VENEREAL DISEASE IMPORTED BY MARINERS*

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Over the years several investigations have been made into the nationality of patients attending the venereal diseases clinics of Great Britain by the British Cooperative Clinical Group (1956, 1963a, b). The results of these surveys are of special interest in inland areas where promiscuity is found especially in migrant immigrants, but at seaports peripatetic native and foreign mariners are equally promiscuous (Schofield, 1964). Much of the venereal disease seen at seaports is imported; Härö and Pättälä (1961) reported that 50 per cent. of the cases of gonorrhoea seen in Finnish seamen were acquired abroad.

The investigation reported here was planned to estimate the amount of venereal disease imported by mariners into the locality of the VD clinics at South Shields and Tynemouth, to compare the origins of mariners with the source of their infections, to see if there were patterns of behaviour common to infected mariners, and to review methods of limiting the importation of venereal disease into the country through the seaports.

Methods and Materials

At the VD clinics in South Shields and Tynemouth, a note was made of the nationality of mariners attending as new patients during 1963, and of the port in which they had run risks causing them to attend. Where multiple risks had been run, then that causing most anxiety was the one noted. Only new cases were considered, and no account was taken of those attending with travelling books.

Nationality was taken to refer to the place of birth rather than to the ethnic group of the patient. In keeping with the clinic contact records, Great Britain was divided into three areas:

- A. Local, the area normally served by the two clinics;
- B. The rest of North-east England, the area covered by the other venereal diseases clinics on the rivers Tyne, Wear, and Tees;

C. Elsewhere in Great Britain, *i.e.*, the rest of England, with Scotland, Wales, and Northern Ireland.

The rest of the world was divided into ten arbitrary areas as follows:

- (1) Eire.
- (2) Scandinavia (Norway, Sweden, Finland).
- (3) Northern Europe (Belgium, Netherlands, Denmark, Germany, Poland, the East Baltic Seaboard).
- (4) Southern Europe (Portugal, Spain, France, Italy, Malta, Greece, Romania).
- (5) East Mediterranean (Turkey, Iraq, Aden, Bahrain).
- (6) Central and South America (Curaçao, Jamaica, Haiti, Panama, Argentina, Brazil, Ecuador, Venezuela).
- (7) Africa (Ghana, Mauritius, Nigeria, Sierre Leone, Somalia, South Africa).
- (8) Asia (India, Pakistan, Thailand, Malaysia, Indonesia, Japan).
- (9) North America (Canada, United States of America).
- (10) Australasia (Australia, New Zealand).

The countries in parentheses within each area are those which were named either as a source of infection or as the birthplace of a mariner.

Results

During 1963, 502 male patients attended the two clinics and 269 (53·6 per cent.) of them were mariners, of whom 163 (60·6 per cent.) were British and 106 (39·4 per cent.) were foreign. Mariners accounted for most of the venereal disease seen in males: seven out of thirteen cases of syphilis (five of the six with early contagious syphilis), one case of latent yaws, 52 (55·3 per cent.) of 94 cases of gonorrhoea, 55 (52·4 per cent.) of 105 cases of non-gonococcal urethritis (NGU), all four cases of lymphogranuloma venereum, and the one case of chancroid. In addition there were 149 mariners (52·5 per cent.) among 284 men who came to the clinic but showed no evidence of venereal disease (NVD).

Of 150 who ran risks abroad, 145 (97 per cent.) were mariners. The other five were two tourists with gonorrhoea and two others who attended for a

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check-up following risks in Spain, and a Chinese waiter who attended with gonorrhoea which developed after he had flown back to work on Tyneside from a holiday in Hong Kong.

Table I shows that, while the majority of risks (54 per cent.) were run abroad, twice as many risks were run both in the locality of the clinics and "elsewhere in Great Britain" as in any area abroad. Asia, Central and South America, Northern Europe, and Southern Europe were the most common foreign sources, while no venereal disease was acquired from East Mediterranean, African, or Australasian areas, nor was any risk run in Eire.

Nationality is considered in Table II. About two-fifths of patients were locals, while about a sixth each came from "elsewhere in Great Britain" and Southern Europe, twice as many as from Asia, and four times as many as from each of Northern Europe, East Mediterranean, and Africa. No one came from North America, nor anyone with venereal disease from the "rest of North-east England".

Table III compares the source and nationality of patients with syphilis. Numbers are small, but the majority (four) acquired the disease in their own country. Two of the three cases acquired locally were from prostitutes, whose infections were traced back to a foreign mariner (seen elsewhere) who acquired the disease in Germany in 1962.

A Jamaican, referred as a possible contact of contagious syphilis, was found to have latent yaws.

Lymphogranuloma venereum was found in one Greek and three local mariners. The infections were all acquired in Brazil. Chancroid was acquired by one local mariner in Canada.

The sources and origins of those with gonorrhoea are compared in Table IV. Because of its short incubation period it is not surprising that only two infections were acquired outside Europe. There were more risks than patients from the locality of the clinics, from the "rest of North-east England" (no patients at all), and Scandinavia, while there were more patients than risks from "elsewhere in Great Britain" and Southern Europe. Only Europeans were infected in Northern Europe.

Table V compares the origins and places of risk of those who attended suffering from non-gonococcal urethritis. Risks were world-wide, a fifth being outside Europe. There were more risks than patients from Scandinavia and Asia, and no patients from Northern Europe. There were twice as many patients as risks from the locality of the clinics.

The origins and places where they ran risks of mariners found without evidence of venereal disease are compared in Table VI. There was an excess of patients over risks for those areas near the clinics, the immediate locality, the "rest of North-east England" and Southern Europe, while an opposite trend was observed for Central and South America, Asia, and "elsewhere in Great Britain". Other areas had equal amounts of risks and patients.

TABLE I
SOURCE OF INFECTION OR RISK, AND DIAGNOSIS, OF 269 MARINERS
INCLUDING ONE WEST INDIAN WITH LATENT YAWS

Source	Diagnosis							Total
	Syphilis	Latent Yaws	Lympho-granuloma Venereum	Chancroid	Gonorrhoea	Non-Gonococcal Urethritis	No Venereal Disease	
Local	3				17	13	25	58
Rest of N.E. England ..					6	4	6	16
Elsewhere in G.B. ..					6	9	35	50
Scandinavia					5	4	5	14
Northern Europe ..					7	9	17	33
Southern Europe ..	1				9	5	9	24
East Mediterranean ..							3	3
Central and South America	1	1	4		1	2	21	30
Africa						2	3	5
Asia	2				1	5	22	30
North America				1		2	1	4
Australasia							2	2
Total	7	1	4	1	52	55	149	269

TABLE II
PLACE OF BIRTH AND DIAGNOSIS OF 269 MARINERS INCLUDING ONE WEST INDIAN WITH LATENT YAWS

Place of Birth	Diagnosis							Total
	Syphilis	Latent Yaws	Lympho-granuloma Venereum	Chancroid	Gonorrhoea	Non-gonococcal Urethritis	No Venereal Disease	
Local	2		3	1	9	25	68	108
Rest of N.E. England ..						3	9	12
Elsewhere in G.B. ..					10	9	24	43
Eire					1			1
Scandinavia					1	1	5	7
Northern Europe ..					6		7	13
Southern Europe ..	2		1		15	4	16	38
East Mediterranean ..					2	4	4	10
Central and South America		1			1	1	2	5
Africa					4	5		9
Asia	2				3	3	13	21
Australasia	1							1
Total	7	1	4	1	52	55	149	269

TABLE III
NATIONALITY AND SOURCES OF INFECTION OF SEVEN MARINERS WITH SYPHILIS

Nationality	Source of Infection				Total
	Local (G.B.)	India	Brazil	Greece	
Local (G.B.) ..	1		1		2
Indian		2			2
Greek	1			1	2
New Zealand ..	1				1
Total	3	2	1	1	7

Table VII shows the patterns of behaviour of mariners attending the clinics, comparing for each diagnostic category their origins, whether visitors or locals, and whether their risks were run locally, in their own area (the same thing for local mariners), or elsewhere. For syphilis the numbers are small and there is little difference between the number of risks run in their own areas or elsewhere, for visitors or locals. The commonest sequence of events in gonorrhoea was that of a visitor with a risk elsewhere, secondly a visitor with a local risk, and thirdly a visitor with a risk in his own area.

There were very similar patterns of behaviour for non-gonococcal urethritis and for no venereal disease; the commonest was a visitor or equally a local mariner with a risk elsewhere. All other possibilities were much less common.

Discussion

Venereal disease imported by mariners accounted for 44.5 per cent. of that seen in males at the two clinics during 1963. Excluding those treated before arriving at the clinics, 23 (44.2 per cent.) of the 52 mariners with gonorrhoea acquired their infection abroad. This compares with 50 per cent. in Finnish seamen (Härö and Pätäälä, 1961). The total amount of gonorrhoea imported, 26 (28 per cent.) of 94 cases, is much higher than that reported by Härö, Kiistala, and Salo (1963), who found in Helsinki during 1961 that 9 per cent. of all male gonorrhoea was imported, although in the 15 to 19 age group the incidence rose to 19 per cent. These figures reflect the differences in clinic populations, the two local clinics having a much higher proportion of mariners.

This high rate of imported disease in the seaport clinics is of the greatest significance, because there can be no control, much less eradication, of these diseases within the country while these fresh infections, which maintain the reservoir, continue to be imported. Mariners, both native and foreign, are just as promiscuous in seaports as are the peripatetic immigrants inland so it is imperative to prevent the infections they import from being spread to the local promiscuous women, that first step in the dissemination of the diseases. Immigrants do not bring any notable amount of disease with them, but they do increase the spread of infections already within the country.

TABLE IV
ORIGINS AND SOURCES OF INFECTION OF 52 MARINERS WITH GONORRHOEA

Origin of Mariners	Source of Infection								Total
	Local	Rest of N.E. England	Elsewhere in G.B.	Scandi- navia	Europe		Central and South America	Asia	
					North	South			
Local	4		1		2	1		1	9
Elsewhere in G.B.	5	2	1		1	1			10
Eire					1				1
Scandinavia				1					1
Northern Europe	1		1	1	2		1		6
Southern Europe	4	2	2	1	1	5			15
East Mediterranean		1	1						2
Central and South America ..	1								1
Africa	1	1		1		1			4
Asia	1			1		1			3
Totals	17	6	6	5	7	9	1	1	52

TABLE V
ORIGINS OF 55 MARINERS AND PLACES WHERE THEY RAN RISKS CULMINATING IN NON-GONOCOCCAL URETHRITIS

Origin of Mariners	Place of Risk										Total
	Local	Rest of N.E. England	Elsewhere in G.B.	Scandi- navia	Europe		Central and South America	Africa	Asia	North America	
					North	South					
Local	7		1	2	7	3	2	1	2		25
Rest of N.E. England		1	1						1		3
Elsewhere in G.B. . .	2	1	4		1					1	9
Scandinavia						1					1
Southern Europe . . .	1	1	1							1	4
East Mediterranean . .	1		1	1		1					4
Central and South America	1										1
Africa		1	1	1	1			1			5
Asia	1								2		3
Totals	13	4	9	4	9	5	2	2	5	2	55

Knowledge of the source of infection is very important for several reasons, not the least for the proper medico-social management of the disease. Interrogation with a view to contact tracing should be carried out whenever there is any hope of getting a contagious person, near or far, treated. The greater the distance, and therefore the longer the time, from the risk the more chance there will have been for the mariner to have been treated before attending the clinic, but this information is not often forthcoming unless definite inquiry is made. Depending upon the amount of this treatment suitable arrangements can

be made for adequate serological surveillance locally or elsewhere.

It is important to ascertain the source of risk in the search for latent cases of diseases having a known geographical distribution; as all the mariners acquiring lymphogranuloma venereum did so in South America, since mid-1963 a routine lymphogranuloma venereum complement-fixation test (LGVCFT) has been done in all cases taking risks in that area. So far one unsuspected case has been found, a steward attending with an anterior non-gonococcal urethritis who denied self-treatment with antibiotics. The

TABLE VI
ORIGINS OF 149 MARINERS WITHOUT VD AND PLACES WHERE THEY RAN RISKS OF INFECTION

Origin of Mariners	Place of Risk												Total
	Local	Rest of N.E. England	Else- where in G.B.	Scandi- navia	Europe		East Mediterranean	Central and South America	Africa	Asia	North America	Austra- lasia	
					North	South							
Local ..	12	1	22		8	4		9	2	9		1	68
Rest of N.E. England ..		1	2			1		2	1	2			9
Elsewhere in G.B. ..	4	3	3	1	2		2	2		6		1	24
Eire ..				1									1
Scandinavia						1		2		1	1		5
Northern Europe ..			1	1	4			1					7
Southern Europe ..	2	1	3	1	2	1		4		2			16
East Mediter- ranean ..			2	1			1						4
Central and South America ..	1							1					2
Asia ..	6		2		1	2				2			13
Total ..	25	6	35	5	17	9	3	21	3	22	1	2	149

TABLE VII
RELATIONSHIP BETWEEN ORIGIN WITH REGARD TO THE CLINICS, PLACE OF RISKS, AND THE DIAGNOSIS IN 268 MARINERS EXCLUDING THE ONE WEST INDIAN WITH LATENT YAWS

Patients	Place of Risks	Diagnosis						Total
		Syphilis	Lympho-granuloma Venereum	Chancroid	Gonorrhoea	Non-gonococcal Urethritis	No Venereal Disease	
Visitors	Own Area ..	3			9	8	13	33
Visitors	Locally ..	2			13	6	13	34
Visitors	Elsewhere ..		1		21	16	55	93
Locals	Elsewhere ..	1	3	1	5	18	56	84
Locals	Locally ..	1			4	7	12	24
Totals		7	4	1	52	55	149	268

clinical condition resolved and the CFT titre fell steadily with a course of tetracyclines, being reported negative before discharge.

Apart from searching for undiscovered disease a knowledge of the source of infection can be important in gonorrhoea, as seaport clinics can monitor the sensitivity of strains imported from abroad to the antibiotics in common use, and by fermentation tests confirm that the organism is, in fact, gonorrhoea. This is of great importance when patients claim to have been treated elsewhere.

Nationality or ethnic group is of far less significance. There is no evidence of a colour bar locally—

or in Great Britain as a whole for that matter. The only indication of racial discrimination brought to light by this investigation was that only Europeans were infected with gonorrhoea in Northern Europe.

For the most part the nationality of foreign mariners reflected the work carried out at local shipyards. The large number of mariners from Southern Europe was due to the fact that several Greek ships underwent prolonged overhauls locally. The men not only ran risks in the North-east of England but others, possibly out of boredom, found time to attend for check-ups for risks run elsewhere.

The apparent disparity between the figures in

Table II and those sent to the British Cooperative Clinical Study Group on the nationalities of patients treated during 1963 is due to a difference in geographic areas between the two studies.

The disparity between sources of infection and nationality seen in Tables I and II is underlined in Tables III to VI. Taking the areas as chosen for this investigation, only 57 (21.8 per cent.) of the 268 mariners ran risks in their own areas, and if all Great Britain is considered as one area the figure rises only to 102 (37.1 per cent.). Therefore in over 60 per cent. the nationality of mariners was irrelevant.

Table VII sets out the separate patterns of behaviour associated with different conditions. These patterns are governed in part by the varying periods that the diseases take before symptoms become apparent, and on these to a certain extent depends where the patient seeks treatment, but some mariners wait to seek aid until they are within, or in some cases out of, a particular area.

There were few cases of syphilis, but they were all acquired either in the mariner's own country, or locally. The long interval between risk and symptoms was enough for some to have come from as far away as India, or to have returned to the Tyne from a foreign voyage having been infected in the locality of the clinics.

All the mariners with lymphogranuloma venereum were infected in Brazil, although in the past patients seen in the clinics have been infected in the Caribbean and West Africa. The governing factors were infection in the tropics and development of symptoms in transit to the Tyne.

Those suffering from gonorrhoea presented the generally accepted pattern of behaviour of those with venereal disease. The commonest sequence of events was for a visitor to come for treatment having run a risk elsewhere, and not in his own area; the second commonest was for a visitor to have run a risk in the locality of the clinics. In both these cases the peripatetic person, outside the *mores* of his own people, had lowered his moral standards and exposed himself to infection, but sought treatment when symptoms appeared and before returning to his own area. The third commonest sequence was for a visitor to have been infected in his own area, and here possibly two factors are concerned: the symptoms of gonorrhoea became so marked on the outward trip from his port that he needed treatment quickly, and furthermore he wanted to be cured before he returned home. There were few local mariners, and they were infected as often locally as elsewhere. When the latter was the case their symptoms appeared on the return trip, but they were unable to get treatment on board ship. When the former, they were often standing by a

ship and thought the risk had been "safe". It was rare for an experienced mariner to have been infected in his own port.

In non-gonococcal urethritis and in those with no venereal disease the patterns of behaviour of the patients concerned were similar. By far the commonest was for a mariner, either local or a visitor, to run a risk outside either his own area or the locality of the clinics. The local mariner did not seem ashamed to attend the clinic, but possibly the long interval between the risk and attendance lessened the chance of the stigma of venereal disease in his own eyes. Check-ups were often taken many months after the risk concerned. A certain number of the mariners in this group were treated on board ship for various conditions, often urethritis, and the exact diagnosis will never be known, so the attendance at a venereal diseases clinic was, in effect, for a final test of cure.

The common factor is of risks being run elsewhere, the majority of venereal disease not being acquired in the port where treatment is sought, but being imported. If this importation could be controlled, either by treating mariners before they infected the promiscuous women in the ports, or by treating these women before they infected the local men, then, but not until then, could some control be attained over the reservoir of infection in the country as a whole.

The first line of defence against the importation of venereal disease is by treatment of the mariner on board ship. Possibly 50 per cent. of gonorrhoea in mariners is so treated (Schofield, 1964). It appears fairly effective as far as it goes, but because of the lack of specialist control and supervision it is unsatisfactory. There is need for closer liaison between ships and VD clinics, and for a reliable person, such as a medical technician on those ships not carrying a doctor, who as part of his work would undertake the intermediate management of venereal diseases at sea, as advised by specialists in the ports visited during the voyage. This measure has been advised by the World Health Organization (Resolution WHA 13.52 (1960)).

The second line of defence relies on the vigilance of the Port Health Authorities, the medical officers of the Shipping Federation Ltd., and, to a lesser extent, the general practitioners in the seaports. The closer the co-operation between these agencies and the VD clinic, the greater the number of mariners who will be referred for treatment before the local women can be infected. It is helpful if the health inspectors of the Port Health Authorities can have supplies of cards with the addresses and times of the local clinics to distribute to ships arriving in the port, if clinics are accessible to the docks, and if at least

one in each area is always open for immediate diagnosis and treatment.

The third, but by no means least, line of defence is the goodwill towards the VD clinics in the ports, both of the local promiscuous women and mariners the world over. The goodwill of the former is essential if any local control is to be attained, but it is a slow process, needing much tact and patience on the part of all the clinic staff coming in contact with these women. Gaining the goodwill of the mariners is even slower, as clinics are recommended, or otherwise, by word of mouth, and perhaps half the world away, so that there is a slow build-up of a potential clientele. Notices in the public lavatories giving times and addresses of local clinics, with, if possible, simple directions for getting there, are of value not only for mariners but for other visitors and even townspeople who are often unaware of the address of the VD clinic. These notices, which in ports could well be multilingual, are posted by the local medical officers of health, whose co-operation is essential in this as in all matters of prevention and control of disease.

The relative success or failure to control the importation of venereal disease can be judged by comparing the numbers of landmen, whom we are trying to protect, infected locally with (a) the number of women named as contacts locally and (b) with the numbers of mariners treated. In 1963, 34 landmen were treated for gonorrhoea acquired locally, which compares with 51 women contacts and 52 mariners, a ratio of 2:3 in each case.

One looks forward to effective international tracing of contacts as the medico-social management of venereal disease becomes more widespread and its value acknowledged. In practice it will be difficult at first, even with a suitable proforma, such as that recommended by Burgess (1963), unless the name and address of the contact is known. Possibly certain circumscribed areas could be chosen for preliminary trials—one might well be the North Sea-Baltic area. From this area and Great Britain came 38 cases (73 per cent.) of gonorrhoea in mariners.

In their descriptions of contacts mariners often strike one by their lack of observation, conscious or otherwise, of points which could help in identifying local women. There is often an obvious attempt to flatter, especially with regard to age and also appearance, even when an honest attempt is made—often it is not. Usually alcohol is blamed for the amnesia, an amnesia not borne out by the ability of some to retrace their steps at a later date with identical consequences. Most men do not want to be known as informers in case of reprisal by the woman or others, although more are becoming co-operative

when it is explained to them that it is for the sake of the woman's health alone that we want her to attend for treatment, which will be confidential, and that she will never know from us who named her.

If contact tracing is to be effective on an international basis, then not only should the informants have a guarantee of secrecy for their treatment and information, but it must be clearly understood that the contact named, male or female, will enjoy equal secrecy of treatment wherever it is carried out. For this reason it is important that all such information should be treated as medical confidence, and be passed from clinic to clinic rather than through lay people in municipal authority offices.

Summary and Conclusions

- (1) During 1963, 502 new male patients attended the venereal diseases clinics at South Shields and Tynemouth; 269 (53·6 per cent.) were mariners, of whom 108 (40·1 per cent.) were local men, 12 (4·5 per cent.) came from the rest of North-east England, 43 (16 per cent.) from "elsewhere in Great Britain" (a total of 60·6 per cent. from Great Britain), and 106 (39·4 per cent.) were foreigners.
- (2) Risks of infection run by mariners were 58 (21·6 per cent.) in the locality of the clinics, 16 (5·9 per cent.) in the rest of North-east England, 50 (18·6 per cent.) "elsewhere in Great Britain", and 145 (53·9 per cent.) abroad; these latter accounted for 97 per cent. of the 150 risks run abroad, and 29 per cent. of all male risks.
- (3) The 145 risks abroad accounted for the attendances of three out of six cases of contagious syphilis, the one case of latent yaws, all four cases of lymphogranuloma venereum, the one case of chancroid, 23 (24·5 per cent.) of 94 cases of gonorrhoea, and 29 (27·6 per cent.) of 105 cases of non-gonococcal urethritis, seen among all male patients at the two clinics.
- (4) Differences between the origins of mariners and the sources of their infections are discussed. It is observed that they were unrelated in over 60 per cent. of cases.

It is essential to ascertain the place of risk for use in possible contact tracing, for close questioning to discover whether or not a mariner has already been treated, in the search for latent cases of diseases of a circumscribed geographical distribution (the routine testing by the LGVCFT of patients with risks in South America has already led to the discovery of one unsuspected case), and for monitoring

sensitivities to antibiotics of gonorrhoeal infections acquired abroad.

- (5) Individual patterns of behaviour for patients suffering from different diseases were found, but in part were governed by the time taken for the various diseases to become symptomatic. The few with syphilis were mainly infected in their own country, and sufficient time had elapsed before symptoms and signs developed for them to have arrived at, or returned to, Tyneside. Mariners with gonorrhoea were mainly visitors infected outside their own areas, either locally or elsewhere. This is the pattern of behaviour generally expected in venereal disease, with infection and treatment outside the patient's own area. The patterns of behaviour for those attending with non-gonococcal urethritis or without venereal disease were almost identical; the commonest sequence of events was for a mariner, either visiting or local, to have run a risk outside either his own area or the vicinity of the clinics before attending the clinic. The local mariners had less fear of the stigma of venereal disease from these risks; this was possibly associated with the long intervals between risk and attendance.

- (6) In all, 44.5 per cent. of venereal disease in males was introduced into the locality of the clinics from other areas. The continual importation of venereal diseases through ports ensures the maintenance, in the country as a whole, of the reservoir of infection, contact with which by highly promiscuous, peripatetic immigrant populations causes widespread and sometimes explosive dissemination, so that control or eradication of these diseases will be impossible for this, if for no other, reason.

- (7) There are three lines of defence against the importation of venereal disease:

(a) Treatment on board ship. This is unsatisfactory, and will remain so until adequately trained medical technicians are appointed to all ships, to ensure continuity of treatment and management of venereal disease between visits to specialists in the various ports.

(b) The vigilance of Port Health Authorities and medical officers of the Shipping Federation Ltd. in referring incoming mariners to venereal diseases clinics before they can infect local women.

(c) The goodwill towards the VD clinic of promiscuous women in the locality and mariners the world over. The former is essential

if any local control is to be attained, and the latter is important in ensuring that mariners attend for check-ups of their own accord.

- (8) The aim of this defence is to cut down the infection of landmen by women infected by mariners, and the measure of success or failure can be gauged by comparing the numbers of landmen infected locally with the numbers of women named as contacts and the numbers of mariners. In 1963, in relation to gonorrhoea, there were 34 landmen, 51 women named as contacts, and 52 mariners, a ratio of 2:3 in each case, in the locality of the clinics.
- (9) There is need for a serious attempt at international contact tracing, possibly initially in certain areas, such as the North Sea-Baltic area. 73 per cent. of gonorrhoea in mariners was acquired either in Great Britain or ports in the above area. There are great practical difficulties in tracing contacts, especially unless a name and address is provided. Descriptions tend to flatter even when honestly given, and they are often not so, in an attempt to avoid unpleasant consequences. Not only should informants be guaranteed secrecy but it should be clearly understood that the contact named, male or female, will enjoy equal secrecy of treatment wherever it is carried out. For this reason information should be passed from clinic to clinic at a medical level, rather than through lay people employed by the municipal authorities.

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Maladies vénériennes importées par les marins

RÉSUMÉ

- (1) En 1963, 502 nouveaux patients mâles vinrent se faire soigner aux dispensaires des maladies vénériennes de South Shields et Tynemouth; 269 (53,6%) étaient marins dont 108 (40,1%) des environs. 12 (4,5%) venaient du reste de la partie Nord Est de

l'Angleterre. 43 (16%) d'ailleurs en Grande Bretagne (soit un total de 60,6% d'anglais et 106 (39,4%) d'étrangers.)

- (2) Les risques d'infection courus par les marins étaient 58 (21,6%) localement, 16 (5,9%) dans le reste du Nord Est de l'Angleterre, 50 (18,6%) ailleurs en Angleterre et 145 (53,9%) à l'étranger. Ce dernier chiffre représente 97% des 150 risques courus à l'étranger et 29% du risque total pour les hommes.
- (3) Les 145 risques courus à l'étranger, furent à l'origine des trois cas sur six de syphilis contagieuse, d'un cas de pian latent, des quatre cas de lymphogranulomatoses vénériennes, du cas de chancre mou des 94 cas de gonococcie, et des 29 sur 105 cas d'urétrite non-gonococcique (27,6%) vus parmi les patients mâles aux deux dispensaires mentionnés.

- (4) On compare les lieux d'origine des marins et de leur source d'infection et on constate qu'il n'y a pas de rapport dans 60% des cas.

Il est essentiel de s'assurer du lieu du risque pour l'utiliser dans la recherche du contact, pour découvrir par un interrogatoire serré si oui ou non, un marin a déjà été traité, pour trouver les cas latents de maladie dans une région définie (le test systématique par LGVCFT de personnes courant des risques dans l'Amérique du sud a déjà mené à la découverte d'un cas insoupçonné), pour vérifier la sensibilité aux antibiotiques des infections gonococciques acquises à l'étranger.

- (5) On remarqua une certaine individualité dans les manifestations de ces infections chez différents patients, due en partie au temps qui s'écoula avant que les symptômes n'apparaissent.

Le petit nombre atteints de syphilis furent surtout contaminés dans leur propre pays. Le temps écoulé entre la date de leur infection et de leur arrivée permit aux symptômes de se développer. Les marins atteints de gonococcie furent en grande partie contaminés en dehors de leur ville, soit localement soit ailleurs. C'est ce qu'on attend en cas de maladie vénérienne. Infection et traitement en dehors de la localité du patient sont généralement la règle. Ce fut également vrai dans le cas des urétrites non-gonococciques ou non-vénériennes. La suite la plus courante des événements fut celle-ci; les marins étrangers on du pays avaient couru un risque en dehors de leur localité ou du voisinage des dispensaires avant de venir se faire examiner; les marins du coin avaient moins peur des suites des maladies vénériennes. Ce qui explique vraisemblablement le long intervalle entre le risque de contamination et l'assistance au dispensaire.

- (6) En tout 44,5% des maladies vénériennes, chez les mâles, provenaient d'autres régions et furent introduites dans les environs des dispensaires. L'importation continuelle des maladies vénérienne par les ports, assure le maintien dans le total du

pays d'un réservoir d'infection, du au contact avec des émigrants ambulants d'une grande promiscuité, et cause une diffusion et quelques fois une dissémination explosive de la maladie, si bien que pour ces raisons, si non pour d'autres, le contrôle ou élimination de l'infection est impossible.

- (7) Il y a trois lignes de défense contre l'importation des maladies vénériennes.

(a) Traitement à bord. Ceci n'est pas satisfaisant et ne le sera pas, tant qu'un personnel qualifié ne sera pas attaché à tous les bateaux pour assurer la continuité du traitement des maladies vénériennes entre les visites aux spécialistes des différents ports.

(b) La vigilance des services de santé des ports et des médecins de la "Shipping Federation Ltd." en referant les marins qui débarquent aux dispensaires de maladies vénériennes, avant qu'ils puissent contaminer les femmes du pays.

(c) La bonne volonté envers les dispensaires de maladies vénériennes des femmes prostituées de la localité, et des marins du monde entier. La 1^{ère} est essentielle si on veut arriver à un contrôle local et la dernière est importante pour s'assurer que les marins viennent aux visites médicales de leur plein gré.

- (8) Le but de cette défense est de réduire le pourcentage d'infection des hommes sédentaires, par les femmes que les marins ont contaminées, et on peut mesurer le succès ou l'échec de la lutte anti vénérienne en comparant le chiffre des hommes sédentaires contaminés localement avec le chiffre des femmes désignées comme contact, et le chiffre des marins à l'origine de l'infection. En 1963, en ce qui concerne la gonococcie il y eut 36 sédentaires contaminés, 51 femmes contacts, et 51 marins contaminés, soit une proportion de 2/3 tous dans la région des dispensaires.

- (9) Un sérieux effort est nécessaire pour retracer les contacts internationaux, si possible tout d'abord dans certaines régions telles que la côte nord de la Baltique.

73% des cas de gonococcie chez les marins furent acquis en Angleterre ou dans des ports de la région mentionnée ci dessus. Il est difficile de retrouver les contacts à moins, que leur nom et adresse ne soient données les descriptions même faites avec des intentions honnêtes, tendent à exagérer on souvent à atténuer les faits en vue d'éviter des conséquences déplaisantes. Non seulement les informateurs devraient avoir la garantie de secret, mais il devrait être clairement compris que le contact homme ou femme jouira également du secret, quelque soit l'endroit ou le traitement est fait. Pour cette raison les renseignements devraient être passés d'un dispensaire à l'autre sur le plan médical plutôt que par l'intermédiaire de gens non médecins, employés par les autorités municipales.