SYPHILIS AT A VENEREAL CLINIC:
AN ANALYSIS OF CASES ADMITTED DURING TWELVE MONTHS.
BY E. F. SKINNER, M.A., M.B.CAMB., M.R.C.P. LOND.,
ROYAL HOSPITAL, SHEFFIELD.

THE following notes are set forth merely as an analysis of cases that have been admitted to the clinic during the period August 31st, 1918, to August 31st, 1919. During this period of twelve months the methods of the clinic and the routine work have been uniform, and though the number of cases is small, some interesting features have developed, and may be of use in comparison with similar details from other clinics. 354 new cases of syphilis have been admitted during the 12 months, 229 males and 125 females; the ages of these patients have been analysed, and the admissions at various age-periods tabulated as follows:—

Age-period.	M.	F.	Age-period.	M.	F.
Under 1 year ...	3	7	Between—		
Between—			40 yrs. and 45 yrs.	17	7
1 yr. and 10 yrs..	5	5	45 „ „ 50 „ ...	14	6
10 yrs „ 20 „ ...	16	23	50 „ „ 60 „ ...	5	3
20 „ „ 25 „ ...	54	28	At 66 yrs. ...	1	1
25 „ „ 30 „ ...	56	21	Not stated.	3	3
30 „ „ 35 „ ...	32	16	—	229	125
35 „ „ 40 „ ...	23	5			

It must be observed that these figures are not ages of incidence of disease, but ages at which patients have sought admission to hospital, and it is noticeable that nearly twice (1·8) as many males are admitted as females, whilst a glance at the table will show that during the early years (1–10) and the later years the sex incidence of admission is practically the same; thus the real difference in the male and female admission-rate occurs between the ages of 20 and 50, and during this period more than twice as many males as females are seen.

There are doubtless many reasons for this, but it seems likely that the knowledge of the existence of clinics and the dangers of venereal disease as set out in propaganda literature and public notices generally is not reaching the female population to the same extent as the male; consequently steps should be taken at once to approach women more directly, either through existing organisations or by other special means.

This inference drawn from the table of age admissions of the two sexes is borne out by experience in the clinic, for whereas many men state that they have come up because they have seen the various public notices it is only very rarely that women say this; further, whereas many men seek advice before any sign of disease has appeared or has had time to appear, women do not come up until symptoms have developed, and these usually in the secondary stage. This point will be referred to again under the examination of the Wassermann-reaction results. One important conclusion apparently can be drawn from the 12 months' work: namely, that the female population is not yet aware of the dangers of syphilis and of the existence and facilities of venereal clinics to anything like the same extent as the males, and that active measures to remedy this are urgently needed.

Absentees.

In every out-patient department of a general hospital there are always a certain number of

patients who come once or twice and then disappear, and a venereal department suffers in this respect perhaps more than others, for two reasons: firstly, the venereal patient is apt to be a casual person, and not one given to much thought; and, secondly, because the régime is not such a comfortable one as that of an ordinary medical out-patient department. Considering these two points, it is surprising how relatively few patients do become absentees.

Out of 354 patients admitted with syphilis during the 12 months only 58, or about 16 per cent., have failed to complete the full course, and of these only 24 failed to complete the first three injections. These figures seem fairly satisfactory, but it would be interesting to know the experience of other clinics where a full routine is employed. The sexes are represented in these figures, thus:—

	M.	F.
Failed to complete first three injections ...	16	8
Failed to complete full course ...	25	7

If a patient fails to report at the clinic at his proper date his number is noted on a black list, and at the end of two months, if the absence still continues, a printed letter is sent to him informing him that his non-attendance has been noted, and that he is advised to come again for further advice. Such a letter, in a large number of the absentee cases, either brings the patient up again or produces a letter explaining the absence, which in the case of the men is generally that they have left the district in search of employment. This is a point of some importance, and as a practical inference it might be urged that in the notices issued by the L.G.B. as to clinics great stress should be laid on the necessity of continuity of treatment. If patients are compelled to leave a district the transfer form should be completed, and advice asked as to where they are to report themselves in the new district. These transfer forms are not sufficiently used.

I have laid stress on this, as it has seemed at times that discontinuity of treatment is worse than no treatment—that is to say, that symptoms of recrudescence after an incomplete course of salvarsan are occasionally more intense than the same symptoms would have been at the same period in an untreated case; this, however, is merely a clinical impression and cannot be supported by observed data.

Marital and Congenital Cases.

The next point of interest was the number of marital cases, and in this series of 354 the number was 42, or nearly 12 per cent. Of these, 14 wives infected their husbands and 28 husbands infected their wives—that is, twice as many males were unfaithful as females. This is not the place to discuss ethical questions, but though this figure is admittedly large, if the abnormal mental and physical strain of the past three years is taken into account it is not large enough to warrant some of the gloomy statements that have been made lately on the platform and in the press.

During the 12 months, 29 cases, or about 8 per cent., of congenital syphilis have been admitted and treated, 10 males and 19 females, and these may be divided into two groups, the infantile congenital syphilis and the "lues tarda." The first group includes the snuffles, dermatoses, anæmias, &c., while the latter group comprises keratitis, otitis, &c., and these two groups are represented as follows: Infantile group, 14 admissions; "lues tarda," 15 admissions.

Most of the first group came up from the maternity and child-welfare centre, whilst the second class of case generally comes from the special departments of the hospital. These cases have all been treated by means of intravenous or intramuscular injections of neo-salvarsan, and the results in the babies have been very satisfactory; the keratitis cases have not shown the same improvement, though here I have seen sufficient benefit, particularly in the younger cases, to warrant a much more sanguine prognosis than is usually given. The cases of otitis have not reacted so well and, from those I have personally treated, my conclusion would be that once the eighth nerve becomes involved the deafness is steadily progressive, a fact possibly due to the enclosed course of this nerve.

It would be of great benefit if at every maternity and child welfare centre there were facilities for doubtfully syphilitic babies, possibly the subjects of syphilis, to be seen at the centre by a venereal medical officer, who could at once transfer them to the clinic if treatment were considered necessary. Dr. H. Scurfield, the medical officer of health of Sheffield, has kindly granted me facilities for seeing any such doubtful cases, and I have found this privilege extremely valuable, as congenital syphilis is not always an easy thing to diagnose. To miss cases at present is almost a national disaster, not only on account of the individual child, but from the fact that the mother is very often unaware of any taint in herself. It may be mentioned here that pregnant women are carefully watched, and the full course of salvarsan given up to the middle of the seventh month (one case has been carried on up to the beginning of the ninth) without any ill results to the mother, and as early as possible after the baby is born the mother brings it up for inspection. Two fine babies have been born during the 12 months of mothers who have had complete courses, and though the time since their birth is very short (one is 10 months old) they are still both apparently healthy infants.

Incidence of Clinical Types.

Primary cases.—For the purposes of this analysis a case has been called primary when the presence of a sore is noted without any other signs of the disease except inguinal adenitis, and the number of cases falling into this category during the 12 months is 47, or 13 per cent., and of these only 5 were females. Primary cases (47): males, 42; females, 5.

A striking fact about these cases is that of the 42 men 31, or roughly 74 per cent., gave a negative Wassermann reaction when first seen, whilst of the women not one had a negative blood; in other words, the women present themselves later than the men, even though a few do come up during the early stage of the disease. This emphasises the conclusion drawn from the age-table previously given.

	Males.	Females.
Primary cases with negative Wassermann	31	0
" " " positive	11	5

Secondary Cases.

Unfortunately, this type of case still furnishes the largest number of admissions, and there is obviously a great deal of work necessary before the general public is sufficiently alive to the advantages of early treatment and the dangers of quack methods. A large number of men who come up during the secondary stage confess to having sought advice from such unauthorised sources, and many more attempt to carry out home treatment of their own devising.

The number of secondary cases has been 238, or 64 per cent. of the total admissions, made up as follows: males 147, females 91.

Tertiary cases.—Forty cases of tertiary syphilis have been admitted, 30 males and 10 females. This figure is purposely kept small, as it seems clear that venereal clinics are not primarily intended for such cases, but a certain number have been put on the register for the sake of watching the effect of salvarsan on such conditions as aortitis and locomotor ataxia. Other cases of tertiary syphilis are given anti-syphilitic treatment, but are not put on the venereal department register as it seems unfair to saddle the department with the added financial burden of this type of case.

Wassermann Reaction.

During the routine course of treatment the blood is examined on three occasions, before the first injection, after the fourth, and also after the seventh, and on the results of these examinations, together with clinical evidence, the further conduct of the case depends. Each case must be judged on its own merits, and no hard-and-fast rules can be laid down, nor do I wish here to go into the details of how such decisions are arrived at, as this paper is intended merely as a summary of the work done at the clinic, and only one or two conclusions based on the year's work are mentioned. The facts elicited do not present any new features, but their recital may be useful.

Primary cases.—Of the primary cases, 47 in all, 31, all men, were admitted with negative W.R., and in none of these has the reaction subsequently become positive. Sixteen of these have completed their course; the remaining 15 are still under treatment. Of the 16 completed cases, 5 have had one Wassermann test after two months' observation, during which time treatment is limited to daily inunction with mercury, and two cases have passed their second period of observation (5 and 9 months respectively after admission), all with completely negative Wassermann reactions.

Of the 16 primary cases admitted with positive reactions, 13 have completed the course, and of these the Wassermann was negative in 11 on the second test (by which time—45 days after admission—1·3 g. of salvarsan have been given with 4 gr. of mercury) and has remained negative. Of the other 2 cases, one became negative after the fifth injection, and the other gave a doubtful negative after the last injection of the routine course. This last case is interesting, as there was an intermission of three months after the third injection. This behaviour of the Wassermann reaction leads to the view that only in the earliest stage, with a negative W.R.—that is, before it has become positive—can treatment be depended on to keep the W.R. permanently negative; once the W.R. has become positive, though it may be reduced to negative by active treatment, sooner or later it again becomes positive with or without symptoms. This is well seen in the secondary cases, who, of course, all give a strongly positive W.R. at the commencement of treatment.

Secondary cases.—Fifty-five have been picked out of the total number of secondary cases as these have all completed at least a full course and have had all the necessary tests recorded. Of these, all starting with strongly positive (+++) bloods, 34 have given negative W.R. (−) at the end of the course, 4 have given a doubtful negative (±), 15 have remained positive (+) all through. These reactions I have grouped as A, B, C.

Amongst the routine questions put to each patient is one to elicit, if possible, the time of infection and date of onset of symptoms, and these two dates have been worked out for the cases falling into the above three groups, and the period of time elapsing between infection and commencement of treatment is shown in the following table.

Group.	A.	B.	C.
Average number of days since infection	70	92	89
Average number of days from onset of symptoms to starting treatment ...	36	66.5	65
W.R. at completion of treatment ...	—	±	+

From these figures it seems quite clear that in those groups B and C, where the W.R. did not become negative, the time intervals are considerably longer than in group A. One would have expected group C to show the longest time intervals, but in this series such is not the case, and it is possible that the difference between ± and + in these cases is really small. It is interesting to note that the average age of these groups becomes progressively higher, thus: average age, group A, 26.2; B, 28.7; C, 30.8. It is possible that this may eventually be found to have some bearing on the blood reaction and account for the readings in group C; at present, however, the figures are accepted as they stand.

The interval "onset of symptoms to commencement of treatment" is a much more accurately-determined one than "date of infection to commencement of treatment," since the average out-patient dates all events from the various feasts, Easter, Whit-Sunday, and so forth, and the exact date of any particular exposure to infection is generally rather hazy in consequence. In groups B and C this interval is nearly twice that in group A, and seems to render the blood more stable positively (+) and a negative W.R. more difficult to produce.

The cases in Group A all gave a negative W.R. after 81 days' treatment, but of the 34 in this group only 15 have been under observation sufficiently long to note the result of the further test, that is, two months after cessation of active treatment; of these, 7 have remained negative, whilst 8 have become positive again. These groups could be further split up into various classes according to the reactions to the test, but the numbers dealt with are too small to warrant such minutiae, and only the broad facts shown in the three groupings above are of any value.

Two examples of groups B and C, which may be called the "retarded" groups, may be given as typical records of the way the W.R. behaves under treatment.

Example.

	1	2
First day of treatment. W.R. ...	+++	+++
Complete course.		
Last day of treatment. W.R. ...	+	+++
Follow-on course.		
End of F.O.C.* course, W.R. ...	—	—
Two months' observation.		
End of this period. W.R. ...	+	±
Second F.O.C.		
End of this course. W.R. ...	—	—

* Follow-on course (F.O.C. = 0.3, 0.4, 0.6 grms. "606" at fortnightly intervals; 1 gr. Hg intramuscularly weekly).

All these records emphasise the fact that where a long interval has occurred between the onset of symptoms (or date of infection) and commencement of treatment—that is, where a positive W.R. has been long established—the latter can only temporarily be made negative. This opens up the difficult question of whether in late syphilis a positive W.R. reaction should necessitate active antisyphilitic treatment in every case, the answer to which question must be left open for the present. It is extremely difficult to determine the point at which active treatment must cease, and no general rule can as yet be formulated, but one frequently sees patients who have no sign or symptom of disease and who are clinically perfectly fit yet whose W.R. has returned to positive after two months' cessation of treatment. On the strength of such positivity a second full or modified F.O.C. course is given, producing a negative W.R., which, again, often becomes positive after a second period of "no treatment." Should such a patient receive a further course at this stage? Each case must be judged on its own merits, but it seems to me that too much stress can be placed on the W.R. in these cases, and the possibility of a permanent cure with a + W.R. must be kept in mind. It will be some years yet before this question can be definitely answered, and the best one can do at present

is to keep the patients as far as possible under observation and on the appearance of any symptoms, however mild, to urge further active treatment.

Summary.

1. Primary cases are still in a grave minority of admissions.

2. Women do not seek advice in the primary stage, and steps should be taken to disseminate knowledge of the dangers of venereal disease and the advantages of the clinics amongst the female population.

3. Continuity of treatment is essential for cure, and discontinuity a possible danger.

4. Only where treatment is commenced before the W.R. has become positive can a cure be definitely promised.

A NOTE ON THE LATER HISTORY OF FOUR CASES OF TOTAL LARYNGECTOMY.

BY SIR CHARTERS SYMONDS, K.B.E., C.B.,

CONSULTING SURGEON TO GUY'S HOSPITAL.

THERE are some operations for the removal of malignant disease of the tongue, pharynx, and larynx which leave such a condition of misery that they had better not have been performed. And moreover, if recurrence takes place, the suffering is far greater than if the disease had been left to run its course. This view was at one time taken of complete laryngectomy, against which it was further urged that, unable to speak, reduced, in fact, to dumbness, such a person could neither be useful nor find any joy in life. Experience has happily revised these views, and has shown that a man without his vocal apparatus can not only communicate with his fellows, but conduct a business involving a fair amount of conversation.

The object of the following note is to exhibit, as far as can be done on paper, the condition of four people, three men and one woman, who have lived in comfort and happiness, and done useful work for 8, 12, 15½, and 22 years respectively. One—the woman—has died of old age, and it will be seen that hers was the most extensive of all the operations. The importance, in view of possible recurrence of estimating before operating the possibility of complete removal cannot be overestimated, especially where the pharynx is concerned. A primary pharyngeal cancer extending to the larynx cannot, in my experience, be removed with any prospect of eradication, and the after-condition is one of such misery as to render all such undertakings unwise and even unjustifiable. Particularly is this the case when a fixed and deep-seated mass of glands complicates the condition.

Record of Cases.

These records have a value also in showing the immunity that can be obtained even when the disease is extensive. These people can be understood of those around them by simple lip-movements and the vibration of such an amount of air as can be taken into the mouth and pharynx, while with the tube presently to be described the patient can be heard in a large room.

CASE 1.—Mrs. G. When seen in 1897 was wearing a tracheal tube and had complete laryngeal obstruction. The growth could be seen fungating upwards through the larynx, and there was also some external fullness. The entire larynx, together with a wide area of the pharynx, both lobes of the thyroid gland, with underlying lymphatics, were removed. On account of the wide removal of the pharynx there was some