TRACHOMA IN LONDON: THE END OF A CHAPTER

BY

ARNOLD SORSBY, M.D., F.R.C.S.

On May 10, 1944, the last five remaining children in the trachoma block at White Oak (L.C.C.) Hospital were discharged and the block closed down. It would be obviously fallacious to assume that trachoma no longer exists in London, but the conclusion is warranted that the affection no longer presents a problem of epidemic proportions among school-children of the metropolis—a state of affairs that prevailed within living memory.

Elsewhere (Sorsby, 1935) an account has been given of how trachoma came to be introduced during the first half of the last century among children under the care of the Poor Law authorities. The workhouses, the private contractors' schools of the type of Dotheboys Hall, the barrack schools of the multiple and conflicting Poor Law authorities of London, and the rudimentary medical and hygienic services provided by these authorities all tended to make trachoma—and other infections—endemic in Poor Law institutions. The need for effective isolation and treatment had been pressed upon the authorities by numberless ophthalmologists and physicians; it was unanimously held by oculists that the then existing state of affairs was "an arrangement for favouring the production and spread of the disease, and then keeping it in check by unceasing, laborious, and expensive medical treatment"; and the medical officer of one of these Poor Law schools bluntly testified that "hundreds of eyes admitted healthy have been attacked, here, and it is useless, and would be cowardly, to attempt to deny or conceal it." In 1872 Bridges spoke of the Anerley Poor Law School as "a great ophthalmic infirmary"; Nettleship, in 1875, found that only 20% of 8,798 children at Poor Law schools examined by him had eyes free from infection; and in 1890 Sydney Stephenson was hoping for a time "when 'ophthalmia at Hanwell' will not form a standing and attractive headline for the evening papers."

That trachoma could be stamped out by effective segregation and treatment was not merely a matter of informed opinion; it had been proved by a short-lived experiment carried out for Anerley by Nettleship and his wife at a temporary isolation school in 1872, and by Stephenson in 1889 for Hanwell in an iron-built structure which the authorities of that school had been compelled to erect against their will. But the "bane of the Poor Law school" continued with it till the end. It was not until a departmental committee of the Local Government Board reported adversely in 1897 on the whole spirit and structure of the Poor Law schools that action became possible. The recommendation of this committee that there be established one or more ophthalmic and other hospital schools under the control of a central authority for the metropolis made it possible for the Metropolitan Asylums Board to proceed with the building of the necessary hospital schools. Two such institutions, with a total bed capacity of 720, were opened at White Oak Hospital on March 20, 1903, and High Wood Hospital on July 26, 1904. Three schools had been planned in 1897, but so effective were the measures adopted at Hanwell, which had served in the meantime as a central isolation school, that doubt arose whether one school would not be adequate. The temporary isolation school at Hanwell, erected in 1889, rather than the opening of White Oak Hospital, may therefore be regarded as the beginning of the solution of the trachoma problem among Poor Law children in London. The subsequent history is one of continuous decline in the incidence of trachoma as judged by the annual admissions. By 1918 High Wood had become superfluous, and was closed down as an ophthalmic school, and White Oak itself was half empty.

In 1921 children from London County Council schools began to be admitted—a radical departure not only administratively but also clinically, as non-infectious cases, such as children with phlyctenular ophthalmia, were admitted; subsequent to 1924 all chronic eye disease in L.C.C. school-children was being treated at White Oak Hospital. As for trachoma, the following figures show the steady decline in admissions:

1903	..	..	..	..	..	292
1904-13 yearly average	..	..	..	..	..	112
1914-23*	..	..	..	..	..	29
1924-33†	..	..	..	..	..	34
1934-43	..	..	..	..	..	13

* Excluding the years 1915-18, for which no data are available.

† Excluding the year 1924, when there were 201 admissions from an outbreak at Poplar.

The decline in the numbers admitted during the past 10 years has been steady, as can be seen from the figures of actual admissions for each of the years from 1934 to 1943 in sequence: 21, 31, 11, 28, 10, 5, 5, 8, 5, and 7. It is worth noting that these admissions include children from outside the L.C.C. area.

That trachoma is still not infrequent in London is only too obvious by the number of adult patients seen at the eye hospitals. It is difficult to assess the total number, but each patient presents a considerable individual and social problem, and is the source of a potential epidemic. From every point of view, early and persistent treatment is essential. The lack of persistence on the part of many patients and the no less marked lack of adequate in-patient facilities for such patients at eye hospitals raise the question whether the present-day methods of dealing with trachomatous adults could not be bettered. The L.C.C. under pressure of war made provision for the admission to one of their fever hospitals of adults suffering from trachoma, but it is possible that more radical measures are required. Indicative of what can be achieved by systematized and persistent effort, experience at Glasgow may be quoted (Sorsby, 1939). Notification was made compulsory in that city in Oct., 1914, and is still in force. The number of new cases notified has shown an almost steady decline since 1915, as the following figures show:

Year	No. of New Cases	Year	No. of New Cases
1915	112	1930	25
1916	69	1931	32
1917	90	1932	24
1918	47	1933	20
1919	85	1934	17
1920	77	1935	18
1921	68	1936	12
1922	68	1937	15
1923	62	1938	15
1924	53	1939	10
1925	41	1940	7
1926	43	1941	10
1927	30	1942	10
1928	30	1943	3
1929	45		

In terms of case rate per 1,000,000 of population, the following figures illustrate the downward trend:

Year	Case Rate per 1,000,000
1919	78
1924	41
1929	39
1934	15
1939	9
1940-3 yearly average	7

Notification was supplemented from the beginning by systematic treatment in a trachoma clinic, where examination of contacts was also carried out, and by the provision of in-patient accommodation for both children and adults requiring in-patient treatment.

In London, with its excellent school medical service, trachoma in school-children is unlikely to escape observation and treatment, but there are no systematic special provisions for the pre-school child and the adult. Statutory notification of trachoma would seem to be a necessary step; not, indeed, for the purpose of obtaining statistical data—this is a subsidiary consideration in making notification of any affection compulsory—but for the creation of the machinery needed for the detection of this insidious affection, the study of the home conditions under which it may be spread, and the provision of adequate facilities for treatment. London, with its universal contacts in normal times, is especially prone to the accidental introduction of trachoma, and under suitable conditions the disease may spread rapidly, as the epidemic in Poplar in 1924 revealed. To justify action it is unnecessary to conjure up a spectre of infection spreading from a trachoma-infested Continent at the end of the war. The experience at White Oak Hospital has shown that trachoma could rapidly be eliminated from a highly infected school population—and this experience, supplemented by that obtained at Glasgow, rather than imaginary fears, amply justifies an energetic approach to the residual problem of trachoma in the adult population.

Summary

The closing of the trachoma block at White Oak Hospital, Swanley, is recorded. Trachoma may now be regarded as eliminated from the child population of London, in striking contrast to the conditions prevailing a generation ago among the poorer sections of the community.

In the light of the history of this achievement and the more recent experiences at Glasgow, where a great reduction in trachoma has followed statutory notification and the provision of adequate facilities for treatment of both adults and children, it is suggested that the elimination and prevention of trachoma in adults in London demand that the affection be made notifiable and that statutory provision be made for treatment centres.

REFERENCES

- Sorsby, A. (1935). *L.C.C. Ann. Rep.*, Vol. iv, Part III, p. 69.
— (1939). *Rev. int. Trachome*, 16, 148.

KING EDWARD'S HOSPITAL FUND

Guy's Hospital is to be the first to benefit from the provision made by Lord Nuffield, when the Nuffield Trust for the Special Areas was established some seven years ago, that any sums which might be available (through repayment of loans, etc.) from the Trust should go to King Edward's Hospital Fund. A first instalment of £300,000 has been received by the Fund, and Lord Nuffield has asked that out of this a grant of £250,000 should be made to Guy's. This was announced by the Duke of Gloucester when he presided at the recent annual meeting of the King's Fund. In the same speech the Duke said of the Government's health service proposals:

"We wish all success to the Minister in the very difficult task before him, and we welcome the indications he has given of his desire to find an enduring solution which will be generally acceptable. We do not believe that such a solution can be found by any method which fails to preserve the freedom of the medical profession and of voluntary hospitals. While we welcome assistance from public funds, it is of the first importance that it should leave the governing bodies of voluntary hospitals and their medical staffs unfettered in their pursuit of health and healing."

Presenting the report of the Fund's Committee on Hospital Diet Sir Jack Drummond said that the catering service had, with a few notable exceptions, been the Cinderella of the hospital services. In this respect we were a generation behind the U.S.A. and Canada. Courses of lectures and demonstrations in hospital catering, to which hospitals had been invited to send representatives, had been arranged and had been a great success. Much useful information had come out of them, including a suggestion for quarterly refresher meetings, when officers in charge of catering in hospitals might meet to discuss problems. He hoped that the time was not far distant when the difficulties caused by shortage of staff and equipment would be overcome and the feeding of patients and staff would become one of the primary concerns of hospital administrators.

The report of the Radium Committee, which was presented to the meeting by Sir E. Rock Carling, recommended that in future the clinical supervision of radium work in hospitals of the King's Fund should be entrusted to the Radium Commission, which exercised these functions through the whole of Great Britain outside the Metropolitan area. The income of the King's Fund was £325,813 for 1943, and in making this announcement the treasurer said that the Fund had given a good deal of attention to the discussions on the White Paper. "Two things," he said, "stood out as necessary: (1) in the arrangements for hospital services there should be a true partnership between the municipal and voluntary hospital; and (2) voluntary hospitals should continue to receive very large voluntary income."

It may be added as a footnote to the announcement of the £250,000 for Guy's Hospital that this will enable the hospital authorities to start on the plans (which they have had for some time) not only to restore the buildings damaged by enemy action but to bring the bed accommodation up to 1,000; to provide the latest equipment of every kind for diagnosis and treatment; and to build a new college for its medical students and create a great medical teaching centre there. It is also hoped that a "Guy's" will be erected in some country area, within easy access of the parent institute, which will provide for the physical re-education and rehabilitation of patients.

MEDICAL RESEARCH IN EIRE

The report for the year 1943 of the Medical Research Council of Ireland has been issued from its office at 85, Merrion Square, Dublin. The membership of the Council remains unchanged, except that Prof. J. W. Bigger (representing the University of Dublin) resigned owing to his continued absence from Dublin and Prof. W. R. Fearon was nominated by the University to fill the vacancy. During the year the Council continued its policy of assisting scientific investigators in schemes put before it by workers interested in particular problems. Support was also given to schemes of research into public health questions of pressing importance or interest; for example, epidemic goitre in certain areas in Co. Tipperary, and the bacteriology of epidemic diarrhoea and enteritis in Dublin. At the request of the Department of Local Government and Public Health the Council advised on the establishment of a special research into the chemotherapy of tuberculosis, and a grant of £3,000 per annum was voted by the Dail for this scheme; arrangements were also made for investigating the problem of the typhoid carrier. As in past years a number of whole-time grants and grants-in-aid were made to individual workers in various branches of medical science. The report includes a summary of work done by grant-holders during 1943 and a list of their publications.

RELIEF IN EUROPE

Some idea of how UNRRA, the organization of which was outlined in these columns on July 29 (p. 166), is getting to work was given at a press conference recently. The first phase of civilian relief (provisionally estimated to last six months) will be the responsibility of the Allied Armies and the Civil Affairs Branch of the Army. Six to eight public health officers appointed by UNRRA will be attached to the Army's Civil Affairs Branch for this first or military phase and released to UNRRA afterwards. Contact is maintained with the various Allied Governments, particularly with their medical representatives, who know what the problems of relief will be, and it is hoped to appoint further public health officers for purposes of liaison. It was emphasized at the conference that the function of UNRRA is to help re-establish and strengthen a country's national and local health and medical services so that it can deal with its own problems as soon as possible. UNRRA will not force any country to take its help, but will respond to requests. Preliminary discussions have shown that large numbers of doctors and nurses will not have to be recruited; most countries have enough personnel to carry on their normal work. Medical supplies are, however, a different matter. Agreement has been reached between Great Britain and the U.S.A. on drugs and dressings required, methods of packing, labelling, etc. The basic supplies are in two forms. (1) An emergency unit containing drugs, surgical equipment, etc., to meet the requirements of 100,000 people for one month, one hospital of 200 beds with operating theatre and x-ray apparatus, and five 40-bed hospitals. These latter are tented cottage hospitals to supply the needs of remote villages. (2) A standard unit with supplies for 1,000,000 people for three months; this unit will form a pool from which actual needs in particular areas can be met.

As already announced, UNRRA has an epidemiological bureau, which will collect and distribute information, and a special division (the Displaced Persons Division) to deal with one of the most urgent problems—the return home of refugees, with all that that means in the way of medical inspection, prevention of epidemics, quarantine, immunization, etc. As UNRRA has special responsibilities for the supply and distribution of food, it has its own nutrition experts, who will investigate on the spot the actual nutritional conditions of the people. Already liaison with the three Balkan missions in Cairo—Yugoslavia, Greece, and Albania—is complete. Three doctors and three senior nurses are now supervising camps and training suitable refugees in nursing, etc., and other staff are waiting to join them.

The Pedestrians' Association states that the 35 m.p.h. general speed limit for motor vehicles that became law in the United States in October, 1942, for conserving rubber has turned out to be the biggest life-saver since the introduction of motoring. According to the U.S. National Safety Council the number of persons killed was reduced to 2,000 a month in the first month of the limit, compared with 3,920 in the corresponding month of the preceding year. In 1943 the total of road deaths was 23,300 compared with 40,000 in 1941. Though the number of cars in use has greatly diminished, a considerable part of the reduction is generally attributed to the speed limit.