2. *Age at Onset of Disease.*—There was no association, as is illustrated by the following table:

Age at Onset	No. of Cases	Mean Binet I.Q.
Less than 4 years	30	104.1
4-7 years	32	103.8
8-14 years	36	103.9
Total	98	103.9

3. *Interval between Onset of Disease and Performance of Test.*—Once again there was no association.

Interval between Onset of Disease and Test	No. of Cases	Mean Binet I.Q.
0-11 months	21	104.5
1-4 years	38	103.7
5-15 years	39	103.8
Total	98	103.9

Thus there is no evidence either of a depression of intelligence which passes off or of a depression which is produced by the after-effects during the years of childhood.

4. *Occurrence of Clinically Recognizable Cerebral Symptoms at Onset of Disease.*—Group 1: None; 60 children. Group 2: Minor symptoms; 22 children. Group 3: Pronounced symptoms; 16 children.

Group	No. of Cases	Mean Binet I.Q.
1	60	103.4
2	22	105.4
3	16	103.8
Total	98	103.9

The occurrence of cerebral symptoms is therefore of no subsequent significance in regard to the level of general intelligence.

Conclusion

This study shows that an attack of poliomyelitis does not, either at the time or subsequently, depress the level of general intelligence as estimated upon the Stanford-Binet scale. The anxious parent may therefore be reassured so far as basal intelligence is concerned, but two other points must be kept in mind by the physician. In the first place the child affected by poliomyelitis may be absent from school for long periods; unless provision is made by home tuition or, as is done in orthopaedic hospitals, by the provision of special educational facilities, his educational achievement may be very much behind that of his contemporaries, even though his basal intelligence is not affected. Secondly, the child crippled by poliomyelitis may, unless care is taken, develop emotional reactions to his environment which may result in serious personality maladjustments; these may determine definite educational backwardness simulating true mental retardation.

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THE PREVENTION OF DEFAULTING FROM V.D. TREATMENT CENTRES

BY

C. HAMILTON WILKIE, M.B., Ch.B., B.Sc.

Director of Venereal Diseases Services, Leicester Royal Infirmary

With the recent advent of the new chemotherapeutic methods of treating gonorrhoea there is likely to be a considerable increase of "defaulters" from the venereal disease treatment centre. Defaulters are patients who cease to attend before all the necessary treatment has been given or before the complete tests of cure have been performed. In addition, many will not seek medical aid. They will depend on a limited amount of self-administered chemotherapeutic treatment. Consequently, these patients receive no thorough tests of cure. Should this tendency be allowed to develop an increase of venereal disease is possible. Methods of dealing with the question are discussed below and an analysis of male defaulters at the Leicester V.D. centre follows.

Public V.D. Lectures

The education of the public on the dangers of venereal disease is now an important part of the V.D. scheme in Leicester. It may be of value to record some of the results. Two periods of six years are compared—1926 to 1931, and 1932 to 1937 inclusive. During the first period practically no propaganda was conducted.

At first some people opposed the idea of public lectures on such a subject. Indeed, the term "venereal diseases" was avoided in the public notices which advertised the lectures in 1932. The bills displayed on trams and buses, in factories, in public lavatories, and in the police headquarters and St. John Ambulance headquarters were headed "Lectures on Social Hygiene." In 1933, however, it was considered that even the term "venereal diseases" could appear in public notices. The popularity of the lectures was apparent from the beginning, the lecture halls being crowded. Each lecture, with lantern slide demonstration and discussion, lasted about two hours. I preferred my own set of lantern slides to an obviously acted film. The discussion which followed always proved valuable. Questions had to be stopped after some sixty minutes, otherwise they would have gone on for most of the night. Those asked were surprisingly intelligent, as the following examples show.

Can a person get venereal disease from a lavatory seat? Can one get venereal disease from domestic animals? Does a woman necessarily know when she has venereal disease? Can a man get venereal disease from having sexual intercourse with a woman when her period is on? Does circumcision prevent venereal disease? What is the speaker's opinion on masturbation? Is it always certain that a man will contract venereal disease should he have connexion with a woman who is known to have it (no preventives being used)? What is the speaker's opinion on prostitution? Why do we not educate the public more than we do on the dangers of venereal disease? Why not instruct the civilian population on preventive measures? Should young people contemplating marriage have tests for venereal disease? Is there any danger of contracting venereal disease from blood transfusions? Can venereal disease of the testicle follow a kick on that part? What is meant by "whites"?

After one of the earlier public lectures I was accused of making it appear that venereal disease could be cured too easily. It was argued that I was encouraging promiscuity. My accusers, however, represented only a few of the extremely narrow-minded. Those accusations were made a few years ago and are now forgotten. I wonder what effect the newer chemotherapeutic methods of treatment will have on promiscuous sexual intercourse. Already the "new tablets" have been claimed to be antiveneal, contraceptive, aphrodisiac, and abortifacient (!).

In public lectures on venereal diseases special reference must be made to the non-venereal patient. Attendance at

a V.D. centre does not necessarily indicate venereal disease. Every effort should be made to remove the stigma associated with attendance at a V.D. department. The designation "special department" would be better than "venereal disease department." Some centres do use the better term. The importance of the infected patient attending until the completion of treatment and tests of cure must also be stressed. Quite often patients, perhaps defaulters, attend these lectures. It sometimes happens that a few advanced syphilitic patients are present. A ray of hope and encouragement can be of value to them.

Communication with the V.D. Defaulter

Compulsory notification and treatment of venereal disease is not in force in England at the present time. Some authorities believe that a modified form of compulsion should exist, others believe in strict secrecy and free treatment centres. Under the present arrangements confidence between patient and venereologist must be rigidly kept. We do, however, ask the patient if he has any objection to our writing him should he default. Invariably no objection is given. Of course it is explained that any letter sent will be non-committal in character, not revealing the nature of the complaint or the department attended. Some patients return on receiving such a letter. In other instances the letter is ignored or is returned marked "Not found." A few centres now employ a trained social service worker or almoner to follow up defaulters. I believe that an almoner specially trained for this type of work may be useful for women and children. At the present time I am against the practice of employing an almoner for male cases. The specially trained almoner, usually a lady, no matter how tactful, may inadvertently be responsible for other members of the household getting to know that the son or husband is attending the V.D. centre. The average male patient would not feel that secrecy was in force if a social worker attempted to call on him.

Co-operation between V.D. Officer and General Practitioner

Confidential medical reports between the V.D. officer and the patient's own doctor do not in any way constitute a breach of confidence. It is the practice at this centre to give a written report to the doctor who sends the patient to the V.D. department, and also a final report when cured. Approximately 20 per cent. are referred to us from their own doctor. The general practitioner can often give valuable assistance in persuading contacts or possible congenital patients to attend.

As a result of the chemotherapeutic treatment of gonorrhoea, co-operation between the general practitioner and the venereologist will in future be more important than ever. There is a tendency to give insufficient dosage of the sulphonamide derivatives in acute urethritis and not to follow treatment with the necessary tests of cure. Some cases fail to respond to the newer methods and require additional treatment. The irrigating outfit will still play its part. The complete tests of cure, including urethroscopic examination, sounds, routine blood tests, and prostatic smears, are as essential as ever. Indeed, as a result of late relapses appearing I believe that the observation period should be extended. Some of the spectacular "cures" met with are not so wonderful as at first imagined.

Graph 1.—Yearly percentages of male gonorrhoeal cases on the records who defaulted before completion of treatment. A serious type of defaulter.

Average 1926-31, 9.2 per cent.; 1932-7, 7.3 per cent.; for 1938, 7.7 per cent. Increase anticipated for 1939.

Graph 2.—Yearly percentages of male gonorrhoeal cases on the records who defaulted after treatment but before tests of cure were completed.

Average 1926-31, 16.6 per cent.; 1932-7, 9.7 per cent.; for 1938, 12.1 per cent. Increase anticipated for 1939.

Graph 3.—Yearly percentages of male syphilitic cases on the records who ceased to attend before completion of one course of injections. A serious type of defaulter, especially if originally primary or secondary syphilis.

Average 1926-31, 7.4 per cent.; 1932-7, 3.4 per cent.; for 1938, 1.6 per cent. No increase anticipated for 1939.

Graph 4.—Yearly percentages of male syphilitic cases on the records who ceased to attend after completion of treatment, but before final tests of cure (blood W.R. and Kahn tests; C.S.F. examination, and clinical overhaul).

Average 1926-31, 10.4 per cent.; 1932-7, 4.9 per cent.; for 1938, 4.1 per cent. No increase anticipated for 1939.

Graph 5.—Yearly percentages of male syphilitic cases on the records who defaulted before completion of treatment.

Average 1926-31, 16.8 per cent.; 1932-7, 9.6 per cent.; for 1938, 4.3 per cent. No increase anticipated for 1939.

Graph 6.—Analysis of male syphilitic cases who defaulted before completion of treatment.

S 1 = primary syphilis. S 2 = secondary syphilis. L S = all later stages. C S = congenital syphilis. * = all stages (not classified).

Detailed Analysis of Male Defaulters

The six graphs are self-explanatory. They show how the male defaulters at Leicester V.D. centre have varied in the two periods considered in this article. During the first (1926-31) no public lectures were given, while in the second (1932-7) extensive propaganda work and other methods of reducing defaulters were carried out. The defaulters for the year 1938 are also given.

Conclusions

I have no doubt that public lectures on venereal diseases are of value. Certainly we have a few undesirable syphilophobic and gonophobic patients appearing at the clinic after attending a lecture, but this disadvantage is outweighed by the return of defaulters and the attendance of the early infected case.

The graphs given above show that we in Leicester have had a considerable fall in the percentage of defaulters. Two types of gonorrhoeal defaulters dropped from an average of 9.2 to 7.3 per cent., and from 16.6 to 9.7 per cent. respectively. Three types of syphilitic defaulters dropped from an average of 7.4 to 3.4 per cent., from 10.4 to 4.9 per cent., and from 16.8 to 9.6 per cent. This decrease is to some extent due to public lectures.

The confidential letter to defaulters is also responsible for a number returning to the clinic.

Close co-operation between general practitioner and the V.D. specialist is most important, especially in view of the tendency to default at an early date after treatment with the sulphonamide derivatives.

Summary

Methods of reducing defaulters from V.D. treatment and of encouraging patients to attend the treatment centre are considered from the point of view of public lectures, communication with the defaulter, and co-operation between the V.D. officer and the general practitioner.

The results of the adoption of these measures at Leicester are given.

A detailed analysis of male defaulters at the Leicester V.D. centre follows.

Clinical Memoranda

Acute Duodenal Obstruction in a Boy of 8 due to Volvulus of "Volvulus Neonatorum" Type

The following case seems interesting and rare enough to warrant publication.

CASE REPORT

A boy aged 8 was admitted to hospital as a case of suspected appendicitis on February 3, with the following history. On January 8 his doctor was called because he was suffering from abdominal pain and had vomited several times. When seen his pain was not severe, but his parents said he had been in agony during the night. They suggested the pain was due to the fact that he had been to a children's party two days before and had eaten a quantity of nuts. There was no abdominal tenderness, and the boy soon felt better. On January 25 he again vomited twice, but made no complaint of pain. On January 28 he had violent abdominal pains in the night and vomited many times, the vomit being at first yellow and later green. He recovered, but had another attack on January 31. On February 2 his doctor was again called as the boy had pain in the night. When seen he was not distressed and his pulse and temperature were normal, as they had been in the previous attacks. On February 3 his

pulse rate rose to 110, he was tender over the appendix area, and he was sent into hospital.

When I first saw him in hospital he was lying comfortably in bed without any pain. His abdomen was somewhat distended, but there was no tenderness, the temperature was 99.2°, and the pulse 104. There was no tenderness on rectal examination. Two hours later the clinical picture was entirely different; the child was in extreme agony, crawling over the bed on all fours, screaming with pain, and rubbing his umbilical region. It was quite impossible to examine him; he was vomiting large quantities of dark green fluid. Although I could not make a definite diagnosis, his symptoms were so urgent that I decided to operate at once.

Under general anaesthesia the abdomen was opened through a paramedian incision. The whole of the small intestine below the duodenum was found to be completely collapsed and empty. The appendix was 8 inches long, but otherwise normal. There was a Meckel's diverticulum 4 inches long and the thickness of a little finger. This was causing no trouble but was removed. The stomach and duodenum were hugely dilated as far as the crossing of the superior mesenteric vessels over the third part of the duodenum. The caecum and the hepatic and splenic flexures of the colon were unduly low in position and provided with a mesentery. The rotation of the gut, however, had been normal to the extent of the caecum being on the right side, although proper fixation had not occurred. Two or three coils of small intestine were encircling the caecum and ascending colon, and gentle traction on the proximal coil tightened these coils like a knot round the large gut. At this stage the patient became extremely cyanosed because vomiting occluded the air-way. The head of the table was tilted down about 30 degrees, a stomach tube was passed, and two pints of green fluid removed, the patient's condition improving immediately. It was now possible to unravel the knots in the intestine, chiefly by rotating the caecum in a clockwise direction. Normal saline was then poured into the peritoneal cavity and the abdomen closed. On the next day there was a certain amount of abdominal colic, which was relieved by eumydrine tablets. The bowels had not been opened for some days, so an enema was given; these had to be repeated at intervals for a month.

A rather stormy convalescence included chest infection, probably from aspirated stomach contents during the anaesthesia. This was treated by sulphapyridine, but the boy's tolerance to this drug was very poor; it soon caused vomiting, and had to be stopped. However, he gradually and steadily improved and was about to be discharged when, together with several other patients in the ward, he developed scarlet fever. This was his final setback, and he was last seen walking about the town looking happy and well.

There have been no abdominal symptoms since the operation was performed some months ago, and I hope, perhaps fondly, that there was enough peritoneal reaction at the site of the volvulus to cause fixation of the ascending colon and so prevent recurrence of the condition. A barium meal and x-ray investigation subsequent to the operation showed no abnormality except the low position of the hepatic and splenic flexures of the colon.

The interesting aspects of the case are: (1) The "volvulus neonatorum" syndrome occurring at the age of 8. (2) The complete collapse of the whole of the small gut, including that taking part in the volvulus. This collapse was due to the obstruction of the third part of the duodenum by the twisting and traction of the "duodeno-colic isthmus." (3) The occurrence of several acute attacks with symptomatic recovery between them. (4) The agonizing pain caused by the condition, which was commented on by all who saw the boy during an attack, yet half an hour later there would be very little abnormality to observe.

HERBERT PEARSE, M.D., M.R.C.S.,
Honorary Assistant Surgeon, Taunton and
Somerset Hospital.