Summary

Forty-three cases of failure to establish lactation were studied, and Lugol's solution was given to alternate cases. This did not appear to affect the milk yield.

Stilboestrol did not seem to affect lactation adversely.

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Medical Memoranda

Gonorrhoea: A Plea for Diagnosis before Treatment

Even to the most impartial of medical men the plaint of genital discharge by a patient is apt at once to suggest gonorrhoea. That such a high index of suspicion should obtain is in its way commendable, but not quite so praiseworthy is the procedure sometimes adopted. These comments have been prompted by the tendency to administer sulphonamides and even penicillin to cases of urethritis and the like without first attempting to ascertain the cause of the discharge. The assumption that genital discharge is more or less synonymous with venereal disease is not confined to the uninformed and uncharitable layman. Too often the clinician, led astray by a history of coitus followed by genital discharge, takes for granted that the case is one of gonorrhoea. The next false step, prompted no doubt by a desire to cure the patient as quickly as possible, is to prescribe immediately what amounts to specific treatment without first obtaining bacteriological confirmation. Gonorrhoea is by no means the only cause of irritation of the lower genito-urinary tract.

But there are other aspects to be kept in mind—such as the effects of a wrong diagnosis on the state of mind of the individual and on the health of the community. Furthermore, gonorrhoea is capable of causing social repercussions, and it may lead doctor and patient alike into the witness-box. A categorical diagnosis of gonorrhoea, even if correct, is to most patients unwelcome; but a presumptive one, based merely on clinical impression to the neglect of modern diagnostic procedures, is quite unjustifiable, and amounts to professional negligence. A non-committal answer to the patient's question—a reply that the condition "may be gonorrhoea" and that it is "safest to treat as if it were"—may lead to gonophobia and may entail endless trouble before the unfortunate victim is rid of what are perhaps unnecessary fears.

INDISCRIMINATE DRUG TREATMENT

The epidemiological control of infectious genital diseases is becoming an important aspect of modern medicine, but proof or at least sufficiently reliable evidence of an infection in the individual is necessary before measures may be taken to trace and deal with the source of infection. The rapidity with which a few tablets of a sulphonamide or one injection of penicillin may efface all proof of gonorrhoea stultifies any belated attempts to establish a correct diagnosis on bacteriological grounds. Thus a source of infection continues to spread disease still further afield. The hasty and indiscriminate treatment of genital discharge with these drugs shows a complete lack of appreciation of the doctor's duty not only to the patient but to the community. Time and again the venereologist is requested to deal with a patient supposed to have gonorrhoea, only to find the task of arriving at a diagnosis impossible because of previous administration of one or other specific remedy.

The only proof of gonorrhoea is the demonstration of the gonococcus, and treatment should not be started until reasonably adequate measures have been taken to identify the organism. In these days of the rapid control of gonorrhoea with penicillin, when patients, particularly males, tend to seek advice early in their disease, the delay of a day or so while awaiting a laboratory report on a sample of pus is of little significance. In an acute urethritis, in males especially, treatment may be given almost immediately, provided a specimen of discharge is procured first; if the lesion is gonococcal it is almost certain that gonococci will be found. Greater caution is necessary in the case of females, or in any patient in whom the development of gonorrhoea is likely to be followed by important social or medico-legal repercussions, but there can never be any excuse for what virtually amounts to treatment without diagnosis.

The following instances are quoted as illustrative of these remarks.

AN ILLUSTRATIVE CASE

A married man was referred to hospital because of urethritis. The history revealed the following succession of events. Ten days previously he had extramarital coitus and four days later he had intercourse with his wife. Two days thereafter he developed an acute purulent urethritis, for which he consulted his doctor, who, without taking any steps to substantiate bacteriologically the diagnosis of "probable gonorrhoea," had prescribed sulphathiazole; and some 20 g. had been taken before the patient visited the clinic.

It was obvious that the situation was likely to prove difficult in several of the aspects which together determine the spread and control of infection. Clinically, it seemed likely that the condition had been gonococcal; but the sulphathiazole had done its work, and, though there was some residual discharge, it was impossible to prove gonorrhoea. The diagnosis was therefore in doubt. There were also two other problems—that of dealing with a possibly infected wife, and the examination of the other woman, who might still be spreading gonorrhoea. These two difficulties were temporarily shelved by the patient's refusal, because of negative findings, either to have his wife examined or to divulge the identity of the probable source of his infection. Six weeks later his wife developed a gonococcal salpingitis. He then disclosed the identity of his extramarital partner. Reference to the clinic register showed her to be a patient undergoing treatment for proved gonorrhoea who, subsequent to infecting the patient, had done the same to another man, who had brought her to the clinic for examination.

The sequence of incidents and the dates of their occurrence showed that, had a bacteriological examination been carried out in the married man in the first instance, it was highly probable that the development of salpingitis in his wife would have been averted, and that the infection of the other male would also have been prevented, particularly as the woman in question had been persuaded without any difficulty to come forward for examination.

OTHER EXAMPLES

A married man arrived at the clinic distraught over the suggestion of his having acquired gonorrhoea. Accidental contagion is extremely rare in adults, and the only probable source of infection was his wife. The supposition of gonorrhoea seemed justified; he had a very acute purulent urethritis, but a smear and a culture showed it to be staphylococcal. His wife was interviewed, and gave a history of a chronic infection of one of her Bartholinian glands. Examination corroborated this, and pus obtained from the gland gave a pure growth of staphylococci. Both were successfully treated, but their mental relief meant far more to them than the cure of their symptoms.

The need for caution is shown in another case, also considered gonococcal. The condition was somewhat unusual—a chronic inflammation of the lower surface of the glans and the fraenum, with a meatitis and a mild mucoid discharge. Though seldom seen in a clinic for venereal diseases, the condition was fortunately recognized as diabetic.

In the presence of a genital discharge, gonorrhoea must certainly be proved or excluded. Two errors are to be avoided: (1) clinical evaluation on naked-eye appearance alone, and (2) to begin treatment without previous adequate bacteriological examination. The plea for care in arriving at a diagnosis of gonorrhoea is put forward in the interests of the patient, the doctor, and the community.

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