

EDITORIAL

FATAL SYPHILIS

The many attempts made to assess the true fatality rate of syphilis have all proved unsatisfactory for a variety of reasons, but mainly because syphilis, like the mills of God, grinds slowly. The follow-up of patients infected 10, 20, or 30 years previously is hampered in a large community because of false registration particulars in the first instance, and because on marriage women change their surname while both men and women change their address. Even in a small closely knit community such as the city of Oslo or even Norway itself, Bruusgaard¹ failed to trace more than 473 cases out of a total of 2,181. Harrison³ was able to suggest that one substantial leak was due to emigration, since more than 350,000 Norwegians entered the United States of America between 1890 and 1920 and of these 80 per cent. were in the age group of 16 to 35 years. Again, although Boeck did not treat their syphilis, there is no guarantee that subsequent medical treatment by other doctors did not include mercury and iodides. Then there is the question of correct diagnosis in the first instance. The very large number of patients who, 3 to 40 years after their infection, had attained a negative serological test is noteworthy. The figure of 27.9 per cent. which is given is calculated for the total number of 473, 164 of whom were dead. It is even more significant that, of 230 patients who were tested 10 to 40 years after infection, 113 proved serologically negative—practically half the total. It is most surprising to realize how slowly the work of Schaudinn and Wassermann was utilized in diagnosis. In England and Wales in 1914, only eight out of 47 Poor Law Infirmaries treating inpatients suffering from primary, secondary, and tertiary syphilis made frequent use of the Wassermann test^{10a} and still fewer public health authorities used the dark ground or other methods for the detection of *Treponema pallidum*^{10b}.

At the other end the correct certification of death is subject to many errors, some intentional ("compassionate" as McElligott⁵ calls them) and others occasioned by the knowledge that the deceased patient had a positive serological test for syphilis. This is notable in the certification of deaths due to syphilis in Liverpool from 1938 to 1943, where myocarditis and cirrhosis of the liver figure as syphilitic in origin⁹. Rosahn⁸, like Newcomb⁷, believes that the truth of this matter is to be found

in the *post-mortem* room. He criticizes the Bruusgaard record of deaths from cardiovascular disease on the grounds that syphilitics who die of fatty heart or arteriosclerosis cannot be said to die of syphilis. In his series of 198 deaths in untreated syphilitics whom he subjected to autopsy, 46 deaths were *due* to syphilis and a further 31 showed lesions of syphilis.

Two studies on fatality rates in untreated syphilitics are known to be in progress. One, mentioned by McElligott⁵, is a later survey of Bruusgaard's surviving group². The other was prepared by Heller and Bruyère⁴, whose material consists of 410 untreated coloured patients and 201 normal coloured controls: their preliminary findings suggest that the ill effects of untreated syphilis are not to be measured by the direct mortality due to syphilis but by the subtle decline in bodily resistance to intercurrent disease (Mattauschek and Pilcz⁶). Neo-natal deaths in congenital syphilitic infants illustrate this point well.

The task of the venereologist is clear: not least is the necessity for clinical examination and serological testing of all pregnant women and potentially infected children. He must encourage by all means in his power the follow-up in familial syphilis, and foster amongst his colleagues a greater appreciation of the necessity for serological examination of many, if not all, hospital cases. While the immediate results of treatment in latent cases will not be spectacular, the resultant gain in years of useful life and freedom from crippling disabilities will be of profound value to the individual and the community.

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