THE RETURN OF THE VENEREAL DISEASES*

BY

F. J. G. JEFFERISS, M.R.C.S., L.R.C.P.

Consultant Venereologist, St. Mary's Hospital, London

This paper, which puts forward my opinions on the recent increase in the venereal diseases, can be divided into three parts: first, a brief description of the present position and how it has developed over the last few years; second, the reasons why this "return" has taken place; and, third, consideration of the possible solutions to the problem.

Present Position

It is not necessary to dwell for long on the present position as it has been described at length in the medical (Nicol, 1961) and lay press. Up to 1938 venereal diseases were steadily on the decrease; during the war and up to 1946 they increased greatly, as is always the case during such times; and then, when the armed Forces returned home, there was a rapid falling off until the years 1951-4, when many venereologists seriously thought of leaving the specialty, which seemed to be dying. However, in 1955, coincident with the increase of immigration, the figures began to rise again until the numbers of new cases attending the clinics have now passed the 1939 figures and show signs of reaching those of 1946. There is probably an even greater increase than these figures show because, owing to the apparent but deceptive ease of modern treatment, more patients thought to be suffering from venereal disease are being treated by private practitioners and are therefore left out of the national statistics gathered from the clinics. The rise in numbers continues. Gonorrhoea is by far the most prevalent venereal disease, but even early syphilis, which had become a rare condition, is now becoming quite common again.

The statistical information used in this paper comes from three sources: firstly, from the Ministry of Health returns from the clinics of England and Wales; secondly, from the British Co-operative Clinical Group, which is an offshoot of the Medical Society for the Study of Venereal Diseases; and, thirdly, from the special clinic at St. Mary's Hospital, which has nearly twice as many fresh cases of venereal disease as any other clinic, and in fact treats approximately one-tenth of the venereal disease in England and Wales.

The reason for the St. Mary's Hospital clinic being so large appears to be that the surrounding Paddington-Bayswater-North Kensington region is one of the greatest lodging-house and "bed-sitter" areas in London, where unattached males and females live in vast numbers. Recently the West Indians have settled in this part of London, too, living in even greater density than the Irish who used to live here and still do so to some extent.

Fig. 1 shows the variation in the gonorrhoea figures taken from the returns to the Ministry of Health from the clinics in England and Wales (Ministry of Health, 1960). To the 1940-5 figures must be added the large number of cases in the armed Forces. Fig. 2 shows the total number of new cases of all kinds attending the St. Mary's Hospital clinic during the years 1946-61.

Fig. 3 shows the fall and rise in the number of cases of early syphilis attending this clinic since 1945.

FIG. 1.—Incidence of gonorrhoea, England and Wales, 1939-60. The 1960 figure was obtained by the addition of four quarterly returns.

FIG. 2.—Total number of new cases attending St. Mary's Hospital special clinic each year, from 1946 to 1961.

FIG. 3.—Number of new cases of early syphilis attending St. Mary's Hospital special clinic each year from 1945 to 1961.

Causes of Increase in Venereal Diseases

The causes for this recent rise in venereal diseases are three.

Immigration

By far the greatest is immigration. In 1960 70% of the 3,134 new male gonorrhoea patients at St. Mary's were born outside the United Kingdom. That figure was made up of 40% West Indians; 10% other coloured men; and 20% of European stock, including the Irish, white Commonwealth, and U.S. citizens (Fig. 4). It must be emphasized that the immigrants responsible for the spread of venereal disease are by no means all coloured.

The immigrants live under bad and crowded housing conditions, and are mostly young. It is common

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knowledge that the venereal disease rate is always high among young strangers in a strange land—for example, the British Forces abroad in wartime. They do not bring the diseases with them, but by their promiscuity, unbridled by home ties and taboos, they catch it from and spread it around among a certain small group of promiscuous local women, who also have indiscriminate

although some do not refuse a present from a richer or older consort.

The reservoirs of infectious venereal disease appear to be the asymptomatic promiscuous female of low intelligence and the infected passive homosexual, whose symptoms are also often non-existent or very slight.

Promiscuity Among the Young

The third cause is the much-discussed increase of promiscuity among our young people (King and Wisdom, 1960). I personally do not feel that they are very much more promiscuous now than they have always been, only more open about it, but as they have been blamed for part of the increase in venereal disease, we must consider their case and produce some figures to illustrate it.

The British Co-operative Clinical Group (1962), collecting information from 161 clinics in England and Wales in 1960, studied the age-groups of 21,663 male cases of gonorrhoea and found that 6.4% (1,385) were in the age-group 15–19 years. Similar studies in 1957 and 1958 had shown the percentage to be 5.5 (828 cases) and 6.1 (1,058 cases) respectively. The rise from 5.5% to 6.4% in three years has been commented on very seriously, and when it is expressed as an increase of 67.3% it sounds very bad indeed. But if one inquires into the matter further one finds that most of these youngsters are in the 18–19 age-group, and in this clinic 63% of the teenage males in 1960 were born outside the United Kingdom. Therefore, if the situation in the rest of the country is anything like that at St. Mary's—and it appears that it is in Manchester to some extent (Watt, 1961)—it seems that much of this 0.9% rise of gonorrhoea in male teenagers is accounted for by the ever-increasing number of young immigrants and not by our own boys. The British Co-operative Clinical Group (1960) found that there were very few infected males of any race under 17 years old (180 in 1958) attending clinics in this country, and certainly very few are seen at St. Mary's Hospital.

As for schoolchildren, the B.C.C.G. (1960) in 1958 found that there were throughout the country 9 boys and 51 girls under the age of 15 and 180 boys and 306 girls over 15 and under 18 infected with venereal disease out of 22,857 cases. From the recent lurid newspaper articles one might think that there were thousands of infected children needing treatment in specially arranged adolescent diagnostic centres. In 1961, of the patients under 16 years old in this clinic, there were only one boy of 15 with gonorrhoea and four girls of 15 with non-specific vaginal discharges, virgo intacta. It would therefore seem that there is no problem of venereal disease among schoolchildren in this part of the country, but I believe there have been outbreaks on a small scale in the North.

As for older girls, it seems fairly general experience in clinics throughout the country that about a quarter of the females suffering from gonorrhoea are aged 16 to 19 and that the vast majority of these girls are U.K.-born. Nearly all are over 17 years old. In 1960 at St. Mary's Hospital 166 U.K.-born girls under 20 with gonorrhoea were seen: none were under 17, 16 were aged 17, 64 were aged 18, and 86 were 19. On questioning these girls, one often finds that their consorts are immigrants. In the same year at St. Mary's Hospital there were only 77 U.K.-born out of 208 male teenagers with gonorrhoea, whereas there were 166 girls in the same category.

FIG. 4.—Racial distribution of 3,134 male patients with gonorrhoea attending St. Mary's Hospital special clinic during 1960.

sexual relations with men of other races too. It is well known that there are some immigrants who are vicious as well as promiscuous and live on the immoral earnings of low-grade prostitutes. Most of the men who attend this clinic with repeated infections are immigrants. As to the female immigrants, for some time there have been as patients here a small number of European girls, Germans, Italians, etc., who have come to London as domestic servants. Until very recently there have not been many West Indian women with gonorrhoea in the clinic, but now they also are beginning to appear.

Homosexuality

The next most important cause of the increase of venereal disease, anyway in London, appears to be the large number of highly promiscuous infected male homosexuals (Jefferiss, 1956; Nicol, 1960), who are mainly of European stock. Of course, there would be no difficulty in getting the exact figure for the number of men with ano-rectal gonorrhoea or syphilis, the origin of which is obvious, but it is not so easy to find the exact number of cases of homosexually-acquired penile disease, as that may follow heterosexual or homosexual relations, and naturally many men are unwilling to admit to the latter.

However, 70% of the male patients with early syphilis attending this clinic in the last year admitted to homosexual contact, and therefore are largely responsible for the recent marked rise in the incidence of that disease in males, in contrast to the very small rise in female cases (Fig. 3). It is remarkable that though the number of coloured immigrant heterosexuals infected with gonorrhoea is large, only a few are infected with syphilis. We see few homosexual prostitutes, most of the patients being of the shop assistant, clerk, waiter, or "artistic trades" type who enjoy their sex life in this way,

That is a proportion of approximately one boy to two girls. This preponderance of girls over boys is quite the reverse to the usual proportion of patients of all ages in clinics of four males to one female, and would seem to indicate that the majority of the girls are infected either by older men of all races or by young immigrants, their histories supporting the latter alternative.

It is my opinion that the greater part of the increase of venereal disease among young people is due to their association with immigrants of all colours and to the general increase of venereal disease caused by the latter, making promiscuous youth more liable to infection.

Drug-resistance

There is one other factor which has been mentioned as a possible reason for the increase of venereal disease in this country, and that is the resistance of the diseases to drugs. For all practical purposes this is a fallacy. In my experience early syphilis responds completely to the proper dosage of penicillin in all cases and gonorrhoea does so in at least 95% of patients.

Some strains of gonococci have been shown to be partially resistant to penicillin *in vitro*. However, in any of the very few clinical failures that I have seen, and where cultures have been taken, gonococci have been grown which *in vitro* are completely penicillin-sensitive, their lack of response probably being due to the penicillin not reaching the organism for some reason unknown. They have nearly all responded in the end to very large doses of penicillin given over several days.

There is evidence that certain gonococci have become resistant to streptomycin, but the drug has little place in the treatment of gonorrhoea, since experience has shown that the fear of masking syphilis with small doses of penicillin is unjustified, the syphilis either being cured by the dose of penicillin given or appearing in due course with the usual signs.

Methods of Control

There are several ways in which this increase of venereal disease can be checked and reduced. First, and most important, is the limitation of immigration from all countries, especially of unskilled workers and those who have no job to come to, and the repatriation of all people who have been convicted of a sexual crime. Immigrants should be properly housed and accommodation arranged for them before they come here.

Secondly, by educating the public in the dangers of promiscuous intercourse and of venereal disease, particularly in regard to sterility and chronic ill-health from gonorrhoea among women and the disastrous late effects of syphilis. Both women and passive homosexuals often continue to spread the diseases, not knowing that they are infected, and do not come for treatment until it is too late, the women having developed salpingitis and they and the males eventually developing late syphilis. The public should also know that disease is just as easily caught during homosexual as during heterosexual intercourse. Young people should be warned against sexual contact with strange immigrants. Mixed associations, in my experience, between different races are not often successful, the moral values and sexual mores of the races being seldom the same.

Thirdly, patients should if possible be sent for diagnosis and treatment to specialists in the subject,

because the average practitioner is not equipped for making a microscopical or cultural diagnosis, or for tracing the contacts, who must also be treated. The treatment of the often asymptomatic female contact is very important if the reservoir of venereal infection is to be attacked. The exact diagnosis is necessary for legal reasons, especially where a married person is concerned, as it may be asked for in the divorce court later; and the psychological value of a definite diagnosis is important in the management of the patient. Venereal diseases are sometimes unsuspected in certain gynaecological clinics, and the help of the venereologist can be valuable there.

Lastly, and by no means the least important, it should be part of the duty of every medical school to see that its students are properly taught how to recognize the presence of venereal disease and how best to deal with it. Unfortunately, that is not the case in all teaching hospitals.

If all these methods of controlling venereal disease were pursued we should go a long way to stamping it out.

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LANGWITH LODGE

A DIABETIC CONVALESCENT HOME FOR MEN AND WOMEN

BY

J. C. PEASE, D.M., M.R.C.P.

Consultant Physician to the Mansfield Hospitals,
Mansfield, Notts

The idea of having a convalescent home prepared to accept diabetic patients was first put forward in an article appearing in the *Diabetic Journal* of January, 1935. Later in that year five beds were taken over by the Diabetic Association at St. Mary's Convalescent Home at Birchington, in Kent, for the use of diabetic patients. At the end of the second world war more beds were made available at St. Mary's Home, and children in addition to women were accepted (Goodband, 1959). Since 1948 St. Mary's Home has been the responsibility of the National Health Service and at present has accommodation for 50 female patients over the age of 15. Diabetic children between the ages of 3 and 12½, however, are now looked after at the Metropolitan Convalescent Home in Broadstairs.

In 1946 20 male diabetic patients were accepted at the British Red Cross Society's Convalescent Home at Burley-on-the-Hill. This unit was looked after by Dr. Joan Walker from 1946 to 1955, when Burley ceased to be a convalescent home and once again became a private residence. During the nine years that diabetic patients were able to go to Burley, 1,442 men and 199