Lesson of the Week

Cecil Alergant
with an introduction
by Dr B A Evans

Introduction

Cecil Alergant's contributions to the specialty were both unique and extensive. He founded a great tradition in 1967 by inaugurating the first university course which culminated in an examination for a Diploma in Venereology awarded by the University of Liverpool. This remains the only Diploma in the specialty awarded by a university in the United Kingdom.

Cecil's loyalty and service to the Medical Society for the Study of Venereal Diseases were legion, culminating in the Office of Treasurer for eight years and then President from 1975 to 1977. The unfailing presence of Cecil and Joan at Spring meetings, where they provided friendship and support to younger colleagues, is a loss which is deeply felt. Despite crippling angina, Cecil delivered a most memorable contribution to the Cambridge Spring meeting in July 1988, within a month of his death. We are grateful to colleagues in Liverpool who obtained the manuscript, which recalls the unmistakable style of a respected and much loved man.

Lesson of the Week

Ladies and Gentlemen.

On the last occasion I was privileged to address this society, when we met in Brighton some two years ago, I described the case of a patient that I had seen in 1979, shortly before I retired.

Today, I would like to tell you about a patient that I had under my care at a very early stage in my career, way back in 1947. However, in order for you to fully appreciate the circumstances surrounding this particular case, I must risk boring you for a few minutes with some auto-biographical details.

I was demobilised from the R.A.M.C. early in 1947, having spent some three years as a specialist venereologist, in charge of units first in France and subsequently in India. Although I had no job to go back to, I was not particularly concerned, as there was a government undertaking that suitable employment would be provided for all doctors on demobilisation, and that additional posts would be created where necessary.

Brimming with self confidence, I sought an interview with the appropriate authority—the Dean of my old medical school, who had the responsibility of administering the scheme in the Liverpool area. If I had expected to be welcomed with open arms, and

offered a consultant post, I was to be disappointed. My attention was drawn, somewhat unkindly, I thought, to my lack of any higher qualification—and after a couple of telephone calls, I was offered a six months non-resident appointment at a local hospital, with trainee status, and trainee pay, which I had no alternative but to accept. My instructions were to report to a ward known as the Male Clinical Department—M.C.D. for short, to ask for the charge nurse who would be expecting me. Now this of course was pre National Health Service, and, although it loomed large on the horizon, there was still nearly 18 months to go before the brave new world we had all been promised would come into being.

The hospital where I was to work was not one of the prestigious teaching hospitals that I had known as a student, and which were financed by voluntary contributions. This was a so called municipal hospital, run by the local authority, and which like so many other similar hospitals up and down the country, had been a workhouse run by a Board of Guardians until 1929. This unattractive Victorian building housed some 1200 beds, mainly geriatric, but there were 400 beds devoted to dermatology, and a very busy dermatological out-patient department, but no other out-patient facilities.

There was no resident medical staff. A nearby general practitioner had a part time appointment as medical superintendent. A number of consultants were attached to the hospital on a part time basis, and would make either regular visits, not necessarily every day, or were prepared to visit if required. The ward to which I had been assigned had 48 beds devoted to the care of patients suffering from venereal disease, and there was seldom an empty bed. In a nearby building, there was a ward of similar size for female patients. The charge nurse was a quietly spoken man, some 10 years older than myself, and with considerable experience in the care of V.D. patients. I was to learn a great deal from him, and we eventually became firm friends. A remarkable man in many ways; HF was later to spend two years in Ethiopia, as a member of the WHO yaws eradication project, and he had the unique distinction of being the first male ever to be elected to the hitherto all female General Nursing Council.

The patients, I was to learn, were the responsibility of the Consultant Dermatologist, but the actual patient care was undertaken by his assistant. I was soon to meet them both. The senior man had a rather forbidding appearance, and a somewhat imperious manner. He left you in no doubt as to who was in charge. I referred to him—in his absence, needless to say—as “The Great White Chief”. On his infrequent visits to the ward, I would literally be told to leave the room, as “he had certain matters to discuss with the charge nurse”. I never discovered the topic of their conversations, and I deemed it wiser not to enquire.

His assistant, only a few years older than myself, was a quietly spoken individual, friendly from the outset. Until my arrival, he had been in the habit of visiting the ward each morning to do a ward round, write up the new cases, and bring the old ones up to date. However, after a week or so, he realised that I was quite capable of taking over his duties, and he was only too happy to leave me in charge, as he had a very heavy work load in the Dermatology Department and, I judged, a very hard task master.

I found the work interesting, but not unduly demanding, and it left me ample time both for study and a certain amount of moonlighting. After I had been running the ward uneventfully, and as I judged successfully, for a couple of months, I received an unexpected visit from the Great White Chief. He instructed me, in his usual imperious manner, to find a bed immediately for an eight year old boy, who duly arrived the next day.

The history was as follows. Some six weeks previously he had started to complain of some abdominal discomfort. When this persisted, he was seen by the family G.P. who discovered that the boy's liver was enlarged. He was referred to a childrens' hospital, where he was seen by a paediatrician; tests were performed, but no immediate diagnosis was reached. A week or two later, the mother noticed what appeared to be a crop of warts in the peri-anal area. Once more the boy was seen by the family doctor who arranged for a private consultation with a dermatologist—The Great White Chief—who immediately recognised the nature of the boys complaint, and advised urgent admission to hospital.

He proved to be a bright little lad, complaining only of some slight abdominal discomfort, and not apparently particularly bothered about his peri-anal warts. Clinical examination revealed a well looking boy. The abdomen was slightly distended, and a somewhat tender liver edge could be readily felt, an inch or so below the right costal margin. Examination of the peri-anal area revealed the presence of unmistakable condylomata lata. There were no other clinical signs of muco-cutaneous syphilis—no skin rash, no mouth or throat lesions, no adenopathy and no evidence of any primary lesion. Dark ground examination of serum obtained from the peri-anal lesions, was positive for *Treponema pallidum* and S.T.S. were strongly positive.

Now let me make it clear—lest I have left anyone in doubt—that we were confronted with a case of *acquired* secondary syphilis, and not one of congenital syphilis, where muco-cutaneous lesions are virtually confined to the first few months of life.

Treatment did not provide us with any problems. Our main concern was to discover the source and mode of infection.

The boy himself was unable to provide us with any information. There were clearly two possibilities to

be considered: firstly that the infection had been acquired *innocently*, perhaps as a result of sharing the same bed with another member of the same household, such as a sexually active elder brother, or more ominously; that he was the victim of sexual abuse. The first seemed unlikely; the boy was an only child, and he had a room of his own. The other members of the household were his mother, father, and one set of grandparents. One of these, we reasoned, would be the most likely source of our patient's infection and, discovering this source, we came to regard as some sort of personal challenge. Unfortunately I had no out-patient clinic to which they might be referred, and I was reluctant to seek outside help.

I discussed these difficulties at some length with my charge nurse, who came up with what I thought to be the perfect solution. The family, he said, would certainly be coming to see the boy during visiting hours, and although visiting was restricted to an hour in the evening, long after I would have left for home, he himself would still be on duty, and would interview the visitors, and take blood for S.T.S. Within a matter of days both parents and grandparents had visited, had specimens of blood taken, and to my disappointment, all four were sero-negative.

At this stage I decided it was time to question the boy again. He expressed disappointment that he had not had a visit from his uncle, whom he described as "his favourite relative". Moreover, during the course of the conversation he told me that at one time his uncle had been in prison. I must confess to being excited at this new piece of information, and I could hardly be blamed if thoughts of child molesting as the reason for his imprisonment, passed through my mind.

I passed on the information to my charge nurse, impressing on him the importance of arranging for the uncle to visit his nephew, and persuading him to allow us to take a blood sample. A day or two later our prime suspect duly arrived. He readily agreed to provide a blood specimen, which, much to our disappointment, also proved to be sero-negative. In fact, to cut a long story short, we never discovered the source of the boys' infection. Meanwhile his condition improved rapidly, and having completed his treatment, he was discharged to out-patient surveillance.

Now I have often told this story to my students, and asked them what more I could, or should have done; what error of commission or omission I might have made, but have seldom had an answer. However, if they did not know, I am sure that this is not the case with such a sophisticated audience as yourselves. Because this—alas—was not the end of the story. About two months later I received an unexpected visit from the Great White Chief's assistant. Although friendly, there was something about his manner which made me wary. He asked me

if I remembered the young boy with secondary syphilis. He then went on to ask me if I did not think I had taken too much responsibility on myself, and that with hindsight it might have been better if I had shared that responsibility with a more senior colleague. Privately I thought that my handling of the case had been impeccable, and that no amount of consultation would have improved upon it. Whatever my thoughts, I was not prepared for what was to follow.

Yesterday, he went on, I received a telephone call from the Medical Superintendent at Fazakerley, which, I should explain, was a hospital for infectious diseases. I was asked, he continued, to see a 60 year old woman who had been admitted the previous day with diphtheria. The Medical Superintendent suspected that this might not be a case of diphtheria, and I was able to confirm that it was, in fact, a case of secondary syphilis. An understandable mistake, I thought magnaminously. I realised, however, that he had not finished. This 60 year old, he continued, was your patient's grandmother.

In my pre-occupation to discover the source of the infection, I had completely overlooked the question of secondary contacts; and yet, with hindsight, it is easy to imagine how readily a caring relative, nursing

a sick and perhaps fretful child, who might well have had highly contagious mucocutaneous lesions for several weeks prior to admission to hospital, might become infected. I cannot supply you with any details as I was denied any further contact with the case.

In conclusion, ladies and gentlemen, a brief word about the *Dramatis Personae*. The Great White Chief, whose bark was very much worse than his bite, was Dr Frederic Glyn-Hughes. Fred Hughes left school at the age of 14 to work as a lab. boy. He so impressed his chief, Professor Glyn, that he paid for him to go through medical school. In gratitude, he took on his name, and became Dr Glyn Hughes. Although no great academic, he was a fine dermatologist whose opinion was much sought after. He died some years ago. His young assistant, who cut me down to size all those years ago, and happily still with us, is Dr Cyril McGibbon who too became a distinguished and successful dermatologist. One of his sons is a consultant dermatologist at one of the London teaching hospitals. Some of you may know him.

That is all that I have to say, ladies and gentlemen; thank you for listening.