SYPHILIS AS A

PUBLIC HEALTH PROBLEM

by

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In the medical field the two fundamental needs of man are prevention and cure. Cure he will demand for himself because pain or disability urges the need. Prevention is another matter for its rewards are remote. Pain and damage being a remote menace, the courage of indolence drives him down the easy way. This is a common human trait -- to be deplored, but to be recognized and dealt with as such in this world of things as they are.

Fortunately, in some respects, man sees clearly the need of sanitary regulation and disease prevention. For preventative medicine and the health examination particularly, man requires compulsion, or at least urgence, from his government, insurance company or the philanthropic, commercial or educational organized institute.

During the last two decades, we have seen organized campaigns for preventive medicine and for health examinations. They arrived with the depression. The life insurance companies and recently the pharmaceutical organizations have been more persistent.

The medical profession continues to do three things: informs the public, instructs its own members, and continues research, not only in the laboratory but also in study and experiment in ways of "making organized social machinery drive the wheels of preventive medicine" to make better lives, longer lives and happier lives.

The physical, mental, moral, social and economic damage wrought by syphilis are matters of general knowledge. It is not needful to rehearse the menace of venereal diseases to the individual and to the public. Health statistics tell only a part of the story of the prevalence, with 50,000 new cases of syphilis in New York City and 500,000 new cases in our country each year. The vast number of those who are unaware of their disease cannot be estimated, nor can the number of those who do not submit to examination, cases incorrectly diagnosed or the number of those who find diagnosis and treatment in the drug store and from the quack.

The problem of prevention has been fully recognized by the medical profession, by private, public and governmental health agencies for generations.

The greatest restriction upon the prevention and control of these diseases up to the present time has been what is designated as "public opinion". It has long been maintained that public opinion would not countenance the enforcing of laws to handle this problem effectively in the same way that other communicable diseases have been managed. This great hindrance to effective control in this country is based upon the stigma of moral dereliction implicit in every case, with shielding of the patient by his medical attendant who is bound to preserve professional confidence.

But gradually a change has been evolving in the minds of the public with the diffusion of knowledge concerning these diseases and their

treatment, a more intelligent attitude toward them has come about. Public opinion, now better informed as to what a scourge they are, how they have thrived under concealment, and how they may be treated and controlled, has finally awakened to the importance of strenuous effort toward restricting them.

Syphilis untreated may exist in a latent form for many years. It has been estimated that at least 5% of the population is infected. The late effects are of such a serious nature that early diagnosis and treatment are essential if they are to be prevented.

Infection usually occurs through the skin or mucous membrane of the genitalia as a result of sexual contact with an infected person. The primary lesion is known as the "chancre" which heals and is followed by the secondary stage, usually characterized by a skin eruption. In the tertiary stage gummata appear, and para syphilis or involvement of the central nervous system, (tabes, paresis).

Syphilis is caused by a spirochete (tryponema pallidum) which is difficult to demonstrate by staining methods but which can readily be recognized by an experienced microscopist by dark field examination of fresh exudate from a chancre. Diagnosis in the primary stage is usually made by demonstration of the spirochete, and the preferable procedure is to send the patient to a physician or laboratory skilled in this work.

Immunity seems to be an "infection immunity". In other words, the only immune person is one already infected. Immunity develops early in the disease and tends to disappear after cure.

Shortly after the disease becomes apparent (usually 10-21 days) the blood will give a positive reaction for syphilis. The most commonly used test is some modification of that described by Wasserman, but many precipitation tests, as Kahn and Kline are being increasingly used. Many contradictory opinions can be encountered as to the relative values of one test over another. However, a recent survey of a number of laboratories has shown surprisingly little difference when the same bloods were examined by different tests. The important point to be emphasized is the examination of the patient's blood in a reliable laboratory, and the type of test used plays a secondary role.

Such tests also serve as a guide to treatment and ordinarily become negative on recovery. Exceptions to this rule occur, however. There are so many factors involved in the treatment of syphilis and the criteria of cure, that it is advisable to secure expert advice as well as to consult some modern test or the subject.

Syphilis presents an outstanding challenge in preventive medicine for three reasons. First, it is one of the most destructive diseases. This fact is not observed in mortality statistics for the reason that most of

of the deaths caused by syphilis are recorded under other classifications such as diseases of the heart and blood vessels, diseases of the nervous system, deaths in early infancy, diseases of the kidneys and others.

The last published census statistics attribute about 26,000 deaths per annum to syphilis.

Syphilis is also a great challenge because of its high prevalence. Based on data from a wide range of sources, it is conservatively estimated that the prevalence of syphilis in the United States is about 5% of the population, and official censuses of cases under medical supervision made in wide areas of the United States indicate that only about one in ten of existing syphilitic infections are under medical care.

A third reason why this disease presents a great challenge is the possibility for its control. Syphilis is today one of the best understood diseases. The causal organism is known, we have accurate means for diagnosis, specific remedies and tried methods of treatment. If treatment can be begun early and continued long enough, the disease can be permanently arrested or cured in virtually all cases. It can be quickly rendered and kept non-infectious and none of the very serious possible consequences of the disease need ever develop. If our knowledge and means for the control of syphilis could be made generally effective, the disease could be stamped out in a comparatively short time. There are, unfortunately, very formidable obstacles to making our means of control generally effective and some of the

major obstacles lie in the very character of the disease which in its onset and course tends to be so deceptive and misleading that as yet more than half the people who have it do not know that they have the disease and an enormous proportion of patients drift away from treatment long before the public health objective and the objective of cure have been achieved. The means for its control are at hand but its achievement calls for the most affective and agressive cooperation of all the official, professional and social agencies in every community.

The strategy of syphilis control includes: the discovery of unrecognized infections; the earliest possible diagnosis; bringing patients under the earliest possible treatment; holding patients under treatment long enough; tracing and bringing under care the sources of infection; bringing the contacts of patients to examination and under treatment if needed; and by education to promote a better understanding of the disease and the means for its control by the professional and semi-professional groups related to it, by patients and especially by the general public. From the Public Health point of view, no source of treatment, whether hospital, clinic or private physician, can escape responsibility for utilizing this full list of control measures. Good progress has been made in recent years in putting some or all of these measures into effect.

There still remains among physicians as among the general public a strong hangover of social taboo and prejudice against "sexual diseases." Even among physicians a considerable confusion between the moral issues and

the medical and public health issues still persist.

Another important reason is, that many private physicians are not equipped in training and experience to treat syphilis. The medical schools have in the past largely restricted their teaching of these subjects to those who purpose to specialize in these diseases. Only in recent years have some of the outstanding schools sought to send out all their graduates prepared to diagnose and treat at least the ordinary, uncomplicated cases of syphilis. Also, in the diagnosis and treatment of syphilis, many important advances have been made in late years with which many physicians have not had opportunity to become familiar. Much more is to be expected from the medical colleges in order to better equip the private general physician for the diagnosis and treatment of syphilitics and many more opportunities for instruction of physicians now in practice need to be provided by way of post graduate courses, institutes, clinical demonstrations and suitable literature.

The private physiciansmust all be enlisted as active and sympathetic workers in the problem of control of syphilis. As with all other infectious diseases, the physician must assume the attitude that he is personally responsible for the spread of any venereal disease infections which come to his notice. Each infected person, at the first visit should receive careful instructions from him concerning the nature of the disease and the amount of treatment which will be required to prevent its spread to others.

Careful confidential inquiries should be made in each instance in order to discover the original source of the infection, just as in cases of tuberculosis, typhoid fever or small pox. Physicians vary greatly in their skill and technique required to persuade a patient to disclose the details concerning the source of his or her infection. The efficiency of a private physician like that of a public clinic, should be judged, not alone by his skill and accuracy in treating cases, but also by his ability to discover the contacts which are the primary or secondary sources of the spreading infection.

Direct personal contact must be established periodically between a responsible well-informed and tactful member of the Health Department, and every practicing physician in the community who treats venereal diseases, in order to have this idea work. The Department of Health can do no more effective service in any branch of its activity than by visiting these physicians in their offices and enlisting their aid.

Many physicians are unaware of the recent advances in therapy for syphilis. The cooperative clinical group in the treatment of syphilitics should be brought to their attention, not alone at medical society meetings and in publications but by direct contact between them and some agency of the Health Department. A minimum standard of treatment should be determined by the best authorities and physicians should be persuaded to administer treatment in an approved manner.

Consultation services are now supplied to physicians by the Health Department without charge in order to assist them in making early diagnosis. Experienced consultants should also be available to give them the benefit of advice and guidance in instances in which the elimination of infection proves to be unusually difficult.

If a patient's financial resources do not permit him to continue private treatment, the physician who is willing to treat him for a reduced fee should receive an adequate amount of the therapeutic material from the Health Department free of charge. If, in spite of careful instruction and efficient medical therapy, a patient discontinues treatment before the termination of the infectious period of the disease, it should be regarded as a proper function of the Health Department to provide the physician, at his request, with Public Health Nurses. They should serve under his direction to assist him in discovering contacts and in persuading delinquent patients to resume treatments.

In order to be sure that every patient continues treatment until the infection is eliminated and he or she is no longer a menace to the community, some sort of registration is essential. It has been demonstrated abroad that effective registration can be established without violating the confidential relationship between doctors and their patients. If registration by initials and date of birth is accepted as adequate, physicians will not hesitate to report their private cases. The actual name and address need

not be disclosed unless a patient willfully discontinues his treatment and exposes other persons in the community to his infection.

Clinics should persuade all patients who can afford to pay a physician to return to their family doctor. However, if a patient can, but will not pay for private treatment, free treatment should be available to him in a public clinic. The protection of the public health is a community responsibility, like public education, a patient with any dangerous infectious disease, scarlet fever, typhoid fever or a venereal infection, should have his choice of providing himself with adequate private treatment or receiving it at the hands of a public agency such as the Deprtment of Health or the Department of Hospitals. In all other respects, the Department of Health should assist the physician in retaining his p rivate patients and in caring for them adequately.

It is most important that the attitude of the Health Department toward private physicians should always be one of collaboration and mutual assistance. Persuasion is much more effective than compulsion, and in the end, much more economical. The creation of an effective registration and follow-up of infected persons, who discontinue treatment, will depend upon the establishment of such a cooperative relationship between the Health Department and the private physician of the community. Physicians will usually collaborate in any reasonable plan which will preserve the established confidential relationship between doctor and patient and encourage infected persons to continue treatment until cured.

In the analysis of the case records of many syphilis clinics one is appalled at the frequency of evidence that potentially infectious patients have drifted away from treatment long before permanent or even temporary non-infectiousness could be assured. Unquestionably one of the major problems in syphilis control is that of holding patients under treatment long enough to assure the public health objective of non-infectiousness and beyond that, the objective of cure.

Frequently the blame and responsibility for failing to continue treatment is shifted wholly on the patient. M.J.Esner, in his article "The value of instructing Syphilis patients" states,"It is high time that we come much more fully to appreciate the importance of thorough going and and repeated instruction of the syphilis patient as a factor in syphilis control, and that we shoulder much of the blame for the commonly bad record in epidemiological and curative results because of failure to assure and sustain the cooperation of the patient through the simple and available means of adequate instruction.

A demonstration test was arranged in connection with Bellevue Hospital Clinic, to determine to some extent the effectiveness of adequately instructing syphilis patients in keeping patients under treatment. One hundred forty-two patients were instructed thoroughly by the Chief of Social Service about their condition and the reasons for the need of regular and prolonged treatment, in addition to the more hurried and partial instruction given by the doctors. After fifteen months the results were analyzed and

compared with a group of patients who had received only the limited instruction usually given. The patients in the instructed group were held under treatment on the average nearly nine weeks longer than the control group and received on the average 9.6 more treatments, 32 less patients were lost to the clinic and were continuing treatment elsewhere.

In order to bring to bear all resources of syphilis control, in private practice and in clinics, much more attention than has been common needs to be given to the adequate personal and repeated instruction of patients.

In the report of an Advisory Committee to the U.S.P.H.S. concerning "Recommendations for a venereal disease control program in state and local health departments," the Committee states that "the informative and educational program against the venereal diseases is in many respects its most important phase."

In the informative program among physicians, among the important considerations is the provision of more effective under-graduate and post-graduate training by medical schools in the clinical management of the venereal diseases. The following principles are recognized as applicable.

1. Modification of the curriculum of the medical school toward better instruction in public health aspects of venereal disease control measures, and that an officer of the U.S.P.H.S. be detailed to study the

status of problems of venereal disease teaching in each medical school of the United States.

2. Recruiting especially interested and unusually competent personnel into the ranks of the health department or to those of its cooperators.

3. Subsidies to medical schools and teaching hospitals either in the form of salaries or for purchase or loan of equipment to be used in teaching and research in the venereal disease field.

4. Post-graduate instruction of practicing physicians.

5. Provision of consultation service.

6. The dissemination of informative literature to physicians.

The educational program in the civilian population should include

1. Preparation and dessimination of educational material to the general public.

2. Radio talks.

3. Pamphlets.

4. Newspapers.

5. Motion pictures.

6. Qualified lectures before audiences.

7. Exhibits.

The pamphlet printed by the U.S.P.H.S. called "Syphilis and your Town", Folder No 2. in a series of venereal disease folders, gives 9 points for syphilis control in any town. These points cover every angle in venereal disease control. Folder attached.

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This papphlet asks nine questions.

I. "Does your state and town have a trained public health staff that knows how to deal with syphilis? A trained, full-time medical officer should be in charge of the control program, staff physicians in clinics must be well-trained; they must know modern methods for diagnosis and treatment of syphilis. Public Health nurses must be employed to assist them in instructing patients and in handling cases. Field workers are needed to find new cases and to follow up cases that have lapsed from treatment. The health staff must know how to locate all possible contacts of a known case. Thus, all who have been infected may be treated before they infect others. This requires common sense, tact and diplomacy -- but, most of all, professional training and experience."

2. "Does your state require reporting and follow-up on all cases of syphilis? The first step in any contagious-disease campagn is to find out where the infections exist. Because of a misplaced social stigma connected with syphilis in the past, cases have not been reported. Reporting of cases also enables the health officer to realize the extent of the disease and the progress made in its control from year to year."

3. "Are patients in your town assured of good syphilis treatment even if they cannot afford to pay? Syphilis pays no attention to economic, class or racial differences. It passes over the boundaries from one

class to another. Every person, rich or poor, white or black, office workers, laborers and the unemployed, must have diagnostic and treatment services. For people of adequate income this means well-trained private physicians. For people of low income, it means free public clinics. Hospital beds should be provided for patients needing bed care."

4. "Do physicians and clinics in your town have access to free laboratory service for blood tests? To find syphilis requires a physical examination -- plus a blood test. Most victims of syphilis show no external evidence of the disease. Neither doctor nor patient may be aware of the infection. With quick and easy access to a free diagnostic laboratory, every doctor can take blood tests for syphilis as a matter of routine. Large cities may have their own laboratories, blood specimens from outlying districts may be mailed to central state laboratories in special containers. State laws should set high standards for the laboratories to meet."

5. "Do your state and town distribute free anti-syphilitic drugs to all physicians and clinics? The average patient would prefer to be treated by his own physician if possible. Often he cannot afford to pay for adequate treatment. Many physicians treat syphilis patients long after the patient can no longer pay for the treatment. It is unfair of society to demand this of doctors, and patients are reluctant to accept such treatment. Free anti-syphilitic drugs supplied by the

state to physicians will in many cases permit treatment to be continued at low cost. Provision of free drugs has been a part of the service provided in every country that has stamped out syphilis."

6. "Is every expectant mother required to have a blood test in your state? Anti-syphilitic treatment if it is started before the fifth month of pregnancy and continued until birth of the infant, will prevent spread of the infection in nearly every case. It is of the utmost importance to discover the syphilitic expectant mother in time. Several states now require by law blood tests for every pregnant woman. This is the greatest safe guard against prenatal syphilis."

7. "Are medical certificates, including a blood test for syphilis required before marriage in your state? Many tragedies of domestic life might have been avoided if the husband or wife knew before hand of a syphilitic infection. By discovering syphilis before marriage, young people not only protect themselves but they prevent their children from tragic prenatal syphilis."

8. "Does every complete physical examination given in your town include the blood test? Most people have good common sense. They want syphilis treatment if they know they are infected. By making the blood test a part of every complete physical examination most cases can be discovered. Every hospital patient should be given a blood test. It should be a part of every insurance examination, for the

expectancy of untreated syphilitics is 20% lower than normal."

9. "Has your town an education program aimed at age groups most frequently acquiring syphilis? Public education is the crux of syphilis control. People must learn to consult a doctor or clinic. They must know that treatment begun early will cure syphilis in nearly every case; left untreated, brain, heart, or nervous system complications develop. They must learn to respect the blood test and request it frequently. They must understand that syphilis strikes youth hardest.

And finally the public must realize the cost of syphilis, -- in care, in lives wasted, in sorrow and in dollars. All this is preventable if adequate control programs can be started and continued in every part of the country. It will be cheaper, too. The cheapest thing a town can do with its syphilis is to cure it.

Doctor Thomas Parran, surgeon General of the United States Public Health Service in his book, "Shadow on the Land" in the preface states, "There are plenty of good books to show the impact of the disease, syphilis, upon the individual. I have only touched upon this aspect of it. What I have tried to express is its impact upon the nation and its relationship to contemporary public health and other public problems. As a federal health officer, it is my task to save lives by applying medical knowledge against the plagues which afflict the most of us, and

the most dangerously; to save taxes by reducing the number of physically and mentally unfit who crowd our public institutions and swell the proportion of the unemployable in the population; to promote research for better methods of doing these things; and to report the truth as I find it to citizen and official alike."

This book gives a summary of studies of control of syphilis in foreign countries and the fundamentals of foreign control are discussed. It becomes apparent:

Whenever and wherever good treatment is provided over a period of years the attack rate of syphilis declines. Organized treatment centers have formed the backbone of the control programs.

The most successful countries have been those which have carried on active measures for the repression of commercialized prostitution.

When, as in the Scandinavian countries, there is added to good treatment and to the repression of prostitution active measures of notification, a case finding and case holding, the most striking declines have occurred.

Nowhere can one show any direct relationship between public health control measures for gonorrhea and the decline in the prevalence of that

disease. A possivle exception to this general rule is to be found in the records of the military forces where prophylaxis can be applied under diciplinary control.

"In general it may be said that in no place in the world has syphilis declined without active governmental intervention. A nationally co-ordinated attack upon it seems as necessary as upon an invading army. And further, gains against syphilis have been greatest in those nations where social legislation has done most to establish public health protection as a basic privilege of citizenship."[1]

What are some of the reasons why our nation has not done more? Dr. Parran discusses these reasons as follows:

"In the first place, the syphilis problem of its very nature is admittedly difficult. It can be shown that this particular lag in our national performance is due neither to lack of medical skill in this country nor in failure to appreciate the value of public health. Since 1900 our tuberculosis rate, for example, has been cut two-thirds; our diptheria rate by nine-tenths; the typhoid rate practically to the vanishing point. But the fact remains that we have not attacked syphilis as we have attacked these and many other plagues. For the most part, we have been content with wishful thinking.

1. Parron, T, Dr., "Shadow on the Land" p.132.

It cannot be repeated too often that first and foremost among American handicaps to syphilis control is the widespread belief, from which we are only partially emerging, that nice people don't have syphilis, and nice people shouldn't do anything about those who do have syphilis.

There are other drawbacks to efficiency in syphilis control. In many respects we would be better off if the nature of the disease itself had not been modified somewhat in successive generations since the fifteenth century. Then it was to be feared from the very beginning. Its early stages brought painful and dangerous symptoms; death not infrequently. Now, it is far less virulent in its early stages, but presumably more deadly in its later manifestations. The last statement may or may not be true, for many hundreds of years elapsed between the first great syphilis plagues that devastated Europe and the medical proof that syphilis was certainly the cause of so much disease of the heart, blood vessels, nervous system, and the other late complications now known to be associated with it.

If syphilis were to strike now with its fifteenth-century velocity, the people who had it would make no mistake that they had it; they would be full of anxiety to do something about it at the very time when the most can be done.

Like tuberculosis, syphilis cannot be cured in a day. The consensus of expert opinion is that about 18 months of continuous treatment is necessary for maximum safety of the patient with early syphilis. It is not cheap treatment. These and other minor inconveniences, incidental to thorough treatment, are important in limiting the attack upon syphilis."

Another stumbling block has been lack of organized effort and lack of trained men.

Dr. Parron says,"The method is to me less important than the direction and velocity of the effort. But next to the handicap of being afraid of our problem, there is no stumbling block in the way of an intelligent planning or the execution of an intelligent plan to compare with our previous incapacity for teamwork. If that can be conquered, the trend of results is up."

Dr. Parron outlines a platform for action as follows:

1. Locate syphilis -- we are all aware that there is no mortal chance that everybody will apply for the Wasserman test volunatrily. It is not possible to set up the machinery for tests on the whole population. The next best thing is to make a blood test whenever and wherever physical examinations are given, as routinely as the doctor

now takes pulse and blood pressure and listens to the heart action.

Some hospitals make the Wasserman test a regular procedure in the admission of all patients for every cause. All hospitals should do it. Every pregnancy means that a Wasserman test is necessary.

Life insurance companies might profitably make a Wasserman test in the medical examination of every applicant for a policy.

Syphilis should be sought among law-breakers. Yet in few cities are the police, the courts and the health department doing anything to find or treat disease among any except women prostitutes arrested in raids.

Certainly one place where there should be complete agreement as to the need for universal Wasserman tests is in connection with applicants for marriage licenses. Twenty-eight states now forbid marriage when either man or woman is infected with venereal infection.

2. Obtain public funds which assure adequate treatment for all infected persons. Reconstruction of clinical facilities will require time, cooperation and shrewd expenditure of all available funds. The following steps must be taken; First, a trained full-time health officer with an adequate staff should be placed in charge of the veneral division of every state and large city department of health. Second, all

states must recognize that a policy with regard to distribution of anti-syphilitic drugs and availability of diagnostic laboratory service cannot be effective unless it is liberal. Third, the communities with state and federal help must greatly increase the number of free and part-pay clinics and adopt reasonable standards of efficiency which will include privacy and consideration for the cooperative patient, active follow-up, a uniform system of case reporting with a central clearing house, and trained personnel with security in tenure.

3. Education of the private physician and general public. Among forty-five per cent of the doctors who do take early syphilis cases, it seems appropriate that each should give thought to his personal responsibility and ask himself: "Am I completely qualified to diagnose and treat syphilis? Am I thoroughly familiar with the accepted drugs and techniques employed against it?" A doctor should not undertake to treat a case of syphilis unless he is willing to see it through. The doctor has a personal responsibility to the patient and to the community. He can by acting through his medical society set the standard for public health work in his state or county or city.

"Perspective sometimes makes things meaningful and sometimes flattens them into mediocrity. It all depends on the angle of vision. As one looks a range of hills from a roadside creeping up the slopes below them they assume a dignity and contour quite unlike a view of

of the same hills from an airplane 5,000 feet up, with good visibility, when they seem the vaguest undulations, quite without significance in the life of man as he soard above them.

Historically, it is fatally easy to glorify the past; to survey events with a reverent upward look. What men have muddled through in times before us takes on the sanctity of perfectly planned achievement. Compromises seem couragious; defeats mere stratigic retirements.

In science, the temptation is to glorify tomorrow. Hardbitten though he may be, realist though he must be, the scientist by the nature of his calling looks eternally ahead, always on the outposts of knowledge, he must continue to explore, survey, define, correct, if he is to extend the boundaries of human achievement.

In the science and art of medicine, in its specialty of public health, this temptation is strong. So much is behind, that we look impatiently forward to the day when syphilis, too, shall be a conquered plague. For the time will come, when the tale that we tell today of the ravages of syphilis will sound as strange in the ears of our descendants as the story of how, in 1822, the 150,000 inhabitants of Manhattan fled their homes because of the terrible plague of yellow fever that had come upon them.[1]

1. Op. Cit., p.286.

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