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ORIGINAL ARTICLE

THE PATTERN OF VENEREAL DISEASES.

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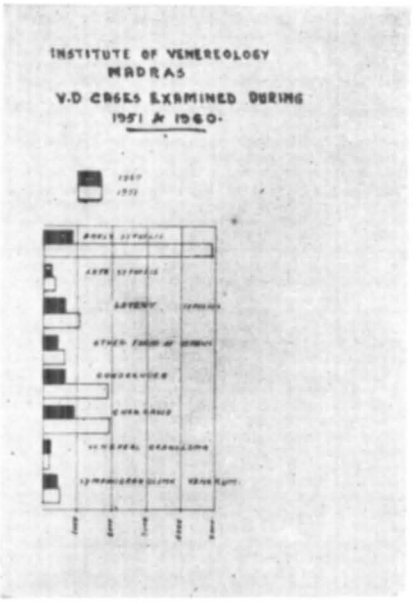
For a comprehensive discussion of the subject, the prerequisite is a lucid definition of the term 'Venereal'. It is known that the mere location of a lesion about the genitalia does not entitle an illness to the quaiifying term 'Venereal'; neither does the resemblance of the causative agent to that of any of the five venereal diseases, make for the diagnosis of a venereal disease; to the casual observer the symptom complex of a disease, may closely simulate the signs and symptoms of any or many of the five venereal diseases, yet as only a few unruly members of a legislature are named by the Speaker as such, even so only a few disease entities are termed 'venereal' by convention. They are Syphilis, Gonorrhoea, Chancroid, Lymphogranuloma Venereum and Granuloma Venereum. There was controversy about fuso-spirillosis on its admission as addition to the existing list.

The restricted definition of the term 'venereal' has posed problems in the antibiotic era in the matter of the disposal of genital ulcers, urethritides and bubos about the vicinity of the genitalia when in any of the conditions there was difficulty in demonstrating the causative agent of the acknowledged venereal diseases, though in the history elicited, the patients invariably referred their appropriate complaints in a chronological sequence to a sex affair.

It is indeed curious that a genital discharge following a sexual congress is categorised venereal, if Neisseriae gonorrhoeae were identifiable in the discharges, whereas an identical urethritis invoked under similar circumstances but in which the gonococcus cannot be made out is classified as non-venereal. Numerous such paradoxic examples with the clinical hall marks of early venereal diseases can be cited to the consternation of the examining Venereologist. These cases are even refused treatment for want of the essential credentials. The causes for this confusion, it is agreed on all sides, are the easy availablity of antibiotics and their administrability but for some reason in subminimal doses only, as judged by the standard schedules of treatment prescribed for them.

An increasing number of problem cases is evidenced in many countries on the continent. The U. K. and the U. S. A. have been alarmed at the phenomenal rise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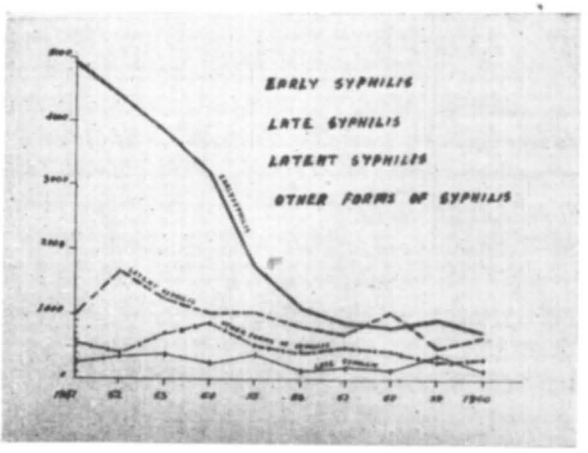
V.D CASES EXAMINED DURING
1951 & 1960.


EARLY SYPHILIS
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OTHER FORMS OF SYPHILIS
1951
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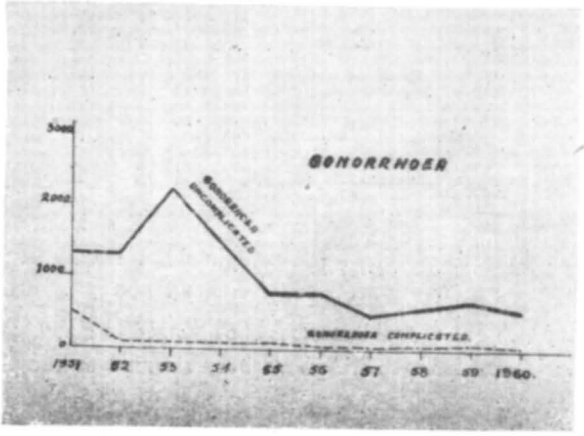
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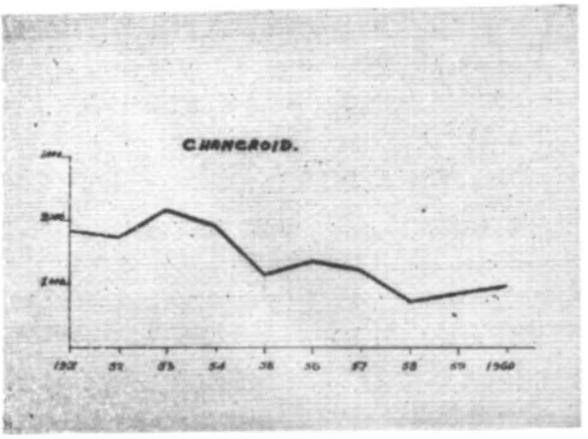
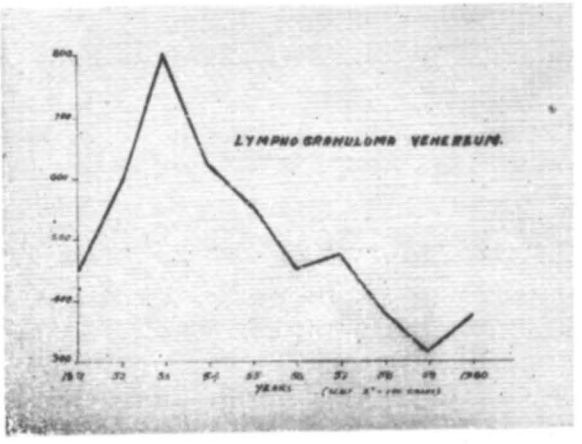
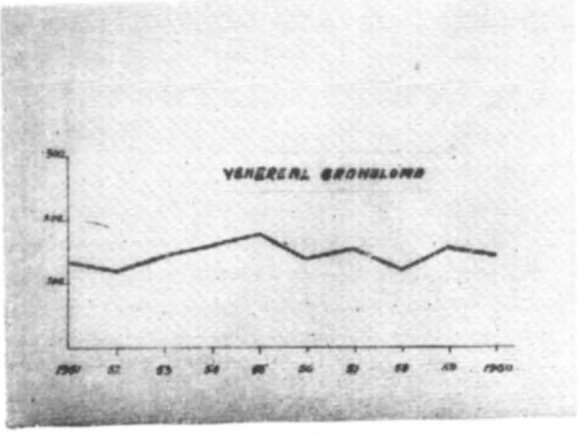
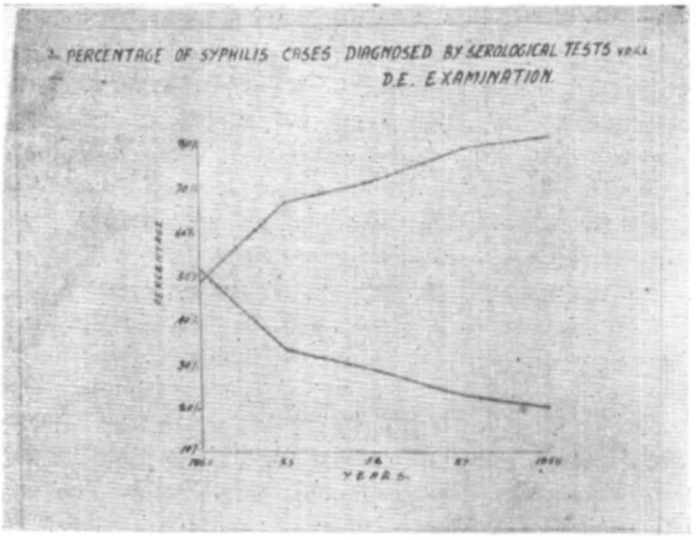

CHANCROID.


LYMPHO GRANULOMA VENEREUM.


VENEREAL GRANULOMA

in the incidence of non-specific genital discharges; non-specific genital ulcers and bubos about the genitalia are also registered in numbers only to be labelled non-venereal and dismissed for disposal, God knows where!

Thanks to the .13th World Health Assembly that met in May 1960, the adjective 'venereal' has been redefined to include, besides the approved venereal diseases, other local or general conditions with a venereal background.



Viewed at in this context, the pattern of venereal diseases has shown quantitatively a definite decline, easily understood through the histograms prepared for the five venereal diseases; the maximum drop is for early syphilis; granuloma venereum alone demonstrating an inclination to an upward trend at the end. Of course all this is false presumption for which reasons are many and varied. Qualitatively too, the pattern of five venereal diseases has shown significant alteration :

Syphilis : The management of syphilis is no more the prerogative of the V.D. Specialist. Decentralisation has insidiously occurred under the influence of the narrow and broad spectrum antibiotics administered by any who can procure them from a drug store and can wield a syringe. None would object to this change over, the dying Venereologist in the least but those on whom the new responsibility of management of V. D. patients rests unfortunately are not the seasoned lot nor are they privileged to possess the essential diagnostic and/or epidemiological facilities to offer the patients the requisite scientific care. No wonder then that the patients who would ordinarily be lost in the multiphasic queues find it simple and time saving to purchase medical aid for token sums of money. The patients who resort to such quick and convenient relief measures are unfortunately not learned enough to continue the treatment to the point of

completion in standard periods of time. They lapse after a few injections, probably due to a waning enthusiasm or a waxing inability to defray even the phenomenally low injection cost, only to suffer ultimately from a sense of security of surface cure and/or a partially healed lesion with fractional treatment. Subsequent examinations of patients in this altered state do not lend to either a correct appraisal of morphology or yeild the diagnostic date in the laboratory necessary for confirmation of V. D. in general or syphilis in particular.

Where syphilis is concerned the dark-field illumination tests are negative to T. P. and the serology is either non-reactive by the VDRL slide test for syphilis or if positive it only provokes the controversial and indeterminate low-titred serologic problem. In the absence of a specific test for syphilis – say the TPI test – the diagnosis of syphilis is nothing short of a dilemma to the Venereologist. Under this circumstance the treatment rendered as per syphilis, is considered quackery while if this is withheld, the genital lesions remain refractory. Truly the days are gone when a larger proportion of early syphilitic lesions coming under the purview of the V. D. Specialist at the Institute were positive for T. P. by the D. F. I. test and a relatively small proportion yielded a reactive report, vide chart.

The histopathologic study under the circumstance is also not of much help for one thing, the T. P. are not demonstrable and for another the reports on architectural changes are just a sheaf of statements signifying 'chronic inflammation'. Further to the problematic diagnosis as alluded to above, the prognosis among the present day patterned syphilitics, whether they be nil, ill or maltreated patients, is not satisfactory. The bubble of a cure of syphilis with one injection of PAM is well nigh burst. Examples are not wanting to confirm the registration of the series of patients who after partial anti-syphilitic treatment have presented neurologic syphilis, cardiovascular syphilis, benign tertiarism in syphilis. Special emphasis has to be laid on ocular syphilis endangering vision.

There is every reason now to believe that inadequate treatment of somatic syphilis shortens the secondary incubation period whereby neurosyphilis or cardiovascular syphilis appears much earlier than otherwise.

Reinfections, once curiosities, have become common place e.g. chancres have been recorded several times in the same individual. Therapeutic paradox has to be substantiated in our experience. Treatment resistance under the umbrella of penicillin has however not been noted in our series.

Congenital syphilis is still with us. Both early prenatal syphilis and, because of several cases of untreated early prenatal syphilis, numerous cases of late prenatal syphilis have reported, many with interstitial keratitis and others with bone lesions or soft tissue gummata.

It is still an unsettled problem if certain cardiovascular and neurological conditions which are highly suggestive of luetic origin, through an elaborate elimination of other etiology, are non-syphilitic even though the only sure indicator of syphilis, namely the STS, registers a negative reaction by the VDRL test.

Serologic syphilis, the other equivalent of latent syphilis, has since figured predominantly, and low titred positive syphilis has come up to the forefront, demanding the establishment of the specific test for syphilis, the TPI test in every one of the four corners and at the centre of our country.

Gonorrhœa in the Sexes : Adult males with gonorrhoeal discharges rarely attend the V. D. Clinic except those indigent and grossly ignorant of the efficacy of and the miraculous cure wrought by antibiotics. The ordinary knowledgeable man in the street attempts self medication with the available modern drugs or has recourse to private, or philanthropic clinics. It is only when the genital discharges fail to respond to chemotherapy or antibiotic medication that the patient turns up for specialists' consultation.

While a relative antibiotic resistance has been recorded in no small numbers elsewhere, no single such case has come to our notice with our usual single dose – the standard schedule of PAM – 6 lakh units, till date. It is probable that a crop of treatment resistant gonorrhoea cases would have appeared in our country too, had lower dose schedules been adopted.

It is to the credit of antibiotic therapy and that at a higher dose schedule that besides absence of treatment resistance, cammon complications of gonorrhoea have become scarce ; para urethral ductitis, Tyson's adenitis, prostatitis and epididymitis in the male, salpingitis, oopheritis, peritonitis, pelvic cellulitis in the female, and articular affections, ophthalmia, iritis and endocarditis in both sexes have become rare ; the oft dreaded vulvovaginitis of gonococcal origin is most infrequent. Rectal gonorrhoea has not been seen at all.

It is our firm belief that the paucity of these complications may be traceable to the admission of non-gonococcal genital discharges as a definite entity in the first place as well as their concomitant complications next. It is possible that these non-gonococcal genital discharges and their complications masqueraded in the past as gonorrhoeal, especially when facilities for or enthusiasm to cultivate the Neisseriae gonorrhoeae in the laboratory was meagre ?

In women, however, a series of cases of Bartholin's abscess has been recorded. Even here, the neisseriae gonorrhoeae have not been demonstrated in the abscess pus. Attempts to culture the organism (N. G.) and subject it to sub-cultures after suspecting it through the oxidase reaction and confirming its existence through fermentation tests failed. The gonococcus complement fixation test, the type specificity test and the FAT to discriminate between non-gonococcal

aetiology, become imperative. In retrospect doubt is thrown on, whether strictures, periurethral abscesses, urinary fistulae and sterility of gonococcal origin ever existed independently at all. Could they have been due to concurrent non-gonococcal aetiology ?

Chancroid : Most venereologists do not concede the existence of chancroids as an independent entity ; that the H. Ducreyi 6 causative agent of Chncroids is a myth to them and they argue that the non-recognition of variegated non-specific genital ulcers in the past must have created the catch basket of chancroids. Nevertheless chancroids exist and often with the complication of bubos in the genital vicinity, quite independent of Herpes. Progenitalis and others, necessitating the application of specific techniques for diagnosis and special manoevres for management.

Granuloma Venereum and Lympho-Granuloma Venereum : May be clubbed together. The poor patronage offered to the prohibitively priced B. S. A's in the management of illnesses in general and V. D. in particular has helped these granulomas to thrive. Relapse, resistance development of malignancy and therapeutic paradox are a few of the features of granuloma venereum.

Lymphogranuloma Venereum : As far as Lymphogranuloma Venereum is concerned because of the wide use of sulphonamides the initial manifestations of the viral infection are little seen. Bubos are becoming rarity and whether due to inadequate therapy of early Lymphogranuloma venereum, complications in the form of ano-rectal syndrome, genito-ano-rectal syndrome with or without strictures and esthiomene with fistulae are still problematic and specific remedies have failed to influence the structural alterations.

Herpes Progenitalis : Other non-specific genital ulcers, non-gonococcal genital discharges and inguinal bubos still pose a diagnostic and therapeutic problem, not to speak of balanitis, balanoposthitis, Queyrat's disease, Bowen's disease, genital warts, molluscum contagiosum venereosum, cornucutaneum genitalis, psoriasis, lichen planus and bullous lesions about the genitalia.

The pattern of venereal diseases has certainly changed quantitatively and qualitatively with the advent of chemotherapy and antibiotics, demanding not a casual acquaintance with V. D. as was wont in the past, but a meticulous training in the composite discipline of venereology aiming at competence in the several other disciplines so as to enable one to diagnose and treat them; and above all to prevent V. D. for which protective inoculatory immunisation procedures are not available.