# Correspondence

## *Pruritic secondary syphilis*

TO THE EDITOR, *British Journal of Venereal Diseases*

SIR—Generations of medical students have learned to respect syphilis as the 'great imitator,' capable of affecting all structures of the human body and mimicking a large number of disorders which comprise the disciplines of medicine and surgery. In spite of this recognition of the protean manner in which syphilis can present, several modern medical texts describe the cutaneous eruption of secondary syphilis as nonpruritic (Lomholt, 1972; Sutton and Waisman, 1975; Drusin, 1972; Allen, 1967; Pillsbury, Shelly and Kligman, 1956; USDHEW/PHS, 1968). Certain authors even advise that the absence of pruritis separates secondary syphilis from similar papulosquamous disorders which do itch (Olansky and Norins, 1971).

Recently, we diagnosed and treated three black patients with secondary syphilis who presented with intensely pruritic papular skin lesions (Cole, Amon, and Russell, in press). In all patients, a careful but unproductive search for lice and scabetic mites was made. Other pruritic dermatoses were excluded by historical data and appropriate laboratory tests. 2·4 m.u. benzathine penicillin were administered intramuscularly to all patients with subsequent resolution of their pruritic skin lesions and a fall in previously elevated VDRL titres.

Sporadic references to pruritic papular (lichenoid and follicular) syphilids can be found in the medical literature (Lochner and Pomeranz, 1974; Stokes, Beerman, and Ingraham, 1944; Conant, 1974; King and Nicol, 1975). In those references, as in our cases, the majority of patients had pigmented skin.

The purpose of this communication is to warn practitioners that secondary syphilis can present as a pruritic dermatosis. This appears to be especially true in patients from darkly-pigmented races with papular syphilids.

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## *Venereology or genito-urinary medicine*

TO THE EDITOR, *British Journal of Venereal Diseases*

SIR—An editorial in the *British Medical Journal*[1] advocated changing the name of venereology to genito-urinary medicine. Discussion and correspondence since show that there are two clearly opposed views on this matter.

Even the most distinguished expert may be wrong. The late Joseph Earle Moore of Johns Hopkins Hospital, the most eminent syphilologist of his era, was wrong when he proposed that venereologists in the United Kingdom, and syphilologists in the United States of America, should turn their attention to chronic diseases because of the 'conquest' of venereal disease by antibiotics.[2] He advocated that venereology should form a minor part of a wider clinical interest. This was a generally held view in the United States so that teaching of the subject in medical schools there virtually ceased, and the developing specialty of venereology disintegrated. Since then there has been an escalation of venereal disease in the United States, so that serious attempts are being made there to revive and develop venereology. Distinguished experts were wrong there. We think that they are wrong here, in advocating the change of name from venereology, for the following reasons:

(1) Genito-urinary (or genital[3]) medicine is not a precise term; it does not define the work of venereology. The venereologist is concerned with the whole person exposed to disease, not just the genitalia or genito-urinary tract. Moreover, there are many conditions of the genitalia and urinary tract that are outside the scope of venereology.

(2) In this country, the specialty dealing with sexually-transmitted diseases has gained a clear identity of its own under the name of venereology. We think that this identity might be lost under any name that is not clearly definitive. Such a loss would, in the long run,

be harmful to the patients that the clinic should be serving. More patients are already attending clinics than ever before, which indicates a wide and increasing acceptance of venereology by the public. As a result, sexually-transmitted diseases are probably better controlled here (the home of venereology) than in any other industrial country.

(3) A new name will not eradicate shame linked to sexually-transmitted disease. Inevitably, there is shame attached by some to the act of extramarital intercourse; displacement of shame from the act to the disease, and to the attendance at the clinic treating the disease, will still occur. Venereology deals with a sensitive area of human behaviour, and this will continue to be the case whatever the name. Allowance for the emotive effect of the term "VD" is already made in that clinics do not operate under that name, but are known under such terms as the Whitechapel Clinic, Lydia Department, James Pringle House, or Praed Street Clinic. The London Hospital runs an additional Diagnostic Clinic in the general Outpatients Department for the benefit of patients suspected of having venereal infection but to whom it is particularly inadvisable to communicate this suspicion. This Diagnostic Clinic deals with less than 3 per cent. of all patients seen by the venereological staff of the hospital, and would still be necessary whatever name the Whitechapel Clinic operated under. If the name Genital[3] Clinic were to come into general use, we suspect that the Diagnostic Clinic would be even more necessary than now.

(4) While the pattern of disease seen in clinics has changed, it is still sexually-transmitted infection that is the reason for existence of the specialty. Clinics for venereal disease were founded to deal with the then known diseases, namely gonorrhoea, syphilis, and chancroid. If we add all the other diseases, now known to be sexually transmitted, these together constitute 74 per cent. of the disease dealt with by venereology clinics in England in 1973. Of the remaining patients, with candidiasis or other conditions requiring treatment, many also will have presented for the exclusion of venereal disease. The specialty has already adapted to its increase in scope. Thus, the new Diploma in Venereology of the Society of Apothecaries of London, the Medical Society for the Study of Venereal Diseases, and the *British Journal of Venereal Diseases*, are each concerned with all sexually-transmitted disease and their differential diagnosis, as is the specialty itself.

(5) The venereologist today is hard-pressed to deal with the increasing incidence of the sexually-transmitted diseases. It is doubtful that he would be able to continue to manage these as effectively as he does now if he also had to deal with urinary infections, renal disease, infertility, and other conditions that might be brought in by the non-definitive terms genito-urinary and genital medicine; his primary aim must continue to be the control of sexually-transmitted disease.

(6) In our experience, standards of patient-care in venereology fall when the specialty is practised by physicians and surgeons whose main interests lie in other fields. Venereologists must be primarily interested in the sexually-transmitted diseases. If a change of name leads to a loss of this primary motivation, standards in venereology will fall.

(7) The suggestion that more and better staff might be recruited to genito-urinary or genital[3] medicine, than to venereology, is surely outdated. In discussions with medical students at The London and the Royal Free Hospitals, an overwhelmingly majority have stated that such a change would be unnecessary, and probably detrimental, as it would be against the trend of increasing frankness of this era. Genito-urinary and genital medicine are euphemisms; moreover, unlike terms such as refuse disposal operative, they do not have the virtue of accurate description.

(8) Most clinics need new premises, not a new name for their old unsuitable quarters.

(9) People now know something about venereal disease and where to go for advice about it; this should not be abandoned lightly.

So some venereologists think that the possible benefits that might accrue from a change of name have not been proven to do so, and that such a change might damage the specialty. The truth could be that either term might serve provided that the specialty is not weakened by dissension and loss of identity. As the result of pressure by a minority[1] of venereologists, the Department of Health and the Royal College of Physicians of London have 'abandoned' the name venereology, so presenting the MSSVD with a *fait accompli*. We think that this action was certainly precipitate and probably both unnecessary and unwise. In contrast, the Joint Committee on Higher Medical Training decided to use the terms genito-urinary medicine, sexually-transmitted disease, and venereology together, so that in due course the matter could be reviewed in the light of experience. This would seem a wise move that should be followed by those advocating change to a name that has not yet earned general acceptance.

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