effects of quack treatment of syphilis by a herbalist; and the facilities for free treatment with Western methods at clinics in town and country.

The medical practitioner cannot stand aloof from this education campaign. He is possessed of the technical knowledge which alone will carry conviction. It is necessary that our ethical code be interpreted liberally in this connection, so as to liberate for the campaign many gifted speakers and writers in the profession who, at present, consider themselves debarred by our ethical rules from participation.

Our legislators have awakened to the urgency of the problem. Last year a valuable debate took place in Parliament on the subject of venereal disease. As a result of it the Government adopted two proposals: firstly, the appointment to the staff of the Union Health Department of a medical officer to co-ordinate the various activities in connection with venereal disease; and secondly, the creation of a committee to advise the Department on problems connected with these diseases. Both of these proposals have been implemented.

It behoves members of our profession to cooperate actively with the various lay efforts for combating this evil.

**Syphilis in South Africa.**

By C. Kevin O'Malley, M.C., M.B., Etc., Medical Officer in Charge Venereal Disease Clinics, Cape Town; Lecturer in Venereal Diseases, University of Cape Town.

Every country has its syphilis "problem." Syphilis appears to be an inescapable concomitant of civilisation; it is only a "problem" when concerted action fails to diminish its yearly casualty list. Many factors are present in the Union of South Africa, considerations of space and population, which tend to nullify the efforts made to combat syphilis; ignorance of the existence of venereal disease, living conditions in which privacy, much less modesty, is impossible, render certain sections of our population a veritable breeding-ground for the propagation of the Spirochaeta pallida.

In this paper only those aspects of syphilis that present themselves in Cape Town will be considered.

Cape Town has a population of 316,759, of which 163,110 are Europeans and 153,640 non-Europeans. Only a small proportion of the population is native. Despite the fact that an active venereal service has been in existence in the city for many years, there is no noticeable diminution in the incidence of fresh cases of syphilis. Facilities for treatment exist at three separate centres where 26 sessions are held each week. In addition, there is a follow-up scheme by which each patient's attendance is regularly checked and defaulting is automatically discovered and dealt with, either by a personal visit, or a statutory warning notice issued by the Medical Officer of Health. And yet, according to the Medical Officer of Health's Report for 1939, 3,809 new cases of venereal disease were registered at the various clinics in Cape Town. Of these, 1,961 were cases of syphilis, giving an incidence rate of 6.3 per 1,000 of the population. A closer analysis of this figure produces some interesting facts of comparison. Firstly, we learn that if we considered only early cases of syphilis, representing infections probably acquired during the year, there are five times more non-Europeans than Europeans: Europeans, .9 per 1,000; non-Europeans, 4.58 per 1,000. If we consider congenital syphilis, then the relative incidence between the races is still more startling. There are 12 times more cases of congenital syphilis amongst non-Europeans than amongst Europeans: European, 1.9; non-European, 24.0. Compare these figures with corresponding figures from Stockholm, a city of 556,954! The comparison shows that:

1. There are 5 times more cases of early syphilis amongst Europeans in Cape Town than in Stockholm (Cape Town 0.9, Stockholm 0.18 per 1,000 of population).
2. There are 20 times more cases of congenital syphilis amongst the European population of Cape Town than in Stockholm (Cape Town 0.19 and Stockholm 0.01 per 1,000 of population).

If non-Europeans are included in the Cape Town figures, the comparison would be much more unfavourable. But the figures, even for our non-European population, show clearly that we have a lot of leeway to make up in our campaign against syphilis.

From the therapeutic standpoint we in Cape Town are by no means backward. We have the same choice of drugs that large centres overseas have; indeed, our range is much larger than some. The standards of treatment and cure are broadly based on the findings of the League of Nations Report on the subject. But we have not the same wide choice in the matter of serological control. The Medical Research Council's fourth modification of the Wassermann test is the only official test subsidised by the Union Health Department. There is no official flocculation test such as the Kahn, Kline, etc. The advantage of having both a serological and a flocculation test at one's disposal, both for the diagnosis and control of treatment, is obvious. It is exploited in most countries where reliance on the Wassermann test alone is not regarded with favour. And rightly so, for the conflicting results, so often given by the Wassermann test just in those doubtful or obscure cases where its help is most needed, merely confuse the issue and create a maze of dubious speculation. A grave objection, from the official point of view, to the employment of two tests is the greatly increased cost. This has been partially solved by the Pennsylvania State Laboratory, United States of America.

In this Institution a flocculation test, actually the Kline test, is performed on all sera. Only those sera which give a positive Kline are submitted to
the Wassermann technique. In other words, the flocculation test acts as an eliminating factor, and since a double test is not done on all sera the cost is not very much greater. The rationale of this attitude is justified by an investigation covering 214,130 sera over a period of two years. The Kline test is sensitive enough to detect the presence of syphilitic reagin, even in early cases. In order to find out if any "positive" cases were being missed by the Kline test, a Wassermann test was performed in 1,000 negative Kline reactors. Only 6, i.e. 0.6 per cent., of these gave a positive Wassermann reaction, none of whom gave a definite history of syphilis. Of the 214,130 sera examined in the whole series, nearly 170,000 were negative to the Kline test, and in these the Wassermann test was not done, so that only in approximately 20 per cent. was it necessary to do the double test.

Syphilis in South Africa presents far more manifestations, especially on the mucocutaneous structures, than it does in European countries. No difficulty would be experienced in filling an album with photographs of eruptions and isolated lesions that are rareties in Europe. Particularly is this the case amongst non-Europeans, who display a wide variety of superficial lesions in the early stages of syphilis. This is true for congenital syphilis too. There are many of the younger doctors in Scandinavia who have never seen an actual case of congenital syphilis. Now the behaviour of syphilitic lesions under the action of antisyphilitic drugs is a good criterion of their efficacy or otherwise. We in South Africa, then, have an advantage over our colleagues in Europe in this respect. For this reason future studies of new antisyphilitic remedies may well be carried out in the Union of South Africa; and there is no reason for supposing that we will always be dependent on arsenical or other heavy metal compounds.

Considering the prevalence of syphilis, especially amongst the non-Europeans, extra-genital chancres are very rare.

Not more than a dozen cases have been observed in the past ten years by the writer, and these have been restricted almost entirely to chancres of the oral cavity and fingers. Amongst the imposing category of extra-genital chancres collected by Fournier, several occur in sites not usually connected with the transmission of syphilis, e.g. the axilla, sole of the foot; these bizarre occurrences are not observed in Cape Town. Isolated secondary lesions in the skin and mucous membranes are occasionally diagnosed as primary lesions (and sometimes it is rather difficult to distinguish them!). This may account for the belief in some quarters that extra-genital chancres are fairly common—in other words, that numbers of people are being innocently infected every year.

Syphilis, being a highly infectious and preventable disease, bulks very largely as a Public Health problem in most countries; and rightly so. It is one of the most easily preventable of all diseases, as its acquisition and further transmission are almost entirely dependent on voluntary individual acts. Consequently each new case of syphilis should occasion enquiry into the probable source of infection and further possible contacts. Sufferers from a venereal disease and medical officers who diagnose them have special obligations which are clearly laid down by law. The Lex Veneri of the various European countries varies considerably. In Britain, and in France under the Third Republic, sufferers from syphilis are not compelled to have treatment. Theoretically at least, they are free to decide their own destiny in this respect, though the transmission of syphilis in marriage constitutes grounds for divorce in both countries. Quite a different outlook obtains in other countries. In Sweden, for instance, the law lays it down quite plainly that every person who suffers from a venereal disease must have treatment. The Swedes have dared, too, to make syphilis and other venereal diseases notifiable by law—albeit anonymously. This places an obligation on the doctor. He must notify to the authorities each case of venereal disease that comes under his observation without necessarily disclosing the identity of his patient. The patient is reported as a case, not as a person. This is anonymous notification. It seems reasonable. The system affords accurate figures concerning the prevalence of syphilis without rudely transgressing the sanctity of the medical confessional. But the law in Sweden goes even further. It imposes the obligation on every doctor to endeavour to trace the source of infection in every fresh case of venereal disease seen by him and to report this suspected source in writing to the health authorities within twenty-four hours. And there are penalties if he fails to do so. King Gustav is unbelievably severe in this respect.

Denmark has much the same kind of laws. In both countries you may enjoy many liberties, but the privilege of walking about with aggressively active Spirochaeta pallida is denied to you. But then these delightful countries offer many other compensations!

The Public Health of South Africa occupies, in relation to venereal disease, a place midway between the laissez-faire attitude of Britain and the uncompromising hostility of Scandinavia. It is not every medical officer in the Union who realises that he has any statutory obligations at all in the matter. Still less is he aware that he may be fined £20 if brought to book for neglecting his duties by some fearless, relentless Medical Officer of Health, Doctors should really know more about Acts of Parliament which affect their professional behaviour, but it's too much to expect all doctors to read through and memorise sections 53 to 69 of the Public Health Act, so the matter is briefly summarised here divested of its legal phraseology. Every medical practitioner who attends or advises any patient in respect of V.D. must—

A. Inform the patient of the nature of the disease and the obligations prescribed by law.
B. Warn the patient not to marry until cured or rendered non-contagious.
C. Give the patient printed information concerning venereal diseases and the obligations of people who suffer from them.

There is no obligation, therefore, on the doctor in South Africa to endeavour to trace the source of infection as in Sweden, for instance. Yet this would be a rational procedure, and it is one that Medical Officers conducting venereal disease clinics in the City of Cape Town scheme are invited to adopt. Special forms are supplied and a special space is provided on clinical case-cards for dealing with venereal disease contacts. Naturally, no compulsion exists for any person to denounce another as having given them a venereal disease. But in every case the position is explained, and if the patient voluntarily gives the name of a person, the Department takes action, provided the information gives reasonable ground for doing so. In this way many young men and many young girls in Cape Town have been drawn into the Department’s organisation, to be treated and followed up until cured of a disease they might otherwise have passed on to others. Yet without this effort to trace contacts the doctor in South Africa has definite obligations under the Public Health Act towards patients with venereal disease. In addition to informing and warning his patient, the medical practitioner must report to the local authority in writing any person whom he knows to have a venereal disease in a communicable form and who is not attending regularly for treatment.

The evidence available tends to show that there is a widespread ignorance of the law concerning venereal disease amongst doctors, and that the medical profession as a whole does not fulfil that important rôle envisaged by these sections of the Public Health Act which lay down the duties of medical practitioners.

The defaulting patient is dealt with rigorously, especially if he is in the early stage of his disease. On the whole he fulfils his obligations reasonably well. The State, too, does its part in financing the efforts of local bodies to supply proper facilities. But the medical practitioner, in the writer’s opinion, does not come up to scratch. And though we may criticise the State, summon recalcitrant patients before a magistrate, the doctor who tells his patients that there is “something wrong with the blood” and fails to report defaulting patients gets off scot-free!

The danger of infection from domestic servants is grossly exaggerated. I can recall no instance, in my personal experience, of syphilis being conveyed by an infected domestic in the exercise of her normal duties. It well may be that gonorrhoea is conveyed to little girls in some instances by servants. But it is difficult to imagine the circumstances unless the maid never washes her hands and the gonococcus survives on her fingers the whole day. It is easy, on the other hand, to conceive an infected mother conveying her disease to her little girl who sleeps with her. But we are considering syphilis. And the State, on the assumption that syphilis is very easily spread by servants, waitresses or waiters, nurses, by anyone in fact engaged in the preparation, handling or serving of food, prohibits such people from carrying out their usual duties as long as they are in a contagious condition. The writer has already expressed his view on the matter, but on the whole it is perhaps wise and desirable that infected persons should be suspended temporarily from carrying out certain duties. But there should be no penalising of such persons, no abrupt dismissals from service, and no doctor should be a party to such social injustices by giving information to mistresses. By all means protect the household. That is only common sense. But protect the person, too, who may have acquired syphilis innocently, e.g. in marriage, and who is obliged by law to have treatment.

This compliance with public health requirements should not serve as grounds for summary dismissal. A real problem is occasioned by the complete lack of co-operation between the various V.D. centres throughout the Union. There is no co-operation because there is no contact. So far there has never been on the part of the central authorities any attempt to organise their anti-venereal work into a concerted, sustained drive. It is a matter which could well be the subject of a conference. Conferences on other aspects of Public Health work are held at frequent intervals—Child Welfare, Tuberculosis, Sanitation, etc. But there never has been, to the writer’s knowledge, any exchange of ideas between the various organisations treating venereal disease; neither are there any official standards of treatment. This is regrettable. The laissez-faire attitude, which encourages a multiplicity of individual standards, is no more productive of results in health matters than in other spheres of life. A uniform, high standard of treatment subject to periodic revision is very desirable. The tremendous distance in the Union between the large centres of habitation is a real obstacle to the establishment of readily accessible health service. Where hospitals do exist, no facilities, as a rule, are available for the treatment of venereal diseases. If syphilis exists to the extent we are told it does in rural areas, then a V.D. service should be available at every hospital subsidised by the State. It could be done with the will and a little organisation. Cape Town itself has set a bad example in this respect. No attempt has ever been made to co-ordinate and concentrate its health centres. The municipal area is dotted all over with hospitals, “homes”, ante-natal, child welfare, venereal diseases and other clinics. The artificial boundaries imposed by a variety of administrative bodies should not be permitted to dissipate the energy demanded by a vigorous health programme. The work of venereal disease centres, ante-natal and child welfare centres overlaps at certain points. They could with advantage be linked together, at least architecturally. To separate them is to add to the long list of problems that attend health adminis-
SYPHILIS IN SOUTH AFRICA.


PREVENTIVE medicine has proved its value in many branches. Antivenereal prophylaxis involves no danger to the patient. Why, then, is it not more frequently applied?

The reason probably is ignorance on the part of the public and of the medical profession of the simple means necessary and the excellence of the results obtainable. There is also a current belief that venereal disease is a just punishment of sin and that preventive measures encourage immorality.

To believe that venereal disease is a punishment of sin, we must assume that all children infected with syphilis, vulvo-vaginitis and gonorrhoea have sinned; that wives infected by their husbands have sinned, and that men suffering from extragenital infection have also sinned.

Must we assume that those who acquire venereal disease from illicit sexual intercourse are specially selected for punishment, while the larger numbers who do not acquire the disease are allowed to escape?

That antivenereal prophylaxis increases immorality has been put forward by persons who do not come into frequent contact with sufferers of this disease. I have failed to find this statement made by those who have. The ever-present doubt that even the best methods of prevention may fail and the unpleas-antness of the methods used are natural safeguards against increased immorality.

Methods of prophylaxis.—The preventive measures may be likened to a system of defence barriers. The strongest and most efficient are those first met; the weakest those last encountered.

Chastity.—The strongest barrier is chastity. This will protect against all but extragenital infection and infection conveyed through moist objects, such as towels, clothing and eating utensils. It should be emphasised that chastity is compatible with health.

Type of sexual contact.—The social status of the sexual contact determines the chance of acquiring venereal diseases. The diseases are least common among faithful married couples, more common among promiscuous individuals, and most common among prostitutes. The amateur prostitute is more dangerous than the professional.

Alcohol.—Alcohol increases the risk of acquiring venereal infection in several ways. Reserve and caution are thrown aside. The sexual act is prolonged. Infection, which otherwise might remain latent, is released in carriers of the disease.