment is the only effective kind. This is particularly true of urethritis "de réensemencement" (its important role in pathology of gonorrhoea has already been emphasized). Peculiar characteristics which may lead one to suspect such a urethritis are a history of many previous attacks, too long or too short an incubation, an outbreak after over-indulgence, capricious behaviour of the symptoms (such as scanty, intermittent discharge), rare gonococci, a partner free from infection (or she may be infected but not the infector: this possibility should be borne in mind). In such forms of urethritis penicillin can dry a discharge which reappears regularly after reactivation or spontaneously. All this raises the suspicion of a focus, which should be traced after clarification of urine through some kind of general treatment (sulphonamides, penicillin, or "grands lavages"). This focus may be found existing in a para-urethral canal, in prostatic cavernulae, in vesicles, or as a *litttritis*.

French Methods of Local Treatment

There is no place in this summary for a more detailed description of methods used in local treatment in France. With many of these, British specialists are well acquainted. Two original methods are worth mentioning. In *skenitis* Dr. Durel advocates the "mise à plat" into the urethra by the use of his special bipolar biactive electrode, one branch of which is placed in the urethra and the other introduced into the Skene's ducts. As for *bartholinitis*, he has abandoned other sclerosing agents (after thorough sterilization of the gland) for the "mise à plat" by way of diathermocoagulation when the sclerosis fails to effect a cure.