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ALL-AMERICA CONFERENCE ON VENEREAL DISEASES.[1]

Report on the Proceedings and the Resolutions of the General Conference Committee.

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INTRODUCTORY COMMENT.

A general conference on world problems of health conservation was called by the League of Red Cross Societies Committee at Cannes, France, April, 1919. Delegates from five nations—England, France, Italy, Japan, United States—were present. The conference agreed that the combating of the venereal diseases was one of the great outstanding problems of the present century. The holding of regional conferences in various parts of the world to further the organization of practical programs for carrying out approved measures was recommended.

The All-America Conference was the first of these regional conferences and was limited to the venereal diseases as the most urgent of the disease-prevention campaigns to be promoted by this method.

After due consideration, it was deemed best to preserve the unofficial character of such conferences, but at the same time to secure official recognition. This Conference was, therefore, called under the joint auspices of the United States Interdepartmental Social Hygiene Board, the United States Public Health Service, the American Social Hygiene Association, and the American Red Cross, with the cooperation of equivalent Federal and volunteer agencies in other countries of the Americas. Official recognition of the importance and timeliness of the Conference was secured through the exchange of diplomatic notes between the respective governments of the participating countries regarding the organization and purposes of the Conference.

The primary purpose of the Conference was to review past efforts in this field and to make a pronouncement regarding the lines along which future activities should be directed. It is expected that the proceedings and the follow-up use which will be made of the findings will stimulate concerted action among the nations participating. Particularly it is expected that within each nation the several States or divisions of Government will unite upon a common program of action.

[1] December 6-11, 1920, Washington, D. C.

The expenses of the Conference were met by appropriations or funds chiefly from the American Red Cross and from the American Social Hygiene Association, the former being the national volunteer organization representing general public interest and participation in health conservation activities, the latter being the national volunteer agency which includes among its activities the specific campaign against the venereal diseases.

The Conference membership comprised 3,000 persons of prominence representing every public and social interest and every section of the Americas. Of this number, 450 attended the Washington meetings as delegates and 136 were drafted to serve on the General Conference Committee and its sections. The Conference functioned largely through preliminary section discussion of questions submitted in advance by the members, and the reporting of recommendations from the General Conference Committee to the delegates for consideration and adoption of resolutions. There were 12 sections as follows:

1. Medical research and laboratory questions.
2. Diagnosis and treatment of syphilis.
3 and 4. Gonorrhea in the male and female.
5. Public health and administrative questions.
6. Clinic and hospital questions.
7. Statistics.
8. Public information and education.
9. Law enforcement measures.
10. Protective social measures.
11. Psychological and psychiatric questions.
12. Social service.

Each section was provided with a secretariat drawn from the personnel of the four agencies under whose auspices the Conference was held. All recommendations from subcommittees were considered by the General Conference Committee, and the latter's findings were reviewed and correlated by a Reference Resolutions Committee for submission to the delegates.

The resolutions finally adopted are included in this part of the report. It has been deemed advisable to include from the minutes and records of the Conference certain comments which explain or illustrate the views governing the delegates in their adoption of the resolution. For ready reference, at the end of each section is given the name of the subcommittee primarily concerned in the formulation of the recommendations of the section, but a full list of the General Conference Committee is given at the end of this report.

RESOLUTIONS OF THE GENERAL CONFERENCE COMMITTEE.

SECTION 1.

MEDICAL RESEARCH AND LABORATORY QUESTIONS.

To Section 1 were submitted questions relating to the establishment of immunity to gonorrhea and syphilis; questions relating to the administrative control of the manufacture and sale of arsenicals and other remedies for the treatment of syphilis; the value of complement fixation tests in doubtful cases of gonorrhea; the standardization of the Wassermann test; a question dealing with the medical aspects of venereal prophylaxis; and, finally, a question dealing with laboratory reports on smears in suspected cases of gonorrhea.

The question relating to the establishment of immunity to gonorrhea and syphilis is, naturally a most important one, since it is intimately related to the feasibility of controlling the venereal diseases by artificial immunization. The following conclusions of this section are, therefore, of special interest:

It is resolved with reference to gonorrhea, that there is no evidence of the establishment of any immunity to the disease beyond that of a more or less temporary relative immunity in the case of existing individual infections. Such a temporary relative immunity may be lost, either as the result of disturbed relations between the infecting organism and the host or through the introduction of a new gonorrheal infection.

The resolution with respect to immunity to syphilis will undoubtedly come as a surprise to those who have been unable to follow the results of the most recent scientific investigations in this field. The belief is certainly still widely held that immunity to syphilis is somewhat analogous to that produced by an attack of smallpox or that of a successful vaccination. This view, however, appears to be erroneous, for, on the basis of a mass of recently accumulated medical facts, the result of careful laboratory investigations, the section resolved, that—

There is no evidence of absolute and permanent immunity to syphilis unless it be due to an existent infection. There is evidence to show that infection may exist without obvious manifestations of disease. The immunity ensuing in such an infection may extend even to the degree of a commensal or symbiotic adaptation.

The section further resolved that the following additional considerations apply with respect to immunity in syphilis:

(*a*) Resistance to growth and multiplication of the infecting organism.

(*b*) Resistance to pathogenic effects of the organism.

In general the latter type of immunity appears to be more pronounced than the former, in consequence of which individuals may continue to harbor the organism of syphilis while possessing a more or less effective resistance to their pathogenic effects.

In view of the surpassing importance of syphilis as a public health problem, it is generally recognized that some form of effective governmental control should be provided whereby the potency and safety of the arsenicals and other remedies used for the treatment of syphilis will be assured. In dealing with this phase of the problem, the section resolved that—

Methods of biological standardization of drugs must be based upon proved properties of biologic action (pharmacologic, toxicologic, pathologic, therapeutic).

Further, before an entirely satisfactory method of standardization of arsenicals and other potent remedies used in the treatment of syphilis can be devised, a thorough knowledge of the biologic behavior of such drugs is absolutely essential.

In as far as this applies to substances of the arsphenamine group, it is recognized that existing knowledge is comparatively limited, and further information concerning their biologic properties is essential before any material alteration of present methods of standardization can be advised.

The value of the complement fixation test in doubtful cases of gonorrhea was dismissed by the section in the following brief resolution:

Resolved, That the complement fixation test has not yet been shown to be of value in the diagnosis of doubtful cases of gonorrhea.[2]

In this connection, it may be stated that several of the members of the conference committee were inclined to regard the complement fixation test as of some value in the diagnosis of obscure joint infections, but even this view subsequently gave place to that expressed by the resolution adopted.

The discordant results occasionally encountered in the reports of Wassermann tests in different laboratories have repeatedly led to the suggestion that the method of making Wassermann tests be standardized. The desirability of such standardization was discussed by the section of medical research and laboratory questions, which embodied its opinion in the following resolution:

Until there is a clearer understanding of the significance of the Wassermann reaction, standardization for diagnostic and prognostic purposes is not desirable. However, the committee recognizes the importance of the adoption of uniform methods within an active organization or for purposes of comparative investigation.

No problem relating to the control of venereal diseases has provoked more discussion than the procedure commonly termed "medical prophylaxis." Before reproducing the resolution on this subject finally adopted by the All-America Conference, the reader may, perhaps, be interested in seeing how the question of prophylaxis was

[2] This statement was supplemented by Sections 3 and 4, as follows: "It is possible, however, that the precipitin test recently elaborated by Meader and Robinson may be of great value."

viewed by some of the medical and other scientific members of the General Conference Committee. The following is the text of a resolution adopted originally by Section 2, the section which dealt with the diagnosis and treatment of syphilis:

It is resolved, That (*a*) the prevention of contact between infected and uninfected individuals is the first principle of prophylaxis. (*b*) If exposure does happen, the following methods of prophylaxis are recognized:

1. The most efficient medical measure probably is the use of a mechanical device that prevents actual contact. Prophylaxis by the use of cleansing and chemical agents before or after intercourse, when early and properly applied, has been demonstrated to have value. It is certainly, however, not a measure that is entirely effective, and its promiscuous application by the individual is open to abuse and may foster the spread of venereal diseases rather than reduce them. For this reason, the sale and use of prophylactic packages has no place in a venereal disease program.
2. Prophylactic administration of arsphenamine immediately after a known exposure to syphilis deserves consideration, but at this time no explicit statement in regard to its efficiency can be made.

This resolution was agreed to also by Section 1 (medical research and laboratory group), but with a reservation as follows:

Resolved, That the question of "prophylaxis" in all of its aspects does not fall within the scope of this section, but the section approves in general all the conclusions reached by Section 2 with reference to this question. On account of the broader biologic aspects, and because of the importance to the race, prophylaxis is not to be advised for general use. We recognize, however, the general importance, even necessity, of prophylaxis under certain exceptional conditions.

The reservations implied in these resolutions were subject to further debate by prominent proponents for greater recognition of prophylaxis and, on the other hand, by advocates of still greater limitations upon the use of such measures. On the one extreme were those who insisted on the great value of medical prophylaxis as practiced in the Army and Navy, and who saw in this resolution a condemnation of present practices. On the other extreme were those who saw in the indorsement of any form of medical prophylaxis an incitement to promiscuity, through an implied insurance against infection and tolerance of acts leading to exposure. The value of properly applied medical prophylaxis in the prevention of infection was generally conceded by both sides. The compromise finally adopted by the All-America Conference on Venereal Diseases was as follows:

Resolved, That the use of medical prophylaxis has a place of demonstrated value in the Army and Navy, and that it should be furnished after exposure, by physicians, clinics, and hospitals, to persons seeking it, but that on moral and practical grounds it should not be advertised or publicly furnished for civilian communities. The public

advertisement and sale of commercial prophylactic packets is condemned.

The last question submitted to the medical research and laboratory section was presented in the form of a question submitted to the section by Sections 3 and 4, as follows:

Can a more satisfactory laboratory report be rendered the physician than under the present method of reporting that the germ "morphologically resembles" or "has the characteristic staining qualities of" the gonococcus?

The section replied to this question in the form of the following resolution:

Resolved, When smears only are sent to laboratories for examination, pronouncement can be made only on the content of such smears. When Gram-positive and Gram-negative organisms have been added to the smear by the technician for control purposes, the laboratory report might state justifiably, "This specimen shows diplococci morphologically and tinctorially gonococcuslike—or does not."

A negative result must not be taken to indicate that gonorrhea does not exist.

Before concluding its sessions, Section 1 discussed the need of vastly greater scientific research with respect to many fundamental problems presented by the venereal diseases, and presented this in the form of the following resolution, which subsequently was unanimously adopted by the All-America Conference:

Resolved, Whereas it is generally recognized that any effective program for the control and suppression of venereal diseases must rest upon an adequate scientific knowledge and understanding of these diseases; and as such existing scientific knowledge and understanding is so limited as to constitute a serious handicap to the meeting and dealing with the problems of these diseases, this committee believes that there is an urgent necessity for the promotion and fostering of researches and investigations of the fundamental problems presented by the venereal diseases, in addition to those problems of more immediate practical bearing.

We therefore urge that this conference lend its support to the greater encouragement of pure scientific research along these lines.

Members of General Conference Committee assigned to Section 1.

Dr. George W. McCoy, chairman.
Dr. A. S. Warthin, vice chairman.
Dr. Walter F. Cobb, secretary.
Dr. Olympio Oliviera Ribeiroda Fonseca.
Dr. Tomas G. Perrin.
Capt. A. F. Ballester.
Dr. Wade H. Brown.
Dr. John A. Amyot.
Dr. M. P. Ravenel.
Dr. José S. Salas.

SECTION 2.

DIAGNOSIS AND TREATMENT OF SYPHILIS.

To this section were submitted questions relating to the application of the Wassermann test and to other diagnostic methods; questions relating to the relative value of arsphenamine, neo-prepara-

tions, other arsenicals, and nonarsenicals; questions relating to the advisability of standardizing the Wassermann test; the advisability of standardizing the treatment of syphilis; the criteria for pronouncing a patient as cured of syphilis. As a result of discussions in other sections, Section 2 was also asked to express an opinion as to the more precise limitations of the term "persons reasonably suspected of having gonorrhea, syphilis, or chancroid," as used in many of the sanitary codes.

The section dealt with the diagnostic tests in syphilis by taking up first the demonstration of *Treponema pallidum* in the various lesions of syphilis. The following resolutions cover this phase of the subject.

Resolved, That—

(*a*) The demonstration of the *Treponema pallidum* by a trained observer is all important in the diagnosis of the initial lesion of syphilis. It may be of importance in the diagnosis of early secondary syphilis and of mucous recurrences. It is of no practical importance in the diagnosis of gummata and late syphilis.

(*b*) In chancre and in the superficial lesions of secondary syphilis the diagnosis is made by the demonstration of the organism in the secretions of the lesions. In the lesions of late syphilis the demonstration must be made by an examination of tissue. Methods are also being developed for diagnosis from the tissues in early syphilis.

(*c*) The proper facilities for the diagnosis of early syphilis must include, in addition to the Wassermann test, a dark-field microscope and facilities for smear and tissue examinations.

(*d*) Failure to demonstrate the *Treponema pallidum* in genital and extragenital chancres presenting the clinical characteristics should be interpreted with reservation.

(*e*) The findings in lesions within or about the mouth must be accepted with great caution inasmuch as confusion with nonspecific mouth Spirochaeta is easily possible. In such cases the procedure of aspirating the bases of lesions and adjacent lymph nodes to obtain material for the demonstration of the *Treponema pallidum* must be considered as of value.

(*f*) Facilities for dark-field examinations ought to be available in every community.

The relative simplicity of diagnosis by means of laboratory tests undoubtedly tends to foster an undue reliance on such tests in the making of diagnoses. In the case of the Wassermann reaction this may lead to disastrous results. The section, therefore, took pains to formulate precisely the significance of the results of the Wassermann test in the following resolutions:

Resolved, That a frank reliable positive blood Wassermann reaction may be assumed to be evidence of the existence of syphilis under the following provisions and limitations:

(*a*) In the absence of all other evidence of syphilis, a diagnosis based upon a positive Wassermann reaction alone should be made with great caution.

(*b*) In the absence of all other evidence of syphilis, a positive blood Wassermann result should be repeated several times by the

original observer and verified at the time by several different observers, if possible. If possible, the presence of other conditions which might cause a positive Wassermann should be excluded.

(c) The positive blood Wassermann test should also be supplemented by a very careful search for other evidence of syphilis, including clinical, serologic, and pathologic, and other examinations.

(d) The presence of a positive blood Wassermann test does not necessarily exclude other diseases as explanations of the symptom complex presented by the patient.

(e) Weak or partial positive Wassermann reaction cannot be accepted as diagnostic signs of syphilis, but may warrant further investigation of the case in question. A weak, positive blood Wassermann reaction in children is no more significant than in adults.

Resolved, That the negative Wassermann reaction should be interpreted in terms of the following limitations and conditions:

(a) In the differential diagnosis of syphilis, a negative blood Wassermann test can not be regarded as evidence of the absence of the disease.

(b) In the early primary stage of syphilis the blood Wassermann test is expected to be negative.

(c) In the active secondary stage, a repeated negative blood Wassermann test is a rare occurrence and should be accepted only after a very careful examination of the case.

(d) In all the forms of late syphilis, especially in those which have been treated and in women in whom the disease may be otherwise symptomless, it is not uncommon to meet with a negative Wassermann reaction, and too much importance should not be attached to such a finding in suspected cases.

(e) For purposes of diagnosis, attention should be drawn to the importance of recognizing by repeated tests the transition from the negative to the positive blood Wassermann in primary stages of the disease.

Closely related to the preceding is the employment of the so-called "routine Wassermann test," concerning which there is still considerable misapprehension. In this connection it may be recalled that here and there the routine Wassermann test has been employed by health officers in the examination of food handlers. (See also page 1600.) The final paragraph of the following resolution constitutes an answer to the question: "Should a routine Wassermann test be part of every medical examination of expectant mothers? In private practice? In maternity clinic service?"

Resolved, That with reference to the so-called routine Wassermann test, the following considerations apply:

(a) A routine Wassermann test should not be relied upon as the sole means of identifying syphilis in any group of persons under consideration, but should be employed merely as part of a general examination.

(b) A routine Wassermann test should not be used in such a way as to create the impression that a person with a positive blood Wassermann reaction is infectious or that one with a negative blood Wassermann reaction is not infectious. It is more important to emphasize the taking of the Wassermann test in early adult life, when it is likely

to be significant, than to indiscriminately make it on the basis of occupation.

(c) In any occupation which demands a general examination for the protection of the worker or in which complications due to syphilis following injury are likely to arise or in which the safety of the public is involved a routine Wassermann test should be a part of the procedure.

(d) A blood Wassermann test, subject to the interpretations given above, should be a part of a medical examination given expectant mothers. No distinction should be made between patients in private practice and in maternity clinics.

There has also been a tendency to base the commitment of certain persons to prison hospitals on the results of the Wassermann test. Inasmuch as such commitment is generally undertaken on the theory that the action is necessary in order to prevent the spread of infection, it is obvious that a positive Wassermann reaction is then regarded as evidence of infectivity. The section dealt with this matter as follows:

Resolved, That with reference to the application of the Wassermann test to the commitment of persons to a prison hospital or detention home, the following considerations apply:

(a) No one should be committed to a prison hospital on the evidence of a single positive Wassermann test, inasmuch as it is not evidence that the patient is a source of infection.

(b) The finding of a single positive blood Wassermann test should be supplemented by a complete examination with special reference to other signs and symptoms of syphilis. The demonstration of active syphilis by such a procedure may require continued observation, and a proper authority should be empowered to detain such a person for that purpose. Any evidence of syphilitic infection of less than two years' duration should be sufficient for detention pending examination of a prostitute. In the exceptional case, the time limit can not be regarded as arbitrarily fixed. It will be apparent that the standard of commitment is not the positive outcome of a Wassermann reaction but the presence of active syphilis.

But not only in these diagnostic phases is the Wassermann test often misapplied and misinterpreted. An equally common misuse of the test is in connection with the treatment of syphilis, and especially as an evidence of "cure." The following pronouncement of this section may therefore be of interest:

Resolved, That with reference to the use of the Wassermann reaction as a guide to the treatment of syphilis, the following considerations apply:

(a) A positive Wassermann is a symptom of syphilis under the conditions mentioned above, and its disappearance should have the same weight as the disappearance of another symptom of the disease.

(b) The peculiar value of blood Wassermann reaction in the treatment of syphilis lies in the fact that it may be elicited when other symptoms are absent, and that it may indicate a recurrence of the disease when other symptoms are absent.

(c) The blood Wassermann reaction should not be used as a sole guide to the duration of a syphilitic infection. The blood Wasser-

mann reaction should not be used as sole evidence of the effectiveness of a particular drug or method of treatment.

(*d*) The blood Wassermann reaction should not be used as sole evidence of "cure," no matter how many times repeated.

In this connection the reader's attention is called also to the statement regarding evidence of cure, as given on page 1602.

Prompted by the section's pronouncement with respect to the routine Wassermann test as applied, for example, to food handlers, the section was asked: "Has the very general legislation regarding food handlers (infected with venereal diseases) been justified by the known facts relating to the extragenital transmission of venereal disease?" To this the section replied as follows:

The section recognizes the basic principle of examination of individuals engaged in occupations where there is danger of transmission of venereal disease because of the nature of the occupation. The removal of such an individual from his occupation on account of the presence of a communicable disease, including venereal disease, should be determined by considerations based upon definite danger of transmission to others, due to the nature of the occupation and the state and stage of the disease.

The same subject was touched upon in a series of pronouncements dealing with the problem of syphilis in professional, business, and industrial life, as follows:

Resolved, That the relation of the syphilitic to his work and his fitness for it is determined by—

(*a*) The possibility of his transmitting the infection through the bringing of others into contact with unsterilized moist material from infective lesions.

(*b*) By the effect of syphilis upon the individual's efficiency and trustworthiness as a cooperative, industrial unit, through its action in damaging his vital structures such as the heart and nervous system.

(*c*) By the effect of syphilis in lowering resistance and promoting complications to strain and injury incident to his occupation.

In any case where the individual presents infective lesions whose secretions may be transmitted unsterilized to others through direct or indirect contacts, the persons presenting such lesions should be denied the continuance of an occupation endangering others until treatment and observation shall have shown him to be free from infective lesions.

In interpreting the term "unsterilized" due regard must be had for the known characteristics of the organism of syphilis.

In the above case and in any case where the risks of the occupation may induce complications due to syphilis, or fellow workers and the public be endangered by lowered individual efficiency induced by the disease, periodic effective general medical examination is recommended. The items of such an examination should be arranged by consultation between the syphilologic expert and the industrial physician or public health official for the particular industry concerned.

Taking up next the treatment of syphilis and answering specifically the question as to the relative value of arsphenamine, neo-prepara-

tions, other arsenicals, and nonarsenicals, the section offered the following resolutions:

Resolved, with respect to the treatment of syphilis, as follows: That—

(*a*) The value of mercury in the treatment of syphilis is established, and its combined use with the arsphenamines constitutes the best modern practice.

(*b*) The iodides remain a useful adjunct in the treatment of certain phases of syphilis.

(*c*) The relative value of arsphenamine and neo-arsphenamine is not determined with sufficient explicitness to warrant a statement at the present time. The value of both preparations is acceptable.

(*d*) The value of arsenicals other than the arsphenamine group is relatively so much less than that of the arsphenamines that they are not worthy of general use in the treatment of syphilis.

(*e*) Other methods of treatment than those involving the use of the arsphenamines, mercury, and the iodides are of subsidiary importance and can not be relied upon as having therapeutic value.

(*f*) Such methods in the treatment of syphilis must be considered as being in the experimental stage.

The suggestion has repeatedly been made that the treatment of syphilis be standardized. This, however, was emphatically rejected by the section. The formulation of minimum requirements, however, was deemed to be justified. Following is the text of the resolution adopted:

Resolved, That with our present knowledge of the various factors involved in the treatment of syphilis, standardization of procedure is not possible. On the other hand, we believe that opinion is sufficiently united upon minimum requirements to justify their formulation as a practical guide. The following considerations deserve special emphasis:

(*a*) In treating syphilis we are treating an individual as well as a disease.

(*b*) The time which has elapsed since the inauguration of modern methods of treatment and our knowledge of the pathology and the pathologic physiology of the disease are insufficient for final conclusions.

It is further resolved, That the outline of the method of treatment now detailed in the Manual of Treatment of Venereal Diseases (the "Red Book" of the United States Public Health Service), published by the American Medical Association, be continued as a guide to the minimum requirements of treatment until supplanted by something better.

The section emphasized the treatment of the infectious lesions as of great importance to the control of the spread of syphilis, and pointed out that control of infectiousness demands attention to the following measures:

(*a*) Early, energetic, prolonged, systematic, and intelligent treatment with arsphenamine and mercury.

(*b*) Careful early instruction of the patient in the hygiene of the syphilitic.

(c) Greater attention on the part of the medical profession to the recognition and treatment of patients showing a tendency to the relapse of infectious lesions.

This was supplemented by the statement that:

At the present time the points of disagreement among experts with reference to the infectiousness of syphilis are so numerous that it is not possible to formulate a standard that will be generally accepted. It is the sense of the All-America Conference that this field of investigation deserves intensive study.

The section urged the great importance of ensuing adequate treatment for syphilis, referring especially to the tendency on the part of patients to discontinue treatment when manifest signs and symptoms of the disease have disappeared. It was resolved that:

There is great need for the following up of cases of syphilis and a system of follow-up should be provided for in their management. The purpose of such a system is to enable the physician to detect signs and symptoms of recurrence of the disease and to provide for continuation of treatment.

In this connection the reader is referred also to the resolutions adopted by Section 5 dealing with those who discontinue treatment while still in the infectious stage (page 1608), and to the physician's duty with respect to such cases (page 1610), and to the system of social-service follow-up (see page 1631).

Since the object of treatment in syphilis is not only to control the infectious lesions, but also, if possible, to effect a cure of the infection, the question naturally arises, What constitutes a "cure"? So far as the employment of the blood Wassermann test for this purpose is concerned, the matter has already been dealt with in the resolution on page 1599. It is now well known that the blood Wassermann reaction may be negative while the reaction of the spinal fluid may still be strongly positive. The section dealt with the evidence of "cure" in the following resolutions:

Resolved, That inasmuch as the researches of recent years have demonstrated that the cerebrospinal fluid may present evidence of the presence of syphilis in the absence as well as the presence of other laboratory and clinical signs of the disease, that the complete examination of the spinal fluid should be employed in the diagnosis and treatment of syphilis in the determination of presumptive cure and in the reexamination of patients under observation. It should be used at such times and in such a manner as competent medical judgment in the individual case may direct.

That the problems presented by the diagnosis and treatment of syphilis are so complex, and the medical decisions at critical moments in its course are so momentous for the individual and society, that persons who have the disease and organizations charged with the medical management of syphilitics should be under the supervision of experts. We recommend that as soon as possible representatives of the private physicians and public agencies carrying on this work

meet to determine as far as possible the training, qualifications, and status of the syphilologic expert.

That with our present knowledge of the disease and its treatment, no generally accepted rule for the determination or attainment of the cure of syphilis can be formulated which shall have practical applicability. This statement must not be interpreted as denying the possibility in the individual case of reducing the disease, by properly combined observation and treatment, to a condition of arrest or latency in which neither the individual nor society at large suffers further ill effects from its presence. The statements made with respect to the prevention of infectivity have equal weight in the effort to achieve the goal of cure.

What has just been said regarding evidences of cure is of immediate applicability to the question so frequently asked by the syphilitic, "When may I safely marry?" Following are the section's conclusions on this point:

Resolved, That with reference to the eligibility for marriage of the individual who has or has had syphilis the following medical considerations apply:

1. The eligibility for marriage of the person who has or has had syphilis depends in the main upon the possibility of his transmitting the disease.
2. The impossibility of absolutely determining by arbitrary rule the limits of infectivity in all cases has been admitted.
3. The problem may be more difficult of solution in women than in men, owing to the paucity of clinical and laboratory evidence of the disease in the former.
4. The clinical experience of many years has justified, as reasonably safe, the following fundamental requirements:

(*a*) Three years of effective treatment.

(*b*) Two additional years of freedom from all signs and symptoms of the disease, under medical observation.

5. It is recognized that special types of cases may call for special interpretation, which, however, in all cases should be founded on the basic principles of effective treatment and prolonged painstaking observation for signs of recurrent or active syphilis.
6. In view of the inevitable element of uncertainty, however small, the prospective marital partner of a person who has or has had syphilis should be informed before marriage of the status of the case.
7. Medical examination to establish the presence or absence of syphilis before marriage should include not merely a blood Wassermann test but an examination, clinical and serologic, of the entire body. If evidence of a previous or probable syphilitic infection presents, such examination should be especially searching, may include a period of observation, and should be interpreted by an expert.

Members of General Conference Committee assigned to Section 2.

Dr. John H. Stokes, chairman.
Dr. Grover W. Wende, vice chairman.
Dr. William S. Edler, secretary.
Dr. Martin F. Engman.
Dr. John A. Fordyce.
Dr. H. H. Hazen.
Dr. Gayetano Masi.
Dr. W. A. Pusey.
Dr. Harry C. Solomon.
Dr. Homer F. Swift.
Dr. Angel Brioso Vasconcelas.

SECTIONS 3 AND 4.

GONORRHEA IN THE MALE AND FEMALE.

Originally it was deemed wise to consider gonorrhea in two sections—one devoted to gonorrhea in the male, the other to gonorrhea in the female. It was thought that the latter group might well consider such problems as vulvovaginitis in infants, and that the referees dealing with such a question would probably be but little interested in discussion of gonorrhea in the male. When the respective sections began to consider the problem presented to them, however, they unanimously decided it would be preferable to join and meet as one section, taking up the subject of gonorrhea as a whole.

The combined Sections 3 and 4 thereupon considered questions relating to effective methods for treating gonorrhea, questions as to criteria which might be used in determining whether and when a case of gonorrhea is "cured," and the very troublesome vulvovaginitis in infants and young children. In addition to this, attention was given to the diagnosis of gonorrhea.

Taking up, first, the last-mentioned item, it may be pointed out that this naturally involves both clinical and laboratory procedures. The section accordingly resolved that—

With our present knowledge the diagnosis of gonorrhea must rest upon the acumen and skill of the physician in weighing the clinic and laboratory evidence. The use of the microscope by the clinician at the time of treatment may be supplemented by the laboratory expert.

So far as laboratory diagnosis is concerned, both bacteriological and serological methods come under consideration. This phase of the subject was accordingly referred to Section 1, which reported on the matter as already referred to in the resolutions on pages 1594, 1596.

Passing now to the treatment and "cure" of gonorrhea, Sections 3 and 4 pointed out that with our present knowledge of the many factors involved no dogmatic statements could be made. In expressing themselves on the subjects presented to them the sections hoped this would "result in making available for those infected with gonorrhea more adequate care and treatment than in the past."

If the minimum requirements as now laid down in available textbooks were generally carried out by the average physician, gonorrheal infections would be cured and prevented more frequently.

Since diagnosis and treatment of gonorrhea in the female has not reached the same degree of perfection as in the male, the importance of greater effort and attention on the part of the general practitioner and the specialist to the diagnosis, treatment, and cure of this disease must be emphasized.

In view of the statement above, it is recommended that the question of the diagnosis and treatment and prevalence of gonorrhea in the female be more intensively studied, and that the results of such investigation be made available to the medical profession at large.

It is further recommended that special study be made of the methods employed in the diagnosis and treatment of vulvovaginitis in infants and young children, and that the results obtained by present methods be tabulated in an attempt to ascertain the most effective method for treating this condition.

It is further recommended that the outline of the method of treatment now detailed in the Manual of Treatment of Venereal Disease (the "Red Book" of the United States Public Health Service), published by the American Medical Association, be continued as a guide to the minimum requirements of treatment of gonorrhea until supplemented by something better.

Bearing in mind the glib promises of cure made by the medical quack and the promoter of patent nostrums, attention is called to the cautious statements made by recognized authorities when asked to determine criteria for pronouncing a case of gonorrhea cured.

Following is a text of the resolution adopted by the sections:

Resolved, That with our present knowledge it is not scientifically and medically practicable to establish a standard for determining when gonorrhea is cured. This statement, however, must not be understood as reflecting upon the ability of any specialist to make such a decision.

In the female the condition is complicated, on account of the fact that the primary manifestations may be so slight as to cause the patient no annoyance, but particularly on account of the tendency of the disease to become latent. This latency is due to the fact that a minimal number of gonococci may be retained for months in a quiescent state in the depths of the cervical glands, and under certain conditions suddenly begin to multiply and give rise to an extension of the disease, accompanied by clinical symptoms. Accordingly, the disappearance of the initial clinical symptoms and the apparent freedom of the cervical secretion from gonococci do not necessarily indicate that the disease is cured.

On the other hand, in the male it is practicable to establish a reasonable standard for determining when gonorrhea has been "probably cured." The criteria are based upon two distinct entities—(*a*) cure of the infection; (*b*) cure of the lesions of the disease.

In gonorrhea, whether in the male or female, the duration of infectiousness has but a single slight relation to duration of the lesions—that is, the symptoms may continue long after the infectiousness has ceased, and, conversely, infectiousness may persist after all obvious symptoms have ceased.

As the problem is confined exclusively to the question of infectiousness, the word "cure," as here used, will be understood as equivalent to cessation of infectiousness.

There is no combination of clinical facts which constitutes conclusive evidence of a cure of gonorrhea in the male. Therefore, the determination as to whether cure has been effected depends upon the acumen and skill of the physician. The patient may be assured that he is probably cured if all of the following criteria are fulfilled:

(*a*) No urethral discharge whatever for one month, during which time the patient is under observation without treatment.

(*b*) The first ounce of urine passed in the morning free from any cloud of pus, as examined in a glass or bottle by a strong light.

(*c*) All shreds in the urine continue to float at least two minutes after agitation of the fluid has ceased.

(*d*) Massage of the prostate and seminal vesicles expresses a fluid which, when examined under the microscope, is found to contain no gonococci or pus cells.

(*e*) It should be possible to pass a 26–F sound into the bladder, and examination the following day should satisfy conditions *a* and *b*.

(*f*) If these findings are confirmed at a second examination one month later, during which time there have been no symptoms or treatment, the patient should be regarded as cured.

All other cases should be examined by an expert, in order to determine whether or not they are cured.

Members of General Conference Committee assigned to Sections 3 and 4 (consolidated in their report).

SECTION 3.

Dr. Edward L. Keyes, jr., chairman.
Dr. Alec N. Thomson, secretary.
Dr. John H. Cunningham.
Dr. A. S. Desloses.

SECTION 4.

Dr. Charles C. Norris, chairman.
Dr. Walter M. Brunet, secretary.
Dr. F. Castillo Najera.
Dr. J. Whitridge Williams.
Dr. Rachelle S. Yarros.

SECTION 5.

PUBLIC HEALTH AND ADMINISTRATIVE PROBLEMS.

It is of striking interest to realize that by far the greatest number of questions coming before the All-America Conference had to do with various phases of administrative control of the venereal diseases. When it is realized that the entire organized attack on these diseases as a health problem is less than a decade old, a survey of the matters discussed by this section comes as a revelation of the enormous amount of progress already made in this difficult field.

Among the questions placed before this section was the very broad one as to the responsibilities of the Federal, State, and local authorities in combating the venereal diseases. In this connection the following resolution was passed:

Whereas, recognizing that venereal diseases are perhaps the most widely distributed of the communicable diseases, that their cure is most difficult and uncertain, that those infected are rarely totally incapacitated, it is

Resolved, That the Federal Government, in addition to its responsibility for the control of venereal diseases in the Army and Navy and Federal institutions, and its quarantine relating particularly to the merchant marine and to immigration, should assume responsibility for the enactment of needed legislation for general educational propaganda and for granting assistance to the States by appropriation of funds so that, as far as possible, uniform and efficient measures may be enforced in all States.

Answering the question further, the section resolved that the responsibility of the State should include:

(*a*) Necessary legislation.
(*b*) Adequate appropriation for:
1. Laboratory diagnosis.
2. Treatment of those in State institutions and indigents in the infective stage.
3. General education, e. g., information for the medical profession concerning the social aspects of the venereal diseases and for the public in regard to the character and treatment of these diseases.
4. Supervision of, and rendering expert aid to, the local authorities.

So far as municipalities are concerned, the section resolved that the responsibility of these should include:

(*a*) Cooperation with the Federal and State authorities.
(*b*) Enforcement of Federal and State legislation within the jurisdiction of the municipalities.
(*c*) Enactment and enforcement of any auxiliary legislation needed.
(*d*) Provision of adequate facilities for institutional care, control, and treatment.

To what has been said, the section added the following:

Your committee feels that the responsibilities, being distributed as they are through the Federal Government, the State and local municipalities, can best be coordinated by the surgeons general of the United States Public Health Service, the Army, and the Navy, aided by an advisory board chosen from State and municipal health authorities.[3]

Among the measures for securing the administrative control of venereal diseases, great weight is naturally laid on the development of an effective system of notification of cases of venereal disease to the health authorities. It is conceded that at the present time such notification is far from effective. Dealing with the problem thus presented the section adopted the following resolution:

Resolved, That where legislation requiring it does not exist it should be provided and that effective notification can be promoted by:
(*a*) An educational campaign directed to the physicians and the people as to the importance, the nature, and the dangers of these diseases; and
(*b*) The provision of adequate and readily available facilities for the diagnosis of these diseases and the instruction of the medical profession and the people of the importance of their utilization; and
(*c*) The provision of adequate and readily available facilities for the treatment and wide dissemination of knowledge in the medical profession as to methods of treatment.

[3] Since the surgeons general of the Federal services mentioned are each subordinate to the secretaries of their respective departments, this plan is practically the same as that now in operation through the Interdepartmental Social Hygiene Board. The proposed advisory board is a new feature.

It is of course folly to insist on notification of venereal diseases without making every effort to utilize such notifications in better controlling the venereal diseases. In response to a question as to how such notifications might be utilized effectively the section submitted the following summary reply:

(*a*) To trace sources of infection.
(*b*) To make possible the enforcement of effective treatment.
(*c*) To supply statistical information as follows:
1. The prevalence of venereal diseases within a given population.
2. The part played by prostitution, commercialized and clandestine, in spreading infection.
3. The part played by congenital infection.
4. The relation of infection to the sexes, conjugal condition, race, age, social and industrial groups.
5. The relation of alcohol to venereal diseases.
6. The relation of narcotics to venereal infection.
7. The relation of venereal diseases to insanity, to feeblemindedness, to delinquencies, to tuberculosis.

Even a little experience with administrative measures for the control of venereal diseases is sufficient to impress one with the importance of insuring sufficient treatment of a patient infected with venereal disease to render such patient noninfective. This is often a difficult problem. The matter has already been touched upon in one of its phases in the resolution of Section 2 dealing with the need of a system of follow-up (see page 1602), and it is also referred to again by Section 5 (page 1609), and referred to by the Section on Social Service (page 1631).

From the standpoint of public health administration, the question of adequate duration of treatment is naturally limited to the infectivity of the lesion. Desirable as more prolonged treatment may be for a given case of venereal disease, the health officer has practically no power to insist on treatment once the infective stage has passed. In dealing with this problem the section accordingly adopted the following resolution:

Resolved, (*a*) That effective isolation and adequate treatment be provided for those persons who, while still in the infective stage, disregard the care required for the protection of others; and (*b*) that noninfectious persons, although not cured, be fully advised of the nature of their diseases and the sequelae without being detained.

The section placed itself on record as favoring the provision of reformatories and other institutions where isolation can be provided in suitable cases for those infected with venereal diseases in an infective stage. The section resolved:

That the isolation now exercised by reformatories and other institutions, where infective persons are detained, is limiting the spread of venereal diseases and will increasingly do so as such places are further developed.

The close relation existing between certain phases of law-enforcement measures for the control of venereal diseases and those for the suppression of commercialized prostitution has not infrequently led to the employment, by police officers, of the sanitary code as a substitute for the criminal code in dealing with vice. The section placed itself on record as strongly deprecating such action on the part of police officers.

An attempt has been made to deal with venereal infection, especially as it occurs in inmates of bawdy houses, by placarding the premises in the same manner that premises are placarded for scarlet fever, smallpox, and other dangerous communicable diseases. The following resolution adopted by the section deals with this method of attack:

Whereas, since too little information is available for giving a satisfactory statement as to the results of placarding premises quarantined for syphilis and gonorrhea; and,

Whereas, because of the nature of the diseases, their prevalence, and the widespread ignorance of their true character:

It is resolved, That the placarding of premises for the purpose of control of patients will be more harmful at this stage to a developing sympathetic public opinion than the (problematical) control of such individuals will benefit the public welfare.

In this connection and in other phases of venereal disease control work the suggestion has been made that the health officer's power to deal with venereal diseases be limited as compared with his power to deal with other communicable diseases. To this the section protests as follows:

Resolved, That no restrictions should be placed upon the powers of the health officer in preventing the spread of venereal diseases, but permission must be granted him to exercise his judgment as to how such powers shall be employed.

The section urged States and municipalities to recognize their responsibilities with respect to the venereal diseases in dealing with persons confined and committed to penal institutions. Following is the text of the resolution:

Whereas, The diagnosis and treatment of venereal diseases should be generally applied as the local conditions will permit; and

Whereas, The State should recognize this responsibility in the conduct and management of its institutions:

Resolved, That a routine laboratory examination should be made on all men and women confined in State penal institutions at the time of their admittance, and in municipalities where the facilities are available laboratory examination should be made on all persons sentenced to penal institutions, and no person should be admitted without clinical examination to detect the existence of syphilis or gonorrhea.

Mention has several times been made of the method of dealing with patients who discontinue treatment while still in an infective stage. The subject once more demands attention, this time in answer to the

question, "To which does the physician owe his first duty in venereal disease, to the patient or to the public welfare?" In passing, it may be of interest to remind the reader that the position here taken by the All-America Conference has recently been upheld by the Nebraska Supreme Court. Following is the text of resolution adopted by the section:

Whereas, Because of the prevalence and communicability of the venereal diseases, and because of their great menace to the public; and

Whereas, This is an occasion when a careless or irresponsible patient may do untold injury to his associates unless he carefully follows the instructions of his physician:

Resolved, That protection of the public must take priority over the obligation to the individual, and while it is always desirable that the relationship between the physician and the patient should be confidential, that when a physician feels that the patient can not be trusted to follow his advice, his duty to the public demands that he exercise whatever means are at his command for their protection.

It has long been recognized that an adequate program for dealing with the venereal diseases demands the suppression of self-treatment by patent nostrums and treatment by unqualified and unscrupulous practitioners. The following resolution was adopted:

Whereas, Qualified physicians have repeatedly pointed out the great difficulty with which the venereal diseases can be successfully treated:

Resolved, That self-treatment, the use of advertised nostrums, and treatment administered by unqualified practitioners, not being effective and affording a false sense of being cured, tend to increase the spread of venereal diseases and the ravages which they cause in direct proportion to their respective uses. The very nature of such treatments prevents the securing of accurate data as to the spread of these diseases.

Resolved, In consideration of the importance of securing the most approved treatment for infected persons, that advertisments of quack medicine and treatment be prohibited by the enactment of Federal legislation withholding patent or license for the sale or distribution of such drugs and forbidding the use of the mails for the purpose of transmitting advertisements of such medicine and treatments, and that the States enact suitable legislation prohibiting similar advertisements pertaining to venereal diseases and their treatment.

Because of the frequency with which venereal infection, especially of women and children, is due to the transmission of the disease through marriage, a number of States have enacted laws providing a measure of control through conditions attached to the granting of marriage licenses. Without discussing the detail of how such a plan may best be carried out, the section expressed its approval of State action in this direction. Following is the resolution adopted:

Resolved, That the State's attempt to govern the issuance of marriage licenses is justifiable because it tends to protect the innocent from infection and limits the spread of venereal diseases if effectively carried out.

So far as the United States is concerned, there is reason to believe that the so-called "segregated district" is a thing of the past. The question has repeatedly been asked as to what evidence exists that the general abolition of these districts has given satisfactory results so far as the control of venereal diseases is concerned. Presented to Section 5, the following answer was returned:

Whereas, due to the fact that the general handling of venereal diseases from an epidemiological point of view was coincident with the general abolition of segregated districts; and

Whereas, the section believes that the abolition of segregated districts has materially decreased venereal infection; Be it

Resolved, That there is not available sufficient concrete evidence to make a definite statement.

Though not originally presented through Section 5, the following self-explanatory resolution adopted by the All-America Conference is placed at this part of the report because it has to do largely with administrative matters:

Whereas, in certain localities it is deemed necessary or advisable to have a dual system of service and regulations in community affairs because of differences in race, language, customs, or other variant conditions;

Resolved, That if practicable in the program for venereal-disease control and the promotion of the preventive measures of social hygiene (1) conscious and adequate provision be made for groups thus classified, and (2) interested and trained members of these groups be secured to assist, by counsel and service, in the carrying out of the full program for the whole community.

As indicated under Section 9, page 1626, considerable discussion occurred among the delegates in attempts to define the powers and limitations of the health officer with reference to detention for medical examination of persons suspected of being infected with a venereal disease. Various opinions were expressed to the effect that innocent persons have been victimized and degraded by unwarranted detention and examination or have been blackmailed to escape such procedure. Recognizing the value of the statute when properly utilized, yet insistent that the rights of innocent persons should be safeguarded, the Conference finally adopted the resolution given below. The original draft of this resolution, prepared by a special committee with representatives from practically all the sections, concluded with the following:

Resolved, That everywhere adequate facilities for voluntary examination and treatment of venereal disease be provided, together with a constructive program for re-education, industrially, morally, and socially;

That increased effort be made through protective and educational work to eliminate conditions that make for prostitution and disease, to the end that youth be safeguarded and its exploitation prevented.

This was subsequently modified and redrafted as the result of discussion in the General Conference Committee and in the evening sessions of the full meeting of the All-America Conference. As finally adopted, the resolutions are as follows.

Whereas, there is urgent need for a decision as to standards by which health authorities may decide who are reasonably suspected of having gonorrhea, syphilis, or chancroid; and

Whereas, the powers of the health officer in reference to the control of communicable disease in general should not be abridged when applied to the control of gonorrhea, syphilis, or chancroid; and

Whereas, voluntary examination and treatment have proved successful when with this medical treatment are united the social forces of rehabilitation:

It is hereby resolved, That the All-America Conference urges the further intensive study and extension of the possibilities and applications of voluntary examination and treatment, but, in view of the undeveloped possibilities of such a program and the urgency of the problem of transmission of gonorrhea, syphilis, and chancroid, the following formulations, more precisely defining those who may be reasonably suspected of having gonorrhea, syphilis, or chancroid and the mode of procedure in regard to them, are recommended for the practice of the United States:

(*a*) All persons who are known to have been exposed to gonorrhea, syphilis, and chancroid shall be examined. This knowledge should come to the health officers from sources in addition to the police.

(*b*) All persons who have been convicted of recent sex offenses involving promiscuity may be reasonably suspected of having gonorrhea, syphilis, and chancroid and be examined accordingly.

Members of General Conference Committee assigned to Section 5.

Dr. W. S. Rankin, chairman.
Dr. Joseph S. Lawrence, Secretary.
Dr. Peter Bryce.
Dr. Hermann M. Biggs.
Dr. Oscar Davis.
Dr. A. H. Desloges.

SECTION 6.

CLINIC AND HOSPITAL QUESTIONS.

In connection with the care and treatment of the venereally infected, a number of questions have arisen dealing with clinic and hospital methods. Thus, Is it preferable to establish special venereal disease clinics apart from other clinics? Should all applicants be treated at public venereal disease clinics even though they may be able to pay? Should general hospitals accept cases of venereal disease? If so, what special facilities, if any, do they require? Are clinics continuing treatment of their patients sufficiently long to lead to results of permanent value?

These questions were dealt with in the following resolutions prepared by the section and subsequently adopted by the Conference as a whole:

Resolved, That relative to the advantages or disadvantages of having venereal disease clinics separate from other clinics there is no ad-

vantage in having a venereal clinic separated from a general clinic when the circumstances are such that a general clinic can be maintained. By way of exception it is recognized that a problem exists in certain cities which can better be met by a separate clinic conveniently located. Such a clinic had best be considered as an emergency provision and as a feeder for the main clinic attached to the general dispensary or hospital. However, it is believed that the establishment of a separate venereal disease clinic under these conditions should be advocated only when the maintenance of a general emergency clinic in that locality is impracticable.

It is further resolved, That the advantages of having the venereal disease clinic operated in conjunction with other clinics and under the direction of a trained personnel are as follows:

1. It promotes recognition by the public that venereal diseases are being dealt with exactly like other diseases. This is of great value in bringing about a proper attitude on the part of citizens in general toward the prevention and control of these diseases.

2. By placing the treatment of venereal diseases on a parity with that of other diseases it tends to establish a precedent for the admission of these patients to general hospitals on the same basis as other patients.

3. The treatment of venereal diseases in the same institution with other diseases promotes a better understanding on the part of young physicians, especially internes and medical students, regarding the importance of these diseases and of the true relationship between them and other pathological conditions.

4. The cost of operating a venereal disease clinic is much less when combined with a general clinic where the services of consultants, attendants, and other personnel, laboratory facilities, complete medical and surgical equipment, quarters, and general utilities are available without commensurate increase in overhead expense. When the venereal disease clinic is maintained separately it is more difficult to obtain the services of internists, neurologists, ophthalmologists, etc.

5. More patients will seek treatment at the general clinic because:

(*a*) Many patients are not aware that they are infected with venereal disease when they apply for treatment.

(*b*) The established general institution is more likely to gain and hold the confidence of its patients.

(*c*) The patient attending the general clinic is not thereby stigmatized as a venereal disease patient, as might be the case if he went to a clinic exclusively devoted to venereal diseases.

In dealing with the treatment, at public venereal clinics, of patients able to pay a private physician's fee, the public health aspects of the problem are clearly recognized, as may be seen from the following resolution:

Resolved, That in general, treatment at public venereal disease clinics should be limited to those unable to pay ordinary private fees, but no person who applies at the clinic should be refused diagnosis, advice, and initial treatment, even though subsequently referred to private physicians.

It is believed that such clinics should never charge more than a nominal fee.

The reader may be interested to see how once more adequate follow-up work is emphasized as necessary in dealing with the treatment of venereal diseases. The resolution is framed in answer to a question as to the sufficiency of treatment at clinics.

Resolved, That while there are no statistics available upon which to form a decision as to whether patients are being treated long enough in clinics to be of any permanent value, there is an impression gathered from general information that in many cases treatment is not continued long enough to be of permanent value. It is recognized that sometimes the clinic is at fault and sometimes the patient. Adequate follow-up work by public health nurses or social workers is necessary. There is an obvious need of precise information which can only be secured by careful surveys and proper statistical methods.

The admission to general hospitals of patients requiring hospital treatment for venereal disease is emphatically recommended by the section for the following reasons:

1. This has been shown to be entirely practicable by the experience of the Army and the Navy.
2. General hospitals do as a matter of fact accept many patients with gonorrhea and syphilis in an active stage on account of a complicated or intercurrent disease. They might just as well accept them as venereal disease patients.
3. The acceptance of such patients by general hospitals in most communities is necessary if a sufficient number of beds is to be provided to meet the need for hospital care. The provision of beds for cases requiring treatment in hospital is an important measure in any well-planned attempt to prevent and control the spread of venereal diseases.
4. Hospitals should do their part in the program for the control of venereal diseases by recognizing them as serious diseases worthy of skillful diagnosis and treatment without discrimination.

The section gave the following list of special facilities required if cases of venereal disease are admitted to hospitals for treatment:

1. Facilities for adequate concurrent disinfection such as are required in the case of pneumonia or tonsillitis and typhoid fever, i. e., sterilization of dishes, utensils, etc., used by the patient and disinfection of discharges and articles which may have been contaminated.
2. A ward dressing or operating room for examination, dressings, and minor surgical procedures.
3. Such special instruments as are required in the ordinary practice of genito-urinary surgery and syphilology.
4. Employment of specialists on the staff or at least the best skill available in the community.

Where a general hospital is supported in whole or in part by public funds, the section resolved that the hospital "should be compelled to accept venereal disease patients under the same conditions as other patients are accepted."

The section also studied the question of medical records of venereal disease patients, and pointed out that from the standpoint of

later study such records are of sufficient importance to "warrant an attempt at a standardized record or at least one including a required minimum amount of data." Such a record should comprise:

1. Census data.
2. Data as to date of infection, geographical source of infection, social status of infected person, medical prophylactic measures used, if any.
3. Concise but sufficiently definite data to support the diagnosis.
4. Laboratory findings.
5. Definite notes on treatment, progress, and conclusion of the case.
6. Social data.

It is recommended that machinery be developed, or, if it is in existence, that it be utilized, to formulate a model record which may be incorporated in a future edition of the "Red Manual" or other publication.

The section also took up the advisability and feasibility of diagnosing or treating venereal disease in the medical department of an industrial plant, and expressed the view that "this is an important problem and should be given careful study." Continuing, the section stated that:

Information is not at hand upon which to draw conclusions for the formulation of a definite general principle. It may be advisable and feasible to diagnose and treat venereal disease in a plant so situated that adequate facilities are not otherwise available. In other instances it would seem more advisable for the plant to take such share of financial responsibility in a community clinic as seems best in the interests of the plant and its employees.

Members of General Conference Committee assigned to Section 6.

Dr. H. G. Irvine, chairman.
Capt. John W. Hart, secretary.
Dr. Walter H. Brown.
Col. W. P. Chamberlain.
Dr. David L. Edsall.
Dr. Lenna L. Meanes.
Lieut. Com. J. R. Phelps.
Lieut. Col. T. F. Ritchie.

SECTION 7.

STATISTICS.

Health officers and others who take an active part in enlisting public interest in the campaign against venereal diseases are constantly being asked to give statistics showing the degree of prevalence of the venereal diseases and the effect of such diseases on the death rate. While it was recognized that accurate statistics on this subject are not available, nevertheless the organizers of the Conference hoped it might be possible, as the result of careful deliberations by those familiar with the subject, to obtain useful approximations which might be used by health officers and others in their educational propaganda. In an endeavor in this direction the Section on Statistics was asked, "What statement does our present knowledge justify in

regard to the approximate relationship of syphilis to deaths under the following headings: Locomotor ataxia; general paralysis of the insane; congenital debility, icterus, and sclerema; organic disease of the heart; angina pectoris; disease of the arteries, atheroma, aneurism; cerebral hemorrhage, apoplexy; softening of the brain; still-births; repeated miscarriages or abortions?"

The answer of the section to this question was expressed in the following resolutions:

Whereas it is impossible at the present time to state what proportion of deaths from such causes as congenital debility, organic diseases of the heart, angina pectoris, diseases of the arteries, etc., are in fact chargeable to syphilis; and,

Whereas it is most important to answer this question finally in order that a measure of the true incidence of syphilis as a factor in mortality may be obtained: Be it

Resolved, That the Conference recommends that a study of this important subject be undertaken as early as possible. This investigation should be cooperative in character, embracing a sufficiently large number of cases and safeguarded as to the statistical requirements of age, sex, occupation, race, social and economic conditions of the classes included;

That parallel with such a study arrangements be made for an investigation to trace a group of individuals from the beginning of their syphilitic history through to the end, in order to determine the proportion of cases which develop the various complications causing death;

That care be taken to utilize all material now extant in the Departments of War and of the Navy. Records covering the history of syphilitic disease from the date of infection until final dissolution of the patients are undoubtedly available in these departments for cadets in the two academies and for Army and Navy officers;

That an appeal be issued to a group of prominent syphilographers to cooperate in such a study by contributing the records of cases of long standing among their private patients; and

That a combined study of the material from these various sources should ultimately make it possible to present a series of indices which will permit the conversion of the crude mortality figures as annually published into a true measure of syphilis mortality.

Touching on the same subject the section adopted another resolution as follows:

Whereas it is apparent from studies made with minute care upon large hospital post mortem material that the full extent to which syphilitic infection is responsible for many of the important causes of death at all ages, and especially at the early and later age group, is not yet known: Therefore be it

Resolved, That the Conference warns against using any existing compilations of deaths reported under the various titles of the international classification, except locomotor ataxia and general paralysis of the insane, as final or complete.

The note of caution which dominates both of the above resolutions is observed also in the reply made by the section to the query as to

the annual incidence of new cases of venereal infection in the general population. It will be observed that the section gives very definite suggestions as to available statistical information regarding infection rate, morbidity incidence in, and mortality from syphilis and gonorrhea, and makes specific recommendations as to how such statistics may be used. Following is the text of this constructive suggestion:

Whereas, there is at the present time no information available which would permit of the determination of the annual incidence of new cases of venereal infection in the general population; and

Whereas, it must follow that disability with resultant economic loss to industries and the cost to taxpayers on account of the insufficiently treated cases can not be calculated with any reasonable degree of accuracy for the general population: Therefore be it

Resolved, That the Conference recommends extreme caution in the presentation of any statistical conclusions for the *general population;* and

Resolved, That the Conference recognizes that there are sufficiently well-controlled studies of the infection rate, morbidity incidence, and mortality from syphilis and gonorrhea in certain age, sex, race, and social groups in various countries to justify their quotation in informational publications; and

Resolved, That the Conference considers it essential in quoting and reporting any figures as to infection, morbidity, or mortality rates for venereal diseases that at least the following data be given at the same time:

(*a*) Author.

(*b*) The number, race, sex, age, occupation, and social or environmental conditions of the group or population unit reported upon.

(*c*) The clinical or laboratory criteria used in arriving at infection or morbidity rate.

(*d*) The registration or notification system under which cases or deaths are reported to official bodies in the population unit studied, if the quotation is made from such sources.

In response to a request for information as to the prevalence of venereal disease among innocents, the section submitted the following statement:

It is agreed that there is no reliable information as to the prevalence of syphilis among innocents in the United States, although it is known to be considerable, consisting of all congenital, some marital, and most extragenital syphilis. The Conference has no information as to the prevalence of gonorrhea among innocents in the United States, although it is known to be considerable, consisting of all gonorrheal ophthalmia, of vulvovaginitis among young girls, and some marital gonorrhea.

The section made the following recommendation regarding the dissemination of statistical information relating to the venereal diseases:

The section recommends that the four cooperating associations (United States Public Health Service, United States Interdepartmental Social Hygiene Board, American Social Hygiene Association,

and American Red Cross) be requested not to disseminate statistical information which has not received the approval of a standing committee of statisticians to whom fundamental questions of a statistical character should be referred.

In view of the notorious failure of private physicians in many cases to report the venereal diseases as causes of death, the suggestion was made that a system of confidential reports, supplementary to the regular death certificate now employed, be recommended by the All-America Conference. The proposal, however, aroused so much controversy that no final action was taken.

The following resolution reported by Section 7, designed to improve the certification of cause of death in cases where syphilis is involved, was unanimously agreed to:

Whereas, the securing of accurate certification on death certificates where syphilis is the cause of death is not at present feasible because of the element of ignorance as to the true cause of death: be it

Resolved, That the Conference recommends the more general use of the Wassermann reaction, post-mortem examinations of tissues, and any other means available to physicians for rendering more accurate the diagnosis of disease in stating causes of death.

Members of General Conference Committee assigned to Section 7.

Dr. Louis I. Dublin, chairman.
Dr. W. H. Davis, vice chairman.
Miss Mary A. Clark, secretary.
Col. Percy M. Ashburn.
Prof. Robert E. Chaddock.
Dr. Katharine B. Davis.
Dr. Haven Emerson.
Major A. E. Love.
Col. Edward B. Vedder.

SECTION 8.

PUBLIC INFORMATION AND EDUCATION.

It was natural, in view of the prominent part taken in the venereal disease campaign by informational and educational activities, that Section 8 should have been faced with a large number of important questions. In contrast to the six or seven questions submitted to most of the other sections, this section received 19 questions at the opening meeting of the conference, and others were subsequently submitted.

The section urged the importance of sex education as an important factor in the control of venereal diseases. The viewpoint runs through many of the various resolutions adopted. Thus—

Resolved, That for the effective combating of venereal diseases it is necessary that the public possess information on various matters concerning sex in addition to the relation of hygiene to these diseases.

It is further resolved, That it is necessary as a constructive measure looking toward the future control of venereal diseases that children should be instructed and trained so that they will develop proper attitude and conduct with regard to the sex side of life and its successful management.

When and where education in relation to sex shall be given has frequently been a subject of discussion. In answer to these questions the section points out that "normal parents, irrespective of their education, are solicitous for the welfare of their children and are desirous of guiding them correctly in sex matters"; continuing, the section emphasizes the fact that education in relation to sex is but a phase of character education as a whole and can not be accomplished at any one time.

"It must be a progressive process of care, guidance, instruction, and example. This fact, together with the intimate relationships of the members of the family, places upon the home the chief responsibility for sex education of children during the earlier years."

Realizing, however, that some parents do not understand the sex nature of their children and do not fully appreciate the need of sex guidance, or feel themselves unprepared to give correct instruction, the section recommended that—

adequate information and guidance be offered through printed matter, lectures, clubs, parent associations, etc., to supplement the knowledge of parents and enable them properly to guide and instruct their children in respect to sex.

In the case of older children and adolescents the responsibility for training and guidance in relation to sex is shared by all educational agencies having to do with young people. Concerning this phase of the program the section expressed itself as follows:

Since education in relation to sex is but a phase of character education, instruction and training directed toward the building up of wholesome sex attitudes and ideals must be developed as organic parts of the entire educational program. The implicit sex aspects of the subject matter and activities of the school program (such as are found in the biological and social sciences, the health and home-making sciences and activities, etc., in junior and senior high schools and colleges) should be given their due proportionate emphasis. They should not be abstracted from their normal settings and framed as separate courses of study.

To avoid duplication and disproportionate emphasis which might result from inclusion of reference to sex in various subjects and activities, some coordinating agency is desirable. The radical need, especially in all higher educational institutions, is for an adequate department of hygiene which, through class instruction, individual health examination with the consequent intimate personal relationship with the students and general supervision of all the hygienic factors that affect student life, constitutes an effective coordinating agency.

It is further important, especially in the junior and senior high schools, to cooperate with parents in guiding or controlling young people in some aspects of their social life which if not supervised carry the possibility of serious danger.

In the professional schools it may be desirable to provide courses in the principles and methods of social hygiene education, including training and guidance of young people.

The important part which should be played by ethical and religious factors in helping control the venereal diseases was tersely expressed in the following resolution:

Whereas, a comprehensive campaign against venereal disease should utilize all available forces; and

Whereas, prominent among these forces are a high individual and collective sex standard and religious inspiration and motivation;

Be it resolved, That in the campaign against venereal disease due account be taken of the ethical and religious factor.

Resolved, That particular emphasis be laid upon the sacredness of the individual life and welfare, and the prevention of their exploitation.

Resolved, That an effective appeal be made to regard the sex function as a racial trusteeship.

That marital unhappiness leads to promiscuity and is therefore a factor in the spread of venereal diseases is well known. One phase of this subject is dealt with in the following resolution:

Whereas, marital unhappiness and failure, due frequently to ignorance of the psychological, economic, and social conditions of normal married life and successful home-making are among the causes of sexual promiscuity and therefore of venereal disease: It is hereby

Resolved, (1) That at a suitable age education of men and women for marriage be undertaken in institutions of higher learning, evening schools, churches, clubs, and other suitable agencies; (2) that trustworthy printed matter be prepared on such phases of the subject as may wisely be discussed in print; and (3) that those contemplating marriage be encouraged to consult reputable physicians for such necessary information and advice as can not be given by the printed page.

It is further resolved, That libraries be urged to make selective use of such books as may be suitable for guidance of those contemplating marriage and to seek the aid of recognized social hygiene agencies in making discriminating selection of such books.

A considerable number of boys and girls leave day school to go to work before they have received adequate instruction as to matters of sex. They present a problem that must be dealt with in a manner slightly different from that employed with those who remain in school. The conclusions of Section 8 with respect to this group are as follows:

Resolved, (1) That these boys and girls be dealt with in continuation schools, corporation schools, special classes, etc.; (2) that lectures supplemented by conferences be provided in factories, department stores, and other places of employment; and (3) that these methods be further supplemented by the use of "house organs" and other publications of many of the larger business organizations and by other printed matter, by the use of exhibits and pictures in business establishments under the direction of the welfare and medical personnel, and by the activities of responsible clubs for boys and girls, including amateur athletic associations. Y. M. C. A.s, Y. W. C. A.s, and similar organizations should be made effective agencies, as some now are, in this work.

It is further resolved, That this instruction include the simple facts of reproduction, the responsibilities of the individual as citizen and as potential parent, the effects of and prevention of venereal diseases, and the principles of self-control through the positive and constructive use of leisure.

The section considered also the pupils in the junior and senior high schools. It was realized that the development of a program in these schools that will bring into subjects now in the curriculum such facts regarding sex and infectious diseases as are considered essential for the welfare of young people will necessarily be slow. Accordingly, it was resolved that in the meantime boys and girls in the upper grades of such schools be provided with instruction in the simple facts of reproduction, in the responsibilities of the individual as citizen and as potential parent, in the effects and prevention of venereal diseases, and in the principles of self-control through positive and constructive use of leisure time, and that such instruction be given in small segregated groups under specially selected teachers of the same sex, preferably through informal and intimate conferences rather than through lectures.

Inasmuch as the students in higher institutions of learning eventually become leaders in the community, where they exert directly and indirectly a profound influence upon the development of personal and public standards, it is clear that such institutions occupy a pivotal position in a program for the control of venereal diseases. In view of this fact Section 8 adopted the following resolution:

Resolved, That institutions of higher learning, both general and professional, be urged to lay emphasis upon equipping their students for (*a*) complete, healthy living, and (*b*) instructing and guiding those who come under their influence in all matters pertaining to normal sex life.

It is further resolved, That all professional schools, but especially those training teachers, be urged to provide time, materials, and pedagogical organization to equip their graduates for the training and guiding of others in matters pertaining to complete, healthy living, including normal sex life.

Because of the general neglect of the welfare of the individual in professional schools for the training of teachers, physicians, nurses, ministers, etc., in the matter of health training and guidance, the section urged that such institutions make adequate provision for meeting the needs of their students. In addition to this, the section adopted the following:

Resolved, That all medical and nursing schools be encouraged to provide short courses of instruction in social hygiene and allied subjects of social medicine with required attendance, or else develop such instruction in a course given in some established department.

It is further resolved, That this proposal be placed before the Council on Medical Education of the American Medical Association, the

Association of American Medical Colleges, the Conference of State Boards of Registration, and corresponding councils and organizations of nurses, and the faculty of each medical and nursing school in the United States; likewise that this recommendation be referred to the proper bodies in each of the other countries participating in this conference.

Those who have had practical experience in carrying out programs of social hygiene education realize how often measures which are applicable in cities are entirely inapplicable in villages and rural districts, because of differences in social relationships. The following resolution of Section 8 deals with the problem thus presented:

Resolved, That special studies of this rural and village situation be initiated by some national organization, such as the American Social Hygiene Association or similar organization in other countries, with a view to arriving at a basis upon which an effective program can be organized.

It is further resolved, That encouragement be given to the many promising undertakings on the part of various rural communities to promote social hygiene education through the cooperation of health and educational authorities with civic and welfare organizations.

A psychological consideration with respect to teaching methods employed in dealing with the venereal diseases is dealt with by Section 8 as follows:

Resolved, That in teaching concerning the venereal diseases, fear should not be deliberately stressed as a deterrent. The element of fear should appear only to the extent that it is inherent in the presentation of the facts themselves. Any morbid tendencies resulting from such unavoidable fear should be corrected by positive and constructive teaching as to the prevention and cure of the diseases.

With these precautions as to the least possible emphasis on fear, such abnormal reactions as may be produced in certain individuals are relatively unimportant in frequency and severity.

In response to a request for information as to the possibility of evaluating the effectiveness of various materials and measures used in educational work, the section offered the following:

Whereas, there is a lack of adequate information as to the effectiveness of various materials and methods (such as pamphlets, placards, motion pictures, advertising, lectures, and publicity) advocated in social hygiene instruction as a means of modifying health and conduct:

Resolved, 1. That scientific methods for the evaluation of such results be employed so far as they are available or can be devised to determine (*a*) the effectiveness of the constructive educational programs now in operation, and (*b*) the extent of the influence of the destructive, antisocial hygiene factors.

2. That there be formulated, in the light of the results of the investigations under (*a*), the necessary modifications in teaching methods and materials to be used in educational institutions and elsewhere.

The section concluded its presentation with the following general resolution:

Whereas, it is important to bring about more intelligent action among persons in administrative, legislative, and judicial positions in handling situations and problems related to the control of venereal diseases through widespread propaganda and education dealing not only with the medical aspects of the venereal disease problem but with all other distinctly allied problems,

It is resolved, (1) That in all parts of the country voluntary machinery must be provided as an adjunct and as a part of the programs of National, State, or provincial, and local health authorities; (2) that where such voluntary machinery is provided it should as far as possible be representative of voluntary agencies definitely interested in some phase of the venereal disease problem; and (3) that any voluntary committee should include strong representation of all official bodies concerned acting in cooperation with State departments of health and education.

Members of General Conference Committee assigned to Section 8.

Dr. Thomas M. Balliet, chairman.
Prof. Maurice A. Bigelow, vice chairman.
Mr. Laurence C. Staples, secretary.
Dr. Gordon Bates.
Mrs. Elmer Blair.
Rev. John M. Cooper.
Dr. George R. Dodson.
Dr. Joseph E. Raycroft.
Dr. M. J. Exner.
Dr. Lee K. Frankel.
Dr. B. C. Gruenberg.
Mr. Louis J. Heath.
Dr. Roger I. Lee.
Mr. Harry H. Moore.
Dr. W. S. Small.

SECTION 9.

LAW ENFORCEMENT MEASURES.

Under the term "law enforcement measures" are embraced principally those measures which have to deal with the various phases of prostitution. Most of them are police rather than health measures; though in many, the police measures have a strong social and medical background. A perusal of the resolutions adopted by this section will convince the reader that no extravagant ideas are entertained concerning the possibility of completely eliminating prostitution by law enforcement measures. That the evil can be greatly minimized, however, by such measures and venereal diseases greatly lessened thereby the experience of the past few years clearly indicates.

Among the questions presented to this section were such as dealt with the imposition of fines on persons convicted of prostitution; with the functions of police and courts in dealing with sex delinquency; with the manner of dealing with the mentally defective; with the supervision of hotels, dance halls, and other places of amusement, taxicabs, and other agencies frequently utilized for the purpose of prostitution and assignation, etc.

How thoroughly the section recognized the force of public opinion in dealing with law enforcement measures directed against prostitution is well indicated by the following general resolution:

Resolved, 1. That the establishment and maintenance of high standards of sex conduct is the best protection of public health from venereal diseases.

2. That up to the level of the highest standards which can be sustained by public opinion, laws penalizing the promotion of and indulgence in illicit sex relations constitute sound and practicable health measures.

3. That the public support of such laws and law enforcement is and should be largely dependent upon the following considerations:

(*a*) That such laws be designed to eliminate particularly commercialized aspects of prostitution and to protect the youth from moral hazards.

(*b*) That neither the laws themselves nor their enforcement be discriminatory. (In all cases to be applied equally to men and women.)

(*c*) That, where possible, such laws should be uniform and of widespread application so as to prevent evasion by offenders.

(*d*) That the courts be given and exercise a wide discretion to pronounce sentences calculated to rehabilitate as well as to deter the individual and to protect society.

(*e*) That the function of police and courts in preventing and curing sex delinquency be not confused and hampered by imposing upon them duties involving directly or indirectly the diagnosis or treatment of venereal diseases.

Dealing more in detail with the laws mentioned in paragraph 3 just given, the section gave the following as meeting the requirements:[4]

1. Laws establishing the civil or criminal responsibility of persons using or permitting the use of real or personal property for the purpose of prostitution, lewdness, or assignation.

2. Laws containing the principles embodied in the vice repressive act approved by the Federal Government and numerous social hygiene societies, and already adopted by eleven States.

3. Laws directed against the procurer, the pimp, and the madam who detains a girl in a house of prostitution.

4. Laws or ordinances requiring all transient hotels and rooming houses to be licensed annually, providing for their supervision and the revocation of license upon violation of laws against prostitution, lewdness, or assignation, and requiring that a proper register of guests be kept.

5. Laws or ordinances licensing taxicabs, dance halls, skating rinks, and other forms of commercial amusements and providing for supervision and revocation of licenses where such taxicabs or places are used for purposes of prostitution, lewdness, or assignation.

[4] The section called attention, with approval, to the model laws and references on pages 51-75 of the "Social Hygiene Legislation Manual," Publication No. 312, issued in 1920 by the American Social Hygiene Association, N. Y.

6. Laws raising the "age of consent" for both sexes to 18 in temperate zones. (By "age of consent" is meant the age below which an individual may not consent to illicit sexual intercourse without rendering the adult partner thereto liable to criminal punishment.)

7. A Federal law prohibiting interstate travel for purposes of prostitution.

8. Laws providing for the early diagnosis, registration, institutional care, training, and supervision of the mentally defective.

With reference to the last-named paragraph, the section expressed the view that such laws "would materially reduce the incidence of venereal disease." The section furthermore recommended—

the inclusion in such laws of a provision establishing psychiatric service for the courts, a service which should be available in securing early diagnosis of mental deficiency before sentence, and which would result in proper care and supervision instead of ill-adapted methods of disposition by the courts.

Special interest attaches to the action of the section in dealing with the question of imposing fines on persons convicted of prostitution. Again and again it has been pointed out that the imposition of the fines usually imposed is a most irrational procedure, in that it stimulates the prostitute to greater activity in order to secure the money with which to pay the fine. Following is the text of the resolution adopted:

Whereas a woman who prostitutes herself for hire, alone of all prostitutes, derives her livelihood thereby; and

Whereas the occasional imposition of petty fines against prostitutes is not a deterrent, but results in stimulating them to greater activity in practicing their business to pay their fines and further makes the community a sharer in the proceeds of prostitution; and

Whereas the majority of States have no reformative institutions for adult women, and the personnel and funds for intelligent supervision of women under probation are inadequate:

Resolved, That the only justification for the imposition of fines as punishments in this class of cases is where the court has no power to impose any other punishment, and that in such cases the most appropriate procedure is to impose so large a fine that the delinquent will be unable to pay and will upon default in payment automatically go to an institution. The imposition of a fine should not be permitted by the police to operate under any circumstances as a license; and

It is further resolved, That the All-America Conference on Venereal Diseases is opposed to the fining system in prostitution cases and recommends the immediate repeal of all laws permitting fining in communities having adequate reformative or penal institutions and probation systems, and a similar repeal of laws permitting such fines in other communities as fast as such communities establish such adequate institutions and probationary machinery.

In reply to the question, "Should fornication be made a crime?" the section presented the following resolution:

Resolved, That the general adoption and adequate enforcement of the laws making fornication a crime would have appreciable influence upon the prevalence of venereal diseases, but that public opinion is not ready for the general adoption of such laws.

Considerable discussion was aroused by attempts to define the term "reasonably suspected of having gonorrhea, syphilis, or chancroid." This term, it should be stated, now appears in the laws of a number of States in connection with the grant of authority to State and local officials to detain such persons for medical examination. The charge was made that the broad powers conferred by such a statute have been misused. A further comment on this point is included at the end of Section 5.

Replying to an inquiry regarding an alleged increase in promiscuity in the United States as a result of the repression of commercialized prostitution, the section agreed that:

There is no evidence of an increase in promiscuity in the United States since 1910; that it is the opinion of the conference that the closing of the red-light districts and the repression of commercialized prostitution which has taken place since 1910, and particularly during the past three years, has materially reduced the total of illicit sex relations in the United States.

Members of General Conference Committee assigned to Section 9.

Raymond B. Fosdick, chairman.
W. Bruce Cobb, vice chairman.
Bascom Johnson, secretary.
Francisco del Valle.
Charles E. Fox.
Henry James.
Charles E. Miner.
T. N. Pfeiffer.
Roscoe Pound.
David Robinson.
Samuel Thrasher.
Frederick H. Whitin.
George E. Worthington.

SECTION 10.

PROTECTIVE SOCIAL MEASURES.

Of the four main activities now in operation in the United States for the control of venereal diseases, three have already been discussed. We now come to the fourth, namely, Protective Social Measures. These measures naturally concern themselves principally with the prevention of sex delinquency in young people during that active and difficult period from adolescence to marriage. The provision of suitable social protective measures is largely a community responsibility. Their inauguration is best achieved, in the opinion of Section 10, by the following as a minimum:

(*a*) A community survey covering educational, legal, social, and economic conditions, special stress being laid upon the importance of thoroughly understanding all of the economic factors involved.

(*b*) A presentation of the results of the community survey either to privately invited groups of leadership in the community or to the public, or both, to the end of securing more effective moral protection of youth; better educational facilities; more constructive use of social resources for individual betterment; improved home life and larger provisions for right use of leisure time.

(*c*) Organization of local committees consisting of representative leaders charged with the task of arousing the public conscience toward the need of improving permanently those conditions which have contributed to sex delinquency and in furthering the carrying out of the program.

(*d*) The promotion of recreation, which is a very important factor in the control of venereal diseases through preventing sex delinquency.

In furtherance of work along these lines the section advocated the establishment of a national clearing house where such surveys could be collected and evaluated.

In connection with the activities of those engaged in developing and supervising protective social measures, the need of individual case records was emphasized. Thus:

Resolved, That case records, scientifically prepared (under the supervision of trained social workers), are necessary and valuable in every protective social program; that they should be used as a basis for—

(*a*) Social diagnosis and treatment for the benefit of the individuals whose cases are reported.

(*b*) The demonstration of the inadequacy of existing institutions and the need of increasing facilities for the care and treatment of delinquents.

(*c*) Giving data for the formulation of a community program which will correct such conditions as are contributing causes of delinquency.

It is obvious that caution, judgment, and tact are essential in handling records of this kind, dealing, as they often do, with sex delinquencies of those who subsequently lead exemplary lives and who come to occupy responsible positions in their community. For this reason the section added the following warning:

Since there are certain dangers of misuse of information thus itemized, we urge great caution in the sharing of such information, and in cases which may reasonably be supposed to have attained rehabilitation and adjustment the future identity of the individual should be safeguarded.

In connection with the community's responsibility with respect to protective social measures, the section also called attention to the problem of feeble-mindedness, as follows:

Resolved, That the importance of community responsibility for carrying out an inclusive program for the care of the mental defective be emphasized.

Replying to a question as to the effect of agitation for a single standard of morals, the section stated:

No reliable information is available by which we may determine as to how far the agitation for the single standard of morals has influenced the moral standards of men and women.

In connection with the rehabilitation of venereal-disease carriers, it was the opinion of the section:

That the personal workers concerned with the rehabilitation of venereal-disease carriers should concentrate their efforts on the early offender; and that an extended period of institutional training and care for the professional prostitute of long standing is necessary.

That the establishment of reformatories with standard equipment for examination, classification, training, recreation, and parole provides the most hopeful method of rehabilitating the oldest offender.

That there is not sufficient information available at this time to determine whether or not detention hospitals for persons infected with venereal disease have proved successful as a means of rehabilitation.

That it be the recommendation of this committee that venereal disease carriers (not convicted of crime) should be treated as recommended by Section 5 with the added recommendation of the provision of a social service follow-up worker.

It should be borne in mind by those interested in the proceedings of the Conference that no hard-and-fast lines could be drawn by the Conference between sections, and the preceding resolutions and findings, grouped for convenience under the heading "Protective Social Measures," touched at many points matters also discussed in the sections on law enforcement and on social service.

Members of General Conference Committee assigned to Section 10.

Mrs. Jane Deeter Rippin, acting chairman.
Miss Maude E. Miner, vice chairman.
Dr. Valeria H. Parker, secretary.
Miss Henrietta Additon.
Miss Mary Driscoll.
Mrs. Martha P. Falconer.
Mr. Ormie Lance.

SECTION 11.

PSYCHOLOGICAL ASPECTS OF THE VENEREAL DISEASE PROBLEM.

Among the questions presented to the All-America Conference on Venereal Diseases, none aroused greater discussion than that dealing with continence (abstinence) in sexual relations for the unmarried. In this connection it must be borne in mind that the entire campaign carried on in the United States during the past few years has been based on the dictum that "continence is compatible with health, and that it is the best preventive of venereal disease." It was natural that this dictum should be of great interest to followers of the Freudian psychology; the statement was also critically regarded by physicians, represented largely by certain members of Section 2. The problem presented to the Conference consisted mainly in harmo-

nizing the views of those who regarded "continence" from entirely different standpoints. On the one hand was the physiological and psychological view as to the effect of continence on health and physical and mental well-being, and on the other was the broad sociologic view which contrasted the alternative of continence with promiscuity and fornication.

The original dictum cited above undoubtedly represents the point of view of the social hygiene worker. The physiological view is presented in the more cautiously restricted statement offered by Section 2, as follows:

Resolved, That the complexity of the question of the relation of continence to health is recognized. It is generally admitted that continence in the sense of total abstinence from sexual intercourse is not a physiologic state in the sexually normal adult. On the other hand, the dangers and disadvantages to the individual and to the race which ensue upon the infringement of continence in the young unmarried man or woman are so serious that they outweigh the possible physiologic disadvantages of sexual abstinence.

On the ground that dangers and disadvantages consequent upon infringement of continence were the same in older persons, the word "young" was subsequently stricken out.

Meanwhile, the psychological section had also dealt with the problem, their interest being chiefly in the alleged disastrous consequences of repression of the sex instinct. It was accordingly interesting to have Section 11 report on this subject as follows:

Resolved, That although there is danger that a superficial and erroneous interpretation of the Freudian psychology in regard to the repression of the sex instinct may be detrimental to the successful development of the program for the control of the venereal diseases, a more thorough-going, complete, and scientific interpretation tends to aid such a program in that it places the emphasis upon the practical means for guiding the sex instinct into socially useful and constructive activities.

With the discussion which the whole question of continence aroused, representatives of the various sections concerned subsequently cooperated and drafted the resolution which was finally adopted as expressing the views of the All-America Conference with respect to continence.

This resolution is as follows:

Resolved, That the complexity of the question of the relation of continence to the total well-being of the individual is recognized. Although it is generally admitted that, after maturity, continence in the sense of total abstinence from sexual intercourse is not a physiologic state, nevertheless the dangers and disadvantages to the individual and to the race which ensue upon the infringement of continence in the unmarried man or woman are so serious that they outweigh the possible disadvantages of sexual abstinence.

Really a part of the continence problem is a question propounded to Section 11, as follows:

"Is there any danger that increasing success of programs of repression of prostitution will bring about psychological or psychiatric damage through sex repression?"

To this the section returned the following reply:

Resolved, That at the present time there is not sufficient evidence upon which to base a statement concerning any possible danger of the repression of prostitution in producing psychological or psychiatrical injuries through sex repression.

Taking up other psychological phases of the work in venereal disease control, Section 8 called attention to the fact that any adequate program of sex education aiming at the development of sound normal attitudes toward sex and at the reduction of venereal diseases must be based upon principles empirically determined. For this reason the section—

Resolved, That research be encouraged for securing data concerning the sex life of normal individuals.

Of special interest to those guiding the educational and informational activities of the campaign against venereal diseases are the statements made by Section 11 with respect to the psychological stages in the development of sex.

Resolved, That there are definite psychological stages in the development of sex, although exact lines of demarcation between them can not be indicated. In general, these stages are:

1. The infantile period, including approximately the years from birth to 4.
2. The prepubertal period, from the age of 4 to the appearance of puberty.
3. The adolescent period, from puberty to the age of approximately 25, or until the time of marriage if it occurs earlier than this.
4. The marital period.
5. The senile period.

Resolved, That any program of education in relation to sex should take account of these stages and should adapt informational matter, teaching, and training to the needs of each period. Furthermore,

In the practical application of this, it should be recognized that what is characteristic or normal for one stage need not be characteristic or normal for another, and the aim should be to avoid arrest at any stage and to provide opportunities for the normal and natural progress of the individual to successive stages until complete development, involving normal sex relations in marriage, and satisfactions incident to normal, happy, family life (including the satisfaction of having and rearing children) be attained.

Resolved, That any practical modifications of existing methods of sex education which should be made in view of our knowledge of the stages of sex development would involve practically a critique of the whole sex-education program and, therefore, can not be considered by the conference.

Members of General Conference Committee assigned to Section 11.

Dr. Willard S. Small, acting chairman.
Mr. William A. White, vice chairman.
Dr. B. C. Gruenberg, secretary.
Dr. Adolf Meyer.
Dr. Thomas W. Salmon.
Mr. Earl F. Zinn.

SECTION 12.

SOCIAL SERVICE.

Although originally no special section had been contemplated for dealing with social service problems, a number of questions arising in connection with the work of various other sections soon made the organization of such a special section advisable. Attention has already been called to the emphasis placed on social service and follow-up work in connection with the resolutions presented by Sections 2, 5, and 6. Following are the resolutions formulated by Section 12 and adopted by the Conference as a whole:

Resolved, That the basic principle of medical social service be recognized and endorsed as essential to the efficient organization of a venereal disease clinic. The work of the social worker is of value to (*a*) *the patient*, through improving morale, removing obstacles to attendance at clinic, and sustaining the interest of the patient in continuing treatment; (*b*) *the clinic*, through aiding in administration, developing the efficiency, and broadening its scope as an educational center, and in helping to create a friendly spirit of service; (*c*) *the community*, through work concerned with the immediate control and elimination of individual cases, in addition to influencing the progress of the local venereal disease campaign in its broader aspects by obtaining and aiding in the dissemination of information.

Resolved, That a social record sheet should be kept upon all venereal disease cases, for the purpose of gathering information that will be of assistance in (*a*) doing follow-up work; (*b*) tracing contacts; (*c*) tracing sources of infection; (*d*) estimating the value of educational methods in vogue as a part of an antivenereal campaign; (*e*) demonstrating economic loss to various industrial and other units in the community; (*f*) demonstrating the social needs of the community, e. g., recreational needs, housing needs, industrial conditions, and the like; (*g*) demonstrating the distribution of infection; (*h*) demonstrating types of prostitution, extent of solicitation, etc.

During the course of the discussions attention was called to a phase of professional secrecy insisted upon in connection with venereal infections, a phase which seriously hampered social service. Thus, most social service workers are warned to be extremely cautious about revealing to the wife the fact that the husband in the hospital has a venereal disease. In some instances a social service worker not connected with the institution caring for the patient, but active with the family in the home, is unable to learn that the patient has a venereal disease. The section presented the following resolution, which was subsequently adopted by the Conference:

Resolved, That in order to increase the efficiency of the operation of venereal disease hospitals and clinics through social service, greater

attention be paid to the completeness of the medical information put into the hands of the medical and social service personnel attached to the clinic for use in the care of the patient and in the protection of the family, friends, and fellow workers through social service.

Members of General Conference Committee assigned to Section 12.

Miss Mary Wadley, chairman.
Dr. Gordon Bates, vice chairman.
Dr. Alec. N. Thomson, secretary.
Miss Florence Brown.
Miss Helen Grant.
Miss Susie Lyons.

GENERAL CONFERENCE COMMITTEE.[1]

Armstrong, Donald B., M. D., acting executive officer, National Health Council.

Ashburn, Percy M., Col. M. C., U. S. A., commanding officer, Field Service School, Medical Dept., U. S. A., Carlisle Barracks.

Balliet, Thomas M., Ph. D., professor of the science of education and formerly dean of the school of pedagogy, New York University.

Bates, Gordon, M. D., secretary, Canadian Council for Combating Venereal Diseases.

Bigelow, Maurice A., Ph. D., director, School of Practical Arts, and professor of biology, Columbia University.

Biggs, Hermann M., M. D., health commissioner of New York State; president, American Social Hygiene Association.

Blair, Mrs. Elmer, chairman, public health committee, General Federation of Women's Clubs.

Brent, C. H., Rt. Rev. Bishop of Western New York, Protestant Episcopal Church.

Brown, Wade H., M. D., member, Rockefeller Institute for Medical Research.

Bryce, Peter, M. D., medical officer, Department of Immigration and Colonization. Canada.

Chaddock, Robert E., Ph. D., associate professor of statistics, Columbia University,

Chamberlain, W. P., Col., M. C., U. S. A., chief, division of field sanitation, War Department.

Cobb, W. Bruce, New York City magistrate.

Coe, George A., D. D., Ph. D., dean, Union Theological Seminary.

Coffee, Rev. Rudolph I., D. D., Rabbi of Collingwood Avenue Temple, Toledo, Ohio.

Cogswell, W. F., M. D., executive health officer, Montana.

Cooper, Rev. John M., D. D., Ph. D., instructor in religion, Catholic University of America.

Crumbine, S. J., M. D., executive health officer, Kansas.

Cunningham, John H., M. D., urologist.

Davis, Katharine Bement, Ph. D., general secretary, Bureau of Social Hygiene.

Davis, Oscar, M. D., president, State Board of Health of Texas.

Davis, William H., M. D., chief, vital statistics division, Bureau of Census, Department of Commerce.

Desloges, A. H., M. D., director, division of venereal diseases, Quebec.

Dodson, George R., Ph. D., president, Missouri Social Hygiene Association.

Drake, C. St Clair, M. D., director of public health, Illinois State Board of Health.

Dublin, Louis I., Ph. D., statistician, Metropolitan Life Insurance Company.

Edsall, David L., M. D., dean, Harvard University Medical School.

Emerson, Haven, M. D., medical director, U. S. Bureau of War Risk Insurance.

Engman, Martin F., M. D., professor of clinical dermatology, Washington University Medical School.

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[1] The general officers and members of the secretariat were ex officio members of the committee.

Evans, William A., M. D., D. P. H., editor, health department, Chicago Tribune.

Fisher, George J., deputy chief scout executive, Boy Scouts of America.

Flexner, Abraham, secretary, General Education Board.

Foley, Edna L., president, National Organization of Public Health Nurses.

Fonseca, Dr. Olympio Oliviera Ribeiroda, member of the delegation from Brazil.

Fordyce, John A., M. D., professor of dermatology and syphilology, Columbia University.

Fosdick, Raymond B., attorney; chairman, War and Navy Commissions on Training Camp Activities.

Fox, Charles E., assistant district attorney, Philadelphia.

Frankel, Lee K., Ph. D., third vice president, Metropolitan Life Insurance Co.

Freeman, Allen W., M. D., executive officer, Ohio State Board of Health.

Fronczak, Francis E., M. D., commissioner of health of Buffalo, N. Y.

Green, Frederick R., M. D., secretary, council on health and public instruction, American Medical Association.

Hagner, Francis R., M. D., professor genito-urinary surgery and venereal diseases, George Washington University Medical School.

Harris, Louis I., M. D., director, New York City Health Department.

Hastings, Charles J., medical officer, Department of Public Health of Toronto.

Hayne, James A., M. D., executive health officer, South Carolina State Board of Health.

Hazen, H. H., M. D., professor of dermatology and syphilology, Georgetown University School of Medicine.

Irvine, H. G., M. D., director division of venereal diseases, State Board of Health of Minnesota.

James, Henry, attorney member, board of directors, American Social Hygiene Association.

Kelly, Eugene R., M. D., State commissioner of health, Massachusetts.

Keyes, Edward L., jr., Ph. D., M. D., professor of urology, Cornell University Medical School.

Lawrence, Joseph S., M. D., chief, bureau of venereal diseases, New York State Department of Health.

Lee, Roger I., M. D., professor of hygiene, Harvard University.

McClenahan, M. B., director, division of venereal diseases, Provincial board of health, Ontario.

McCormack, A. T., M. D., executive health officer, Kentucky.

McCoy, George W., M. D., director Hygienic Laboratory, United States Public Health Service.

McLaughlin, A. J., M. D., assistant surgeon general, United States Public Health Service.

Meanes, Dr. Lenna L., member of the Women's Foundation for Health.

Meyer, Adolf, M. D., professor of psychiatry, Johns Hopkins University.

Miner, Miss Maude E., Ph. D., secretary, New York Probation and Protective Association.

Najera, Dr. F. Castillo, member of the delegation from Mexico.

Nelson, Robert B., scientific assistant, United States Public Health Service.

Nicoll, Matthias, jr., deputy commissioner New York State Department of Health.

Norris, Charles C., M. D., associate professor of gynecology, University of Pennsylvania.

Olin, R. M., M. D., executive health officer, Michigan.

Parker, Valeria H., M. D., chairman, social hygiene committee, National League of Women Voters.

Pedersen, James, M. D., lecturer on urology, Post-graduate Hospital, New York City.

Perrin, Dr. Tomas, G., member of the delegation from Mexico.

Phelps, J. R., lieutenant commander, United States Navy, in charge of prevention of communicable disease, bureau of medicine and surgery, United States Navy.

Pound, Roscoe, Ph. D., LL. D., dean, Harvard University Law School.

Pusey, William A., M. D., professor of dermatology, College of Physicians and Surgeons, University of Illinois.

Rankin, W. S., M. D., executive health officer, North Carolina.

Raycroft, Joseph E., M. D., professor of hygiene, Princeton University.

Rippin, Mrs. Jane Deeter, director, National Girl Scouts of America.

Ritchie, T. F., lieutenant colonel, R. A. M. C., representing League of Red Cross Societies.

Rockefeller, John D., jr., chairman, Bureau of Social Hygiene.

Rose, Wickliffe, LL. B., general director, International Health Board.

Salmon, Thomas W., M. D., medical director, National Committee on Mental Hygiene.

Spencer, Mrs. Anna Garlin, professor of sociology and ethics, Meadville Theological School.

Stokes, John H., M. D., associate professor of dermatology and syphilology, Mayo Foundation, University of Minnesota.

Swift, Homer F., M. D., associate member, Rockefeller Institute for Medical Research.

Thorndike, Edward L., Ph. D., professor of educational psychology, Teachers' College, Columbia University.

Thrasher, Samuel P., superintendent, Committee of Fifteen, of Chicago.

Van Ingen, Philip, M. D., pediatrist, chairman executive committee National Council of Child Health.

Vedder, Edward B., Col., M. C., U. S. A., officer in charge, Southern Department Laboratory, U. S. Army.

Wadley, Miss Mary, chief of social service, Bellevue Hospital.

Walker, George, M. D., associate in surgery, Johns Hopkins University Medical School.

Warthin, Alfred S., Ph. D., M. D., professor and director of pathological laboratory, University of Michigan.

Wende, Grover, M. D., professor of syphilology and dermatology, University of Buffalo.

Whitin, Frederick H., executive secretary, Committee of Fourteen, of New York City.

Williams, E. G., M. D., executive health officer, Virginia.

Williams, J. Whitridge, M. D., dean, Johns Hopkins University Medical School.

Yarros, Rachelle S., M. D., supervisor of education for women, division of social hygiene, Illinois State Department of Health.

Young, Hugh H., M. D., clinical professor of urology, Johns Hopkins University Medical School.

Zinsser, Hans, M. D., professor of bacteriology, College of Physicians and Surgeons, Columbia University.

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Director of public information: Charles Bolduan.
Assistant executives: Robert H. Hoffman, Paul B. Johnson, Gertrude R. Luce, C. M. Sheridan, Bess E. Stimmel, Olive C. Wadlin.
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COURT HOLDS "SLEEPING SICKNESS" NOT COMPENSABLE UNDER COMPENSATION ACT.

The following abstract of a court decision is taken from the advance sheets of the Northeastern Reporter, issue of June 21, 1921:

The claimant in Donovan *v.* Alliance Electric Co., 186 New York Supplement, 813, received a bump on his head in the course of his employment. He subsequently developed sleeping sickness, for which injury he was allowed an award by the New York Industrial Commission. This award was reversed by the Supreme Court of New York, Appellate Division, Third Department, in an opinion by Judge Woodward.

Dr. Kennedy, a witness, while admitting that comparatively little is known of sleeping sickness, testified that recent experience has demonstrated that it is the result of an infection and not the result of trauma; the fact that the claimant developed sleeping sickness following the bump upon his head is merely a coincidence. The evidence the court holds to be entirely insufficient to sustain an award. Judges John M. Kellogg and Kiley dissented.

NECESSITY FOR FUMIGATING LIFEBOATS.

Surgeon Simpson, quarantine officer at the port of San Francisco, recently made a report of an unusual and interesting incident in connection with the fumigation of the steamship *Bali*, bound in from Java. Of the total number of approximately 100 rats destroyed as the result of fumigation, 89 were destroyed by the fumigation of the four lifeboats. The accompanying photographs will evidence to quarantine officers the importance of the careful treatment of lifeboats at the time of fumigation of vessels.

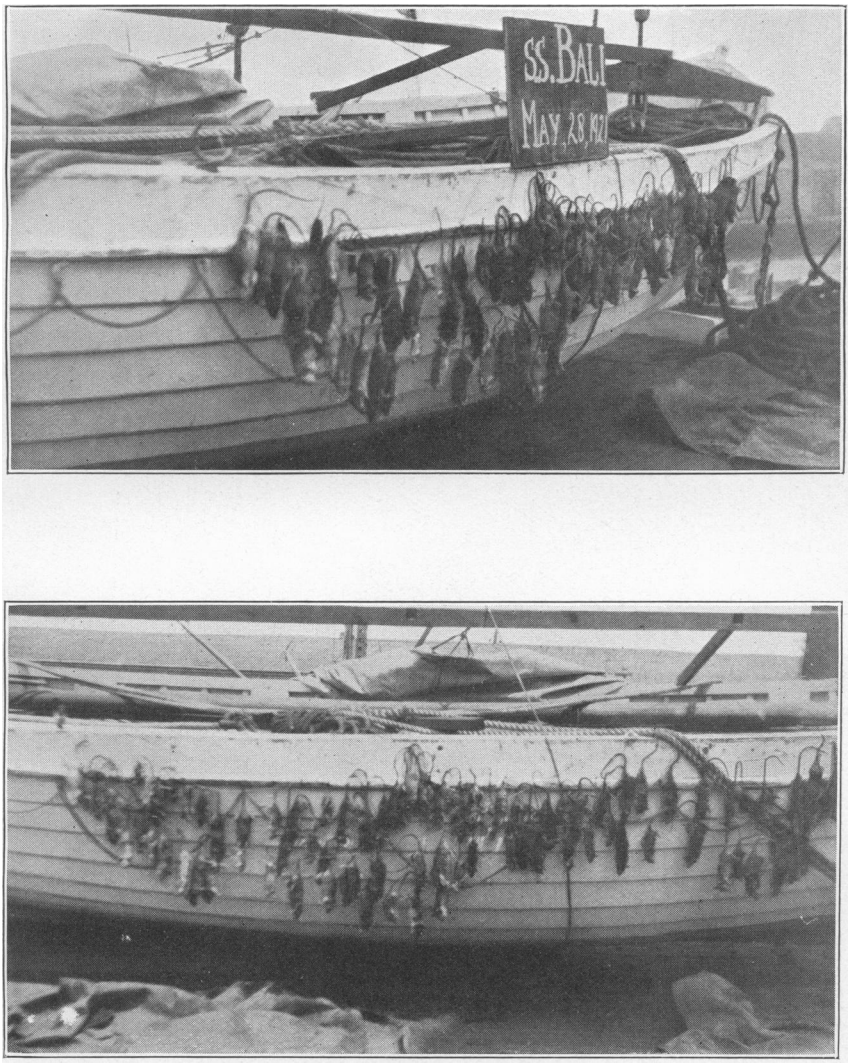
If the lifeboats are furnished with a tight covering, they can be fumigated, and this is the practice that is often resorted to, allowing an excess percentage of gas to compensate for leakage; but where fumigation is a physical impossibility, life boats can be flooded with water.

Rats are prone to frequent lifeboats of a vessel to a greater or less degree because of a water supply that can be found there when not available in other parts of the vessel.

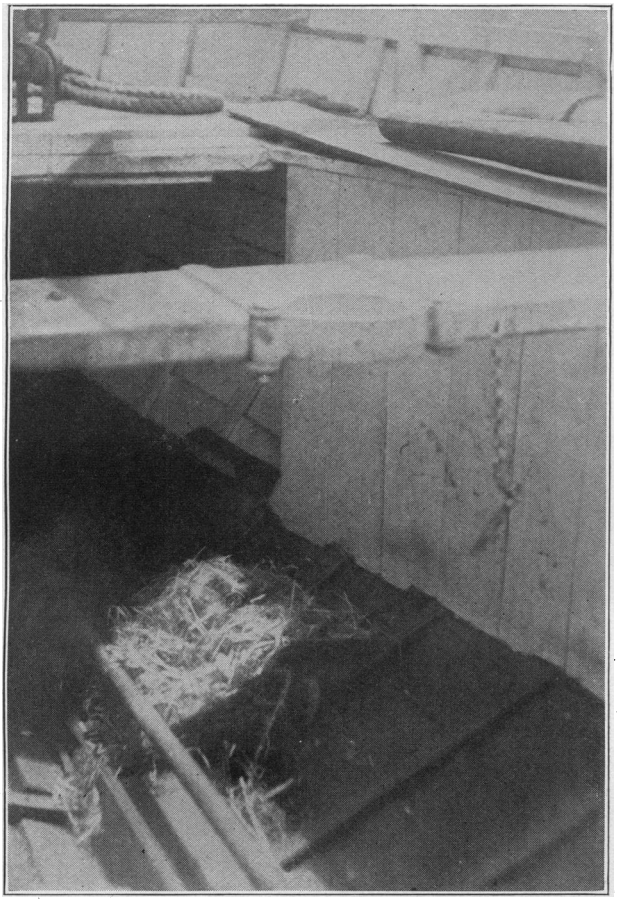
DEATHS DURING WEEK ENDED JULY 2, 1921.

Summary of information received by telegraph from industrial insurance companies for week ended July 2, 1921, and corresponding week, 1920. (From the "Weekly Health Index," July 5, 1921, issued by the Bureau of the Census, Department of Commerce.)

	Week ended July 2, 1921.	Corresponding week, 1920.
Policies in force	47,277,513	44,236,202
Number of death claims	7,735	7,339
Death claims per 1,000 policies in force	8.5	8.7



Eighty-nine rats found in four lifeboats fumigated.



View inside of lifeboat. Twenty-six rats were found in this boat.

Deaths from all causes in certain large cities of the United States during the week ended July 2, 1921, infant mortality, annual death rate, and comparison with corresponding week of preceding years. (From the "Weekly Health Index," July 5, 1921, issued by the Bureau of the Census, Department of Commerce.)

City.	Estimated population, July 1, 1921.	Week ended July 2, 1921.		Average annual death rate per 1,000.[2]	Deaths under 1 year.		Infant mortality rate, week ended July 2, 1921.[3]
		Total deaths.	Death rate.[1]		Week ended July 2, 1921.	Previous year or years.	
Akron, Ohio	229,195	31	7.1	[4] 9.8	2	[4] 7	19
Albany, N. Y	115,071	29	13.1	C 12.4	4	C 3	90
Atlanta, Ga	207,473	57	14.3	C 15.2	9	C 7	.....
Baltimore, Md	752,863	209	14.5	A 15.6	31	A 29	87
Birmingham, Ala	186,133	54	15.1	A 21.1	9	A 10	.....
Bridgeport, Conn	149,967	23	8.0	A 15.1	4	A 8	50
Buffalo, N. Y	519,608	107	10.7	C 10.0	16	C 21	62
Cambridge, Mass	110,444	24	11.3	A 11.6	3	A 3	54
Camden, N. J	119,672	26	11.3	.....	2	.....	.....
Chicago, Ill	2,780,655	550	10.3	A 11.6	98	A 88	.....
Cincinnati, Ohio	403,418	104	13.4	C 11.2	11	C 10	73
Cleveland, Ohio	831,138	163	10.2	C 9.4	23	C 19	62
Columbus, Ohio	245,358	52	11.1	C 11.1	5	C 5	58
Dallas, Tex	165,282	35	11.0	A 13.9	2	A 4	.....
Dayton, Ohio	158,119	38	12.5	C 11.5	2	C 3	33
Denver, Colo	263,152	66	13.1	A 12.1	5	.....	.....
Detroit, Mich	1,070,450	162	7.9	C 9.4	31	C 47	59
Fall River, Mass	120,668	24	10.4	C 11.7	6	C 7	90
Grand Rapids, Mich	141,197	19	7.0	C 12.8	3	C 10	51
Houston, Tex	144,340	37	13.4	.....	3	.....	.....
Indianapolis, Ind	325,215	68	10.9	C 11.3	8	C 7	62
Jersey City, N. J	302,788	59	10.2	C 8.2	11	C 6	.....
Kansas City, Kans	103,884	19	9.5	C 11.2	0	C 3	0
Kansas City, Mo	336,157	77	11.9	C 12.4	12	C 13	.....
Los Angeles, Calif	611,921	140	11.9	A 12.5	15	A 11	71
Lowell, Mass	113,757	23	10.5	A 11.9	8	A 5	129
Memphis, Tenn	165,389	57	18.0	C 16.9	11	C 6	.....
Minneapolis, Minn	392,815	75	10.0	C 11.4	5	C 13	28
Nashville, Tenn	122,036	38	16.2	C 15.8	11	C 3	.....
New Bedford, Mass	125,012	24	10.0	A 14.7	4	A 7	61
New Haven, Conn	167,007	23	7.2	C 8.3	4	C 3	48
New Orleans, La	394,657	112	14.8	A 20.1	16	A 19	.....
New York, N. Y	5,751,867	1,072	9.7	C 9.4	183	C148	72
Newark, N. J	424,885	87	10.7	C 8.9	16	C 9	71
Norfolk, Va	121,260	33	14.2	.....	7	.....	124
Oakland, Calif	226,472	43	9.9	A 10.1	5	A 3	63
Omaha, Nebr	197,066	52	13.8	.....	6	.....	.....
Paterson, N. J	137,463	25	9.5	.....	3	.....	.....
Philadelphia, Pa	1,866,212	448	12.5	[4] 13.4	69	[4] 63	83
Pittsburgh, Pa	602,452	132	11.4	C 12.7	20	C 23	71
Portland, Oreg	264,859	33	6.5	C 11.6	4	C 5	40
Providence, R. I	239,645	66	14.4	C 13.3	6	C 7	49
Richmond, Va	175,686	55	16.3	C 14.2	15	C 12	183
Rochester, N. Y	305,229	53	9.1	C 11.0	6	C 11	47
St. Louis, Mo	786,164	171	11.3	C 9.6	19	C 19	.....
St. Paul, Minn	237,781	40	8.8	C 11.1	3	C 10	30
Salt Lake City, Utah	121,595	29	12.4	A 8.9	4	.....	62
Seattle, Wash	327,227	45	7.2	A 8.4	9	A 6	75
Spokane, Wash	104,442	22	11.0	C 12.0	4	C 3	87
Springfield, Mass	135,877	22	8.4	C 9.5	2	C 2	30
Syracuse, N. Y	177,265	41	12.1	C 15.9	6	C 6	72
Toledo, Ohio	253,696	55	11.3	A 14.0	5	A 7	50
Trenton, N. J	122,760	37	15.7	A 15.3	3	A 6	.....
Washington, D. C	454,025	101	11.6	A 14.4	14	A 16	82
Wilmington, Del	113,408	35	16.1	C 10.8	3	.....	.....
Worcester, Mass	184,972	30	8.5	C 12.4	4	C 9	43
Yonkers, N. Y	103,324	17	8.6	A 10.9	1	A 3	23
Youngstown, Ohio	139,432	24	9.0	C 6.2	6	C 2	76

[1] Annual rate per 1,000 population.

[2] "A" indicates data for the corresponding week of the years 1913 to 1917, inclusive. "C" indicates data for the corresponding week of the year 1920.

[3] Deaths under 1 year per 1,000 births—an annual rate based on deaths under 1 year for the week and estimated births for 1920. Cities left blank are not in the registration area for births.

[4] Data based on statistics of 1915, 1916, and 1917.

PREVALENCE OF DISEASE.

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring.

UNITED STATES.

CURRENT STATE SUMMARIES.

Telegraphic Reports for Week Ended July 9, 1921.

These reports are preliminary and the figures are subject to change when later returns are received by the State health officers.

ALABAMA.	Cases.
Chicken pox	4
Diphtheria	9
Dysentery	26
Hookworm	41
Malaria	6
Measles	2
Mumps	1
Ophthalmia neonatorum	1
Pellagra	11
Scarlet fever	6
Smallpox	5
Tuberculosis	9
Typhoid fever	29
Whooping cough	4

ARKANSAS.	
Chicken pox	8
Diphtheria	3
Malaria	128
Measles	4
Pellagra	14
Scarlet fever	5
Smallpox	13
Tuberculosis	21
Typhoid fever	20
Whooping cough	17

CALIFORNIA.	
Cerebrospinal meningitis:	
Los Angeles	1
San Francisco	2
Influenza	4
Poliomyelitis—San Francisco	3
Rocky Mountain spotted or tick fever:	
Lassen County	2
Smallpox:	
Sutter County	8
Scattering	44
Typhoid fever	18

COLORADO. (Exclusive of Denver.)	Cases.
Chicken pox	3
Diphtheria	18
Measles	20
Mumps	15
Pneumonia	3
Scarlet fever	10
Smallpox	22
Tuberculosis	2
Typhoid fever	5

CONNECTICUT.	
Cerebrospinal meningitis	2
Chicken pox	15
Diphtheria	34
Influenza	1
Measles:	
Hartford	15
Waterbury	10
Scattering	16
Mumps	19
Pneumonia (lobar)	5
Poliomyelitis	3
Scarlet fever:	
Torrington (B)	35
Scattering	38
Tetanus	2
Tuberculosis (all forms)	35
Typhoid fever	8
Whooping cough	41

DELAWARE.	
Diphtheria	1
Malaria	1
Measles	1
Scarlet fever:	
Wilmington	8
Lewes	2
Tuberculosis	5

DELAWARE—continued.	Cases.
Typhoid fever	5
Whooping cough	3
FLORIDA.	
Diphtheria	9
Influenza	2
Malaria	8
Pneumonia	3
Smallpox	24
Trachoma	1
Typhoid fevor	6
GEORGIA.	
Chicken pox	7
Diphtheria	13
Dysentery (amebic)	2
Dysentery (bacillary)	7
German measles	2
Hookworm	7
Malaria	62
Measles	3
Mumps	5
Paratyphoid fever	3
Scarlet fever	7
Septic sore throat	2
Smallpox	21
Trachoma	1
Tuberculosis (pulmonary)	48
Typhoid fever	90
Whooping cough	13
IDAHO.	
Chicken pox	5
Scarlet fever	1
Smallpox	2
Typhoid fever	1
ILLINOIS.	
Cerebrospinal meningitis:	
Monticello	1
Zion City	1
Diphtheria:	
Chicago	127
Scattering	32
Influenza	1
Pneumonia	75
Poliomyelitis:	
Chicago	3
East St. Louis	1
Evanston	1
Highland Park	2
Polo	1
Springfield	2
Waukegan	1
Zion City	1
Scarlet fever:	
Chicago	23
Scattering	44
Smallpox	15
Typhoid fever	30
INDIANA.	
Diphtheria	47
Poliomyelitis—Grant County	1
Scarlet fever	29
Smallpox	37
Typhoid fever	18
IOWA.	
Diphtheria	12
Poliomyelitis	1
Scarlet fever	11
Smallpox	48
Typhoid fever	2
KANSAS.	
Cerebrospinal meningitis	1
Chicken pox	5
Diphtheria	18
Dysentery (bacillary)	1
Influenza	1
Measles	22
Mumps	4
Pellagra	1
Pneumonia	2
Poliomyelitis	2
Scarlet fever	24
Smallpox	26
Tuberculosis	25
Typhoid fever	25
Whooping cough	71
LOUISIANA.	
Diphtheria	8
Smallpox	6
Typhoid fever	32
MAINE.	
Chicken pox	4
Diphtheria	3
Measles	21
Mumps	1
Scarlet fever	15
Septic sore throat	1
Smallpox	7
Tuberculosis	3
Typhoid fever	8
Whooping cough	31
MARYLAND.[1]	
Cerebrospinal meningitis	1
Chicken pox	15
Diphtheria	20
Dysentery	16
Influenza	4
Lethargic encephalitis	3
Malaria	5
Measles	62
Mumps	11
Ophthalmia neonatorum	3
Paratyphoid fever	1
Pneumonia (all forms)	11
Poliomyelitis	1
Scarlet fever	8
Smallpox	2
Tuberculosis	72
Typhoid fever	38
Whooping cough	91
MASSACHUSETTS.	
Cerebrospinal meningitis	2
Chicken pox	73
Conjunctivitis (suppurative)	11
Diphtheria	106
German measles	8
Lethargic encephalitis	3

[1] Week ended Friday.

MASSACHUSETTS—continued.	Cases.
Malaria	3
Measles	271
Mumps	28
Ophthalmia neonatorum	14
Pneumonia (lobar)	22
Poliomyelitis	3
Scarlet fever	72
Tetanus	1
Tuberculosis (all forms)	129
Typhoid fever	19
Whooping cough	118

MINNESOTA.

Cerebrospinal meningitis:	
St. Paul	2
Scattering	3
Chicken pox	10
Diphtheria	23
Measles	21
Pneumonia	1
Poliomyelitis	1
Scarlet fever	46
Smallpox	33
Tuberculosis	66
Typhoid fever	13
Whooping cough	2

MISSISSIPPI.

Diphtheria	11
Scarlet fever	6
Smallpox	13
Typhoid fever	25

MONTANA.

Diphtheria	6
Rocky Mountain spotted or tick fever:	
Billings	1
Townsend	1
Scarlet fever	2
Smallpox	20
Typhoid fever	1

NEBRASKA.

Chicken pox	1
Diphtheria	5
Measles	7
Mumps	2
Scarlet fever	26
Smallpox:	
Beatrice	9
Nuckolls County	22
Scattering	19
Tetanus	2
Tuberculosis	12
Typhoid fever	3
Whooping cough	9

NEW MEXICO.

Chicken pox	1
Diphtheria	15
Measles	1
Pneumonia	2
Scarlet fever	4
Smallpox	3
Tuberculosis	28
Whooping cough	14

NEW YORK. (Exclusive of New York City.)	Cases.
Diphtheria	137
Influenza	1
Measles	397
Pneumonia	65
Poliomyelitis:	
Ellicottville	1
Syracuse	1
Scarlet fever	113
Smallpox	5
Typhoid fever	12
Whooping cough	301

NORTH CAROLINA.

Chicken pox	10
Diphtheria	16
Measles	67
Ophthalmia neonatorum	1
Poliomyelitis	3
Scarlet fever	21
Septic sore throat	2
Smallpox	24
Typhoid fever	127
Whooping cough	153

SOUTH DAKOTA.

Diphtheria	7
Measles	7
Pneumonia	1
Scarlet fever	15
Smallpox	22
Tuberculosis	4
Whooping cough	3

TEXAS.

Chicken pox	28
Diphtheria	30
Dysentery	59
Measles	50
Smallpox	47
Typhoid fever	18
Whooping cough	76

VERMONT.

Chicken pox	47
Measles	68
Mumps	6
Pneumonia	1
Poliomyelitis	3
Scarlet fever	12
Smallpox	1
Whooping cough	37

WASHINGTON.

Chicken pox	10
Diphtheria	11
Measles	48
Mumps	5
Scarlet fever	12
Smallpox	44
Tuberculosis	11
Typhoid fever	4
Whooping cough	24

WEST VIRGINIA.	Cases.
Diphtheria	3
German measles	1
Measles	2
Scarlet fever	2
Smallpox	10
Typhoid fever	4
WISCONSIN.	
Milwaukee:	
Chicken pox	11
Diphtheria	10
Measles	5
Poliomyelitis	2
Scarlet fever	6
Smallpox	2
Tuberculosis	48
Whooping cough	11
WISCONSIN—continued.	Cases.
Scattering:	
Chicken pox	22
Diphtheria	25
German measles	2
Influenza	5
Lethargic encephalitis:	
Calumet County—Brillion	1
Jefferson County—Watertown	1
Sauk County—Baraboo	2
Measles	23
Poliomyelitis	2
Scarlet fever	36
Smallpox	53
Trachoma	1
Tuberculosis	17
Typhoid fever	3
Whooping cough	70

Reports for Week Ended July 2, 1921.

DISTRICT OF COLUMBIA.	Cases.
Chicken pox	5
Diphtheria	12
Measles	43
Scarlet fever	4
Tuberculosis	19
Typhoid fever	2
Whooping cough	34
KENTUCKY.	
Cerebrospinal meningitis—Jefferson County	1
Chicken pox	3
Diphtheria	18
Dysentery	18
Malaria	6
Measles:	
Jefferson County	17
Scattering	7
KENTUCKY—continued.	Cases.
Mumps	4
Paratyphoid fever	1
Pellagra	1
Pneumonia	9
Poliomyelitis—Daviess County	1
Scarlet fever	15
Septic sore throat	2
Smallpox:	
Fulton County	15
Henderson County	8
Scattering	13
Trachoma	2
Tuberculosis	13
Typhoid fever:	
Estill County	10
Scattering	49
Whooping cough	39

SUMMARY OF CASES REPORTED MONTHLY BY STATES.

The following summary of monthly State reports is published weekly and covers only those States from which reports are received during the current week.

State.	Cerebrospinal meningitis.	Diphtheria.	Influenza.	Malaria.	Measles.	Pellagra.	Poliomyelitis.	Scarlet fever.	Smallpox.	Typhoid fever.
1921.										
Massachusetts (June)	9	624	12	7	1,635	1	4	492	.....	59
Nebraska (June)	.....	35	.....	.....	87	.....	4	109	200	6
New Mexico (May)	.....	126	14	.....	240	.....	.....	24	15	10
New Mexico (June)	.....	61	.....	2	110	.....	.....	12	15	11

RECIPROCAL NOTIFICATION.

Connecticut—June, 1921.

Cases of communicable diseases referred during June, 1921, to other State health departments by department of health of the State of Connecticut.

Disease and locality of notification.	Referred to health authority of—	Why referred.
Diphtheria:		
New London, Conn.	State Board of Health, Providence, R. I.	Patient, a resident of Westerly, R. I., was taken to the New London Hospital, Connecticut, for treatment
Epidemic encephalitis:		
Greenwich, Conn.	State Board of Health, Newark, N. J.	Patient was living in Newark, N. J., at onset of disease. She was brought to Greenwich, Conn., and died there.
Measles:		
Milford, Conn.	State Board of Health, Providence, R. I.	Patient left his home in Woonsockett, R. I., to go to summer home in Woodmont (Milford), Conn., on June 16, becoming ill with measles June 19.
Middletown, Conn.	State Board of Health, Newark, N. J.	Patient left Elizabeth, N. J. May 31, becoming ill with measles at her home in Middletown, Conn., June 9. While in Elizabeth patient had played with a child in the incubation stage of measles.
Scarlet fever:		
Brooklyn, Conn.	State Department of Public Health, Boston, Mass.	Father of child ill with scarlet fever ships milk daily to Boston, Mass.
Typhoid fever:		
Willimantic, Conn.	State Department of Health, Albany, N. Y.	Patient arrived in Colchester, Conn., from New York City on June 14, becoming ill with typhoid June 23.
Hartford, Conn.	State Department of Public Health, Boston, Mass.	Patient had visited Springfield and Northampton, Mass., while apparently in the incubation period of the disease.
Stratford, Conn.	do.	Patient was in the incubation stage when she visited Holyoke, Mass., on May 22, the onset of the disease being May 27.

PLAGUE.[1]

HUMAN CASES OF PLAGUE REPORTED.

Place.	Period covered.	Cases.	Deaths.	Remarks.
California:	1921.			
San Benito County	Feb. 7		1	
	June 11	1		

[1] A summary of the reports received of the occurrence of plague and the finding of plague-infected rodents in the United States during 1920 was published in Public Health Reports, Jan. 7, 1921, p. 15.

PLAGUE-INFECTED RODENTS.

Place.	Period covered.	Rodents found plague infected.
California:	1921.	
San Benito County	May 15 to June 4	18
Florida:		
Pensacola	Jan. 1 to Apr. 18	5
	Apr. 19 to July 9	0
Louisiana:		
New Orleans	Jan. 1 to May 26	38
	May 27 to July 9	0
Texas:		
Galveston	Jan. 1 to May 28	1
	May 29 to July 9	0

[1] Ground squirrels, *Citellus beecheyi*.

TYPHUS FEVER.

Navajo Indian Reservation, Shiprock, N. Mex., June 26–July 9, 1921. [1]

During the two weeks period ended July 9, 1921, one new case of typhus fever and one death from that disease occurred on the Navajo Indian Reservation near Shiprock, N. Mex. Delousing was proceeding satisfactorily. A survey of conditions throughout the reservation showed no spread of the disease to adjacent agencies or reservations.

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921.

CEREBROSPINAL MENINGITIS.

The column headed "Median for previous years" gives the median number of cases reported during the corresponding weeks of the years 1915 to 1920, inclusive. In instances in which data for the full six years are incomplete, the median is that for the number of years for which information is available.

City.	Median for previous years.	Week ended June 25, 1921.	
		Cases.	Deaths.
California:			
Los Angeles	1	1	
San Francisco	0	1	
Illinois:			
Chicago	3	3	1
Maryland:			
Baltimore	1	1	
Massachusetts:			
Everett	0	1	
Michigan:			
Detroit	0	1	2
Highland Park	0	1	
Muskegon	0		1
Minnesota:			
Minneapolis	0	1	
New Jersey:			
Phillipsburg	0	1	1
New York:			
Buffalo	0		1
New York	5	5	3
Niagara Falls	0	1	1
Ohio:			
Dayton	0	1	
Pennsylvania:			
Philadelphia	0		1
Rhode Island:			
Providence	0	1	
Tennessee:			
Memphis	0		1
Virginia:			
Richmond	0	1	
Wisconsin:			
Milwaukee	1	1	

DIPHTHERIA.

See p. 1649; also Telegraphic weekly reports from States, p. 1638, and Monthly summaries by States, p. 1641.

INFLUENZA.

City.	Cases.	Deaths.
Alabama:		
Birmingham		1
California:		
Berkeley	5	
San Francisco	5	
Illinois:		
Chicago	3	1
Maryland:		
Baltimore	1	
Massachusetts:		
Boston	1	1
Michigan:		
Detroit	4	
New York:		
New York	3	3
Saratoga Springs	1	
Pennsylvania:		
Philadelphia	2	

LEPROSY.

Connecticut:		
Hartford	1	

LETHARGIC ENCEPHALITIS.

Ohio:			Oregon:		
East Cleveland		1	Portland		2
Mansfield	1				

[1] See Public Health Reports, May 27, 1921, p. 1190; June 24, 1921, p. 1468; and July 8, 1921, p. 1572.

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

MALARIA.

City.	Cases.	Deaths.	City.	Cases.	Deaths.
Alabama:			Louisiana:		
Montgomery		1	Alexandria	16	
Arkansas:			Baton Rouge	1	
Little Rock	2		New Orleans	2	
North Little Rock	1		Massachusetts:		
California:			Boston	1	
Berkeley	1		New York:		
Los Angeles	1		New York	4	
Georgia:			Tennessee:		
Atlanta	3		Memphis	2	1
Brunswick	2		Texas:		
Savannah	3	2	Beaumont	1	1
Valdosta	1		Dallas	2	
Illinois:			Port Arthur	1	1
Chicago	1		Virginia:		
			Petersburg	1	

MEASLES.

See p. 1649; also Telegraphic weekly reports from States, p. 1638, and Monthly summaries by States, p. 1641.

PELLAGRA.

City.	Cases.	Deaths.	City.	Cases.	Deaths.
Alabama:			Louisiana:		
Montgomery		2	Alexandria	18	
Tuscaloosa	1		Massachusetts:		
Arkansas:			Boston		1
North Little Rock	3		North Carolina:		
Georgia:			Charlotte		2
Atlanta		1	Raleigh		1
Kansas:			Winston-Salem	1	1
Topeka	1		Tennessee:		
Kentucky:			Memphis		1
Louisville		1	Texas:		
			Dallas		1

PNEUMONIA (ALL FORMS).

Alabama:			Illinois—Continued.		
Birmingham		3	Galesburg	1	
Mobile		2	La Salle	1	
Montgomery		1	Oak Park	1	
Arizona:			Indiana:		
Tucson		1	Gary	2	3
California:			Hammond		1
Berkeley		2	Indianapolis		4
Long Beach	2	1	Kokomo		1
Oakland		4	Marion		1
Sacramento		1	Terre Haute		1
San Diego		2	Kansas:		
San Francisco	6	3	Kansas City	2	
Santa Barbara		1	Topeka		1
Santa Cruz		1	Wichita		1
Colorado:			Covington		1
Denver		7	Kentucky:		
Connecticut:			Lexington		3
Bridgeport		2	Louisville		7
Fairfield	1		Maryland:		
Greenwich	1		Baltimore	14	9
Hartford		1	Massachusetts:		
New Haven	1		Adams	2	
Waterbury	2	1	Boston	28	17
Delaware:			Braintree	1	
Wilmington		1	Brookline	1	
District of Columbia:			Cambridge		3
Washington		7	Chelsea	1	
Georgia:			Easthampton	2	
Atlanta		5	Everett	3	
Savannah		2	Fall River		4
Illinois:			Haverhill	1	
Alton	1		Lowell		2
Blue Island	2		Lynn		1
Chicago	83	14	Melrose		1
Cicero		1	Northampton		1

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

PNEUMONIA (ALL FORMS)—Continued.

City.	Cases.	Deaths.
Massachusetts—Continued.		
Pittsfield		1
Quincy		1
Salem		1
Somerville		2
Southbridge	1	
Springfield	5	2
Taunton		1
Watertown		1
Winthrop		1
Worcester		4
Michigan:		
Ann Arbor		1
Detroit	23	12
Grand Rapids		1
Hamtramck		2
Highland Park	1	
Kalamazoo		1
Muskegon		1
Port Huron	1	
Minnesota:		
Duluth		1
Hibbing	1	
Minneapolis		4
Rochester		1
St. Paul		1
Missouri:		
Kansas City		6
St. Joseph		3
Montana:		
Great Falls	1	
New Hampshire:		
Keene	1	
Manchester		2
New Jersey:		
Elizabeth		4
Garfield	3	
Hackensack		1
Hoboken		6
Irvington	1	
Jersey City	3	
Newark	35	4
Orange	6	
Passaic		1
Paterson	1	
Trenton	3	2
West New York		1
West Orange		1
New York:		
Albany	5	
Binghamton	4	1
Buffalo	9	5
Ithaca		1
New York—Continued.		
Jamestown	1	
Lackawanna	2	
Lockport		1
Mount Vernon	1	
New York	137	81
Niagara Falls		2
Poughkeepsie		1
Rochester	7	2
Syracuse	1	
Watervliet		1
White Plains	1	
Yonkers	3	
North Carolina:		
Durham		1
Greensboro		1
Ohio:		
Akron	1	
Cincinnati		9
Cleveland	7	
Columbus		3
Coshocton	2	
Dayton	1	
Findlay		1
Mansfield		1
Newark		2
Sandusky	1	
Toledo		3
Youngstown		1
Oklahoma:		
Oklahoma City		4
Oregon:		
Portland		4
Pennsylvania:		
Philadelphia	39	21
Rhode Island:		
Cranston		1
Providence		2
Tennessee:		
Memphis		4
Texas:		
El Paso		1
Utah:		
Salt Lake City		1
Virginia:		
Portsmouth		2
Richmond		2
West Virginia:		
Charleston		1
Huntington		1
Wheeling		1
Wisconsin:		
Racine		2

POLIOMYELITIS (INFANTILE PARALYSIS).

The column headed "Median for previous years" gives the median number of cases reported during the corresponding weeks of the years 1915 to 1920, inclusive. In instances in which data for the full six years are incomplete, the median is that for the number of years for which information is available.

City.	Median for previous years.	Week ended June 25, 1921.	
		Cases.	Deaths.
California:			
Oakland	0	1	
San Francisco	0	1	
Connecticut:			
New Haven	0	1	1
Illinois:			
Aurora		1	
Chicago	1	2	1
East St. Louis	0	1	
Springfield	0	1	
Massachusetts:			
Boston	0	1	
Michigan:			
Alpena	0	1	
Detroit	0	1	
Missouri:			
St. Louis	0	5	2
Nebraska:			
Omaha	0	1	
New Jersey:			
West Orange		1	
New York:			
New York	3	3	
Ohio:			
Cleveland	0	1	

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

RABIES IN ANIMALS.

City.	Cases.	City.	Cases.
Massachusetts:		Virginia:	
Boston	2	Petersburg	1
Missouri:			
Kansas City	3		

SCARLET FEVER.

See p. 1694; also Telegraphic weekly reports from States, p. 1638; and Monthly summaries by States, p. 1641.

SMALLPOX.

The column headed "Median for previous years" gives the median number of cases reported during the corresponding weeks of the years 1915 to 1920, inclusive. In instances in which data for the full six years are incomplete, the median is that for the number of years for which information is available.

City.	Median for previous years.	Week ended June 25, 1921.	
		Cases.	Deaths.
Alabama:			
Birmingham	1	7	
Mobile	0	5	1
California:			
Los Angeles	0	1	
Oakland	0	4	
Pasadena	0	1	
Richmond		3	
Riverside	1	26	
Sacramento	0	2	
San Bernardino	0	1	
San Francisco	1	10	
Colorado:			
Denver	15	27	
Pueblo	1	1	
Georgia:			
Atlanta	6	2	
Savannah	0	5	
Illinois:			
Bloomington	0	1	
Danville	1	1	
Indiana:			
Bloomington	0	6	
Fort Wayne	1	1	
Indianapolis	4	10	
Logansport	2	1	
Marion	1	12	1
South Bend	0	1	
Terre Haute	0	1	
Iowa:			
Clinton	0	1	
Council Bluffs	1	2	
Des Moines	4	5	
Mason City	1	3	
Muscatine	0	1	
Sioux City	5	3	
Kansas:			
Fort Scott	0	1	
Hutchinson	2	4	
Kansas City	2	3	
Topeka	4	2	
Wichita	14	3	
Kentucky:			
Lexington	1	1	
Louisiana:			
Alexandria	1	1	
New Orleans	2	6	1
Michigan:			
Alpena		1	
Ann Arbor	0	1	
Battle Creek	1	1	
Detroit	12	21	
Highland Park	2	1	
Pontiac	1	5	
Sault Ste. Marie	0	2	
Minnesota:			
Duluth	3	6	
Mankato	0	5	
Minneapolis	18	18	
St. Cloud	0	1	
St. Paul	2	19	
Missouri:			
Kansas City	4	8	
St. Louis	1	5	
Montana:			
Billings	0	1	
Great Falls	1	9	
Nebraska:			
Lincoln	3	2	
Nevada:			
Reno	2	2	
New Jersey:			
Newark	0	1	
Trenton		2	
West New York		1	
New York:			
North Tonawanda		2	
North Carolina:			
Charlotte	0	1	
Winston-Salem	0	6	
North Dakota:			
Fargo	0	6	
Ohio:			
Akron	7	2	
Cincinnati	1	1	
Cleveland	4	3	
Lancaster	0	3	
Newark	0	3	
Springfield	1	1	
Toledo	1	2	
Oklahoma:			
Muskogee	1	1	
Oklahoma City	7	3	
Oregon:			
Portland	8	3	
South Carolina:			
Charleston	0	1	
Columbia	0	2	
Tennessee:			
Nashville	1	1	
Texas:			
Fort Worth	3	4	
Galveston	0	1	
Waco	0	1	
Utah:			
Salt Lake City	3	14	
Virginia:			
Richmond	0	4	
Washington:			
Seattle	3	3	
Tacoma	1	2	

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

SMALLPOX—Continued.

City.	Median for previous years.	Week ended June 25, 1921. Cases.	Deaths.
West Virginia:			
Wheeling	0	1	.....
Wisconsin:			
Eau Claire	0	3	.....
Fond du Lac	1	1	.....
Wisconsin—Continued.			
Madison	0	1	.....
Milwaukee	4	1	.....
Sheboygan	0	1	.....
Superior	2	1	.....

TETANUS.

City.	Cases.	Deaths.
Illinois:		
Chicago	1	.....
Massachusetts:		
Boston	1	.....
Minnesota:		
St. Paul	.....	1
New Jersey:		
Atlantic City	1	1
Orange	1	1
Trenton	1	.....
New York:		
Cohoes	1	1
Jamestown	1	1
New York	1	1
Ohio:		
Cleveland	1	.....

TUBERCULOSIS.

See p. 1649; also Telegraphic weekly reports from States, p. 1638.

TYPHOID FEVER.

The column headed "Median for previous years" gives the median number of cases reported during the corresponding weeks of the years 1915 to 1920, inclusive. In instances in which data for the full six years are incomplete, the median is that for the number of years for which information is available.

City.	Median for previous years.	Week ended June 25, 1921. Cases.	Deaths.
Alabama:			
Anniston	0	1	.....
Birmingham	9	6	4
Mobile	2	1	.....
Montgomery	3	1	.....
Arkansas:			
Litt'e Rock	2	2	.....
California:			
Alameda	0	1	.....
Berkeley	1	1	.....
Long Beach	0	1	1
Los Angeles	5	.....	1
Oakland	3	1	.....
San Francisco	4	3	1
Colorado:			
Denver	0	1	.....
Connecticut:			
Bridgeport	0	1	.....
Hartford	1	1	.....
New Haven	1	2	.....
Stonington	.....	1	.....
Waterbury	0	1	.....
Delaware:			
Wilmington	1	1	.....
District of Columbia:			
Washington	4	5	1
Georgia:			
Atlanta	2	2	1
Savannah	2	4	.....
Valdosta	.....	1	.....
Illinois:			
Chicago	6	.....	1
Galesburg	0	1	.....
Indiana:			
Bloomington	0	.....	1
Evansville	0	1	.....
Indianapolis	1	.....	1
Kansas:			
Hutchinson	1	1	.....
Kansas City	1	1	.....
Kentucky:			
Lexington	0	7	.....
Louisville	3	.....	1
Louisiana:			
Baton Rouge	0	1	1
New Orleans	4	1	1
Maryland:			
Baltimore	6	7	.....
Cumberland	0	1	.....
Massachusetts:			
Boston	4	2	.....
Brookline	0	.....	1
Fall River	2	1	.....
Holyoke	0	1	.....
Lawrence	0	1	.....
Lowell	0	2	.....
Malden	0	1	1
New Bedford	0	1	.....
Quincy	0	2	.....
Springfield	0	1	.....

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

TYPHOID FEVER—Continued.

City.	Median for previous years.	Week ended June 25, 1921. Cases.	Deaths.
Massachusetts—Contd.			
Waltham	0	1	.....
Worcester	1	1	.....
Michigan:			
Ann Arbor	0	1	.....
Detroit	5	3	.....
Flint	0	1	.....
Minnesota:			
Minneapolis	1	1	.....
St. Paul	0	2	.....
Virginia	0	2	.....
Missouri:			
Kansas City	1	1	1
St. Louis	2	6	2
Montana:			
Great Falls	0	1	.....
Nebraska:			
Omaha	0	1	.....
New Jersey:			
Atlantic City	0	1	1
Trenton	0	1	.....
New York:			
Buffalo	1	2	.....
Mount Vernon	0	1	.....
New York	21	16	2
Niagara Falls	0	1	.....
North Tonawanda	0	.....	1
Rochester	0	2	.....
Troy	1	1	.....
North Carolina:			
Durham	2	3	.....
Winston-Salem	2	1	.....
Ohio:			
Canton	0	2	.....
Cincinnati	1	.....	1
Cleveland	2	3	.....
Ohio—Continued.			
Columbus	2	1	.....
Lima	0	1	.....
Newark	1	1	.....
Oklahoma:			
Muskogee	0	3	.....
Oklahoma City	0	1	.....
Tulsa	2	2	.....
Oregon:			
Portland	0	.....	1
Pennsylvania:			
Philadelphia	10	4	1
South Carolina:			
Charleston	9	1	1
Columbia	0	2	.....
Tennessee:			
Memphis	1	2	.....
Nashville	4	8	2
Texas:			
Beaumont	1	1	1
Dallas	4	3	.....
Fort Worth	3	1	.....
Port Arthur	.....	3	.....
Virginia:			
Lynchburg	0	2	.....
Portsmouth	2	3	.....
Richmond	1	1	.....
Washington:			
Seattle	0	3	.....
West Virginia:			
Bluefield	0	1	.....
Charleston	4	2	.....
Wisconsin:			
Milwaukee	2	4	.....
Sheboygan	0	1	.....
Superior	0	1	.....

TYPHUS FEVER.

City.	Cases.	Deaths.
New York:		
New York	1	.....

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

DIPHTHERIA, MEASLES, SCARLET FEVER, AND TUBERCULOSIS.

City.	Population Jan. 1, 1920, subject to correction.	Total deaths from all causes.	Diphtheria.		Measles.		Scarlet fever.		Tuberculosis.	
			Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Alabama:										
Anniston	17,734								1	
Birmingham	178,270	51	4		28	1	2		10	6
Mobile	60,151	16					1			2
Montgomery	43,464	22					1			4
Arizona:										
Tucson	20,292	18								10
Arkansas:										
Fort Smith	28,811						2			
Little Rock	64,997				3				6	
North Little Rock	14,048				2					
California:										
Alameda	28,806	11								
Berkeley	55,886	12	1				1			2
Eureka	12,923	2							1	1
Long Beach	55,593	18			1		3		1	1
Los Angeles	576,673	162	43	1	24		20	1	51	21
Oakland	216,361	40	4		3		4		2	2
Pasadena	45,354	17	3		10				1	
Richmond	16,843	1	1				1			
Riverside	19,341	5					1		2	1
Sacramento	65,857	24	4							1
San Bernardino	18,721	2							1	1
San Diego	74,683	35			67	1	3		6	5
San Francisco	508,410	139	26	2	7	1	10		20	12
Santa Barbara	19,441	1								
Santa Cruz	10,917	4					2			
Colorado:										
Colorado Springs	30,105	14			1				7	4
Denver	255,369	64	7	2	2		5			10
Pueblo	42,908		7	1						1
Trinidad	10,906		1							
Connecticut:										
Bridgeport	143,538	24	3		3		2		4	4
Bristol	20,620	2								
Derby	11,238	3	1				2			
Fairfield (town)	11,475						2			
Greenwich (town)	22,123		2		1					
Hartford	138,036	33	5	2	18		4			2
Meriden (city)	29,842		1				1			
Milford (town)	10,193	2			1					
New Haven	162,519	34	10		1		3		23	4
New London	25,688	4								
Norwalk	27,700	6	2							1
Norwich (city)	22,304	6							1	1
Stonington (town)	10,236	2							1	
Waterbury	91,410	13	3		6				9	1
Delaware:										
Wilmington	110,168	30					11			1
District of Columbia:										
Washington	437,571	118	4		79		6		22	6
Georgia:										
Atlanta	200,616	66			5		1			1
Brunswick	14,413	3								1
Savannah	83,252	33	1	1					2	1
Valdosta	10,783	6								
Idaho:										
Boise	21,393	7	1		1		2			
Illinois:										
Alton	24,682	6								1
Aurora	36,397	13	1		2		1		2	2
Bloomington	28,725	7							2	
Blue Island	11,424	3	4							
Centralia	12,491	4								
Chicago	2,701,705	551	163	10	226	1	65	5	115	39
Cicero	44,995	2	1		2				1	
Danville	33,750	7	1				1			
East St. Louis	66,740	10	2		2		2		3	
Elgin	27,454	6			2					
Evanston	37,215	8	3							
Galesburg	23,834	6			4					
Jacksonville	15,713	10								1
La Salle	13,050	5								
Mattoon	13,552	2								

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

DIPHTHERIA, MEASLES, SCARLET FEVER, AND TUBERCULOSIS—Continued.

City.	Population January 1, 1920, subject to correction.	Total deaths from all causes.	Diphtheria.		Measles.		Scarlet fever.		Tuberculosis.	
			Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Illinois—Continued.										
Oak Park	39,830	6	4	2	10					
Pekin	12,086						4			
Peoria	76,121	25	2				2			2
Rock Island	35,177	6			1		1		2	
Springfield	59,183	12	1		6		4			
Indiana:										
Bloomington	11,595	1								
Elkhart	24,277	3					1			
Evansville	85,264	12					2			
Frankfort	11,585	4								
Gary	55,378	14	3		2					
Hammond	36,004	6	2				1		1	
Huntington	14,000	0	5							
Indianapolis	314,194	81	5	1			3		7	11
Kokomo	30,067	6	1						2	2
La Fayette	22,486	5	1							
Logansport	21,626	6					1			
Marion	23,747	7	1	2						
Mishawaka	15,195	4								
Muncie	36,624	10			5					1
Richmond	26,765	5					1			
South Bend	70,983	13			1		2		2	
Terre Haute	66,083	13	4	1			1			1
Iowa:										
Cedar Rapids	45,566		1	1						
Council Bluffs	36,162	5	2				1			
Davenport	56,727						2		1	
Des Moines	126,468		1				2			
Iowa City	11,267		1		2					
Mason City	20,065						1			
Muscatine	16,068	3	3							
Kansas:										
Coffeyville	13,452	5							1	
Fort Scott	10,693	1	5							
Kansas City	101,177		1				4		3	
Lawrence	12,456	3								
Leavenworth	16,912		3							
Salina	15,085	6	1		1					
Topeka	50,022	4	1				4		4	
Wichita	72,128	21	1		9		1		3	
Kentucky:										
Covington	57,121	18	1						4	1
Lexington	41,534	23			1					3
Louisville	234,891	93								5
Paducah	24,735						1			
Louisiana:										
Alexandria	17,510	8								
Baton Rouge	21,782	8	1							
New Orleans	387,219	126	1	1			1		28	13
Maine:										
Auburn	16,985	3					2			
Bangor	25,978								1	
Bath	14,731	0					2			
Lewiston	31,791	8	3				6		2	
Portland	69,272	10		1						1
Sanford	10,691	2								
Waterville	13,351				1		1		1	
Maryland:										
Baltimore	733,826	185	18	1	47		8		23	23
Cumberland	29,837	8					1		1	
Massachusetts:										
Adams	12,967	3								
Amesbury	10,036	1					1			
Arlington	18,665	3			6					
Attleboro	19,731	2	1				1		2	
Belmont	10,749	3	2		1					
Beverly	22,561	5	2				1		1	
Boston	748,060	204	48	3	105		31		33	17
Braintree	10,580	6			1		2		1	2
Brookline	37,748	6								1
Cambridge	109,694	29	6	2	8		3		7	
Chelsea	43,184	9			2				2	1
Chicopee	36,214	6		1						
Clinton	12,979	2			2					

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

DIPHTHERIA, MEASLES, SCARLET FEVER, AND TUBERCULOSIS—Continued.

City.	Population January 1, 1920, subject to correction.	Total deaths from all causes.	Diphtheria.		Measles.		Scarlet fever.		Tuberculosis.	
			Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Massachusetts—Continued.										
Danvers	11,108		5						2	
Dedham	16,792	3								
Easthampton	11,261	1	2						1	1
Everett	40,120	9			3		5		2	1
Fall River	120,485	24	4	2	6		1		12	3
Gardner	16,971	3							2	1
Greenfield	15,462	1					1			
Haverhill	53,884	12			1		1		2	1
Holyoke	60,203	16							3	1
Lawrence	94,270	15			6		5		4	1
Lowell	112,479	16	3						1	
Lynn	99,148	21	2		33				9	2
Malden	49,103	8	3				2		1	
Medford	39,038	8	2		3				4	
Melrose	18,204	3	3						1	
Methuen	15,189	4			1		2			
New Bedford	121,217	23	4				2		5	
Newburyport	15,618	2			4					
Newton	46,054	8	4				2		1	
North Adams	22,282	6							1	
Northampton	21,951	5								
Norwood	12,627	2							2	
Peabody	19,552	1	1				1			
Pittsfield	41,751	18	2				1			
Plymouth	13,045	2								
Quincy	47,876	10	2		29		1			
Salem	42,529	16		1						1
Saugus	10,874	4					1		1	2
Somerville	93,091	25	3		5		1		3	1
Southbridge	14,245	0								
Springfield	129,563	22	3				4		3	
Taunton	37,137	9			1		2			1
Wakefield	13,025	1			3					
Waltham	30,915		2		1					
Watertown	21,457	2			2				1	
Westfield	15,604	1	2							
Winthrop	15,455	3			1					
Woburn	16,574	1								
Worcester	179,754	38			3		2		4	2
Michigan:										
Alpena	11,101	1	1	1						
Ann Arbor	19,516	8	1	1			1		1	
Battle Creek	36,164		2				1		1	
Detroit	993,739	139	64	10	30	1	52	3	29	15
Flint	91,599	18	4		1		1			
Grand Rapids	137,634	38	9	2			1		4	2
Hamtramck	48,615	16	1	1	1			2	3	
Highland Park	46,499	4	2				10		1	1
Ironwood	15,739	2	1		4		1			
Kalamazoo	48,858	15					2		3	1
Marquette	12,718	1								
Muskegon	36,570	10								
Pontiac	34,273	9	22				1		1	
Port Huron	25,944	6					1		3	1
Sault Ste. Marie	12,096	3						1		
Minnesota:										
Austin	10,118	6								
Duluth	98,917	13	2		1		4		8	2
Hibbing	15,089	2			2		1			1
Minneapolis	380,582	86	19	1	11		16	1	32	9
Rochester	13,732	19			7		1			
St. Cloud	15,873		3						1	
St. Paul	234,595	49	11		1		10		14	8
Virginia	14,022		1							
Winona	19,143	2	1				3			
Missouri:										
Cape Girardeau	10,252	3								
Independence	11,686	5							1	1
Jefferson City	14,490	1								
Kansas City	324,410	79	9	1	10		2		3	7
Saint Joseph	77,939	31	2							
Saint Louis	772,897	145	28		5		17	2	43	11
Springfield	39,631	13								1

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

DIPHTHERIA, MEASLES, SCARLET FEVER, AND TUBERCULOSIS—Continued.

City.	Population January 1, 1920, subject to correction.	Total deaths from all causes.	Diphtheria.		Measles.		Scarlet fever.		Tuberculosis.	
			Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Montana:										
Billings	15,100	8								
Great Falls	24,121	7	1		1				2	
Missoula	12,668	2							1	1
Nebraska:										
Lincoln	54,934	11					2			
Omaha	191,601	37			10		3			2
Nevada:										
Reno	12,016	8								
New Hampshire:										
Berlin	16,104	1								
Concord	22,167	1							1	1
Dover	13,029	3								1
Keene	11,210	2					1			
Manchester	78,394	17	8	1	3		1		2	
Nashua	28,379	7	1						4	1
New Jersey:										
Asbury Park	12,400	4			1				1	
Atlantic City	50,682	10	2		4		7	1	4	
Bayonne	76,754						5		1	
Belleville	15,660		1						1	
Bloomfield	22,019	4	1		5		5		1	
Clifton	26,470	2	1		1		1		2	
East Orange	50,710		1		4		6			
Elizabeth	95,682		5		4		9		2	3
Englewood	11,627	4	1							
Garfield	19,381	1	2		1		1			
Gloucester City	12,162				5					
Hackensack	17,667	8					3		1	
Harrison	15,721				4		5		1	
Hoboken	68,166	15	6				2		3	1
Irvington	25,490		6		3					
Jersey City	297,864		13		17		10		11	
Kearny	26,724	4			1		1			
Montclair	28,810	3			4				2	
Morristown	12,548	9					2	1		
New Brunswick	32,779	0	4							
Newark	414,216	107	14	1	73		26		13	9
Orange	33,268	6					1		1	
Passaic	63,824	12	1		1				2	
Paterson	135,866		9		10		13		7	
Perth Amboy	41,707	6	1	1	1		3		5	
Phillipsburg	16,923	4								
Plainfield	27,700	4	1				5			1
Rahway	11,042	3	1							
Summit	10,174	1								
Trenton	119,289	28	9		18		4		6	1
Union	20,651		2						3	
West Hoboken	40,068	7			1					
West New York	29,926	4	1		1		3			
West Orange	15,573	1			2		1		1	
New Mexico:										
Albuquerque	15,157	12							4	6
New York:										
Albany	113,344		2		5		7		9	
Binghamton	66,800	14	6				1		6	
Buffalo	506,775	109	38	5	35		24		21	12
Cohoes	22,987	4								
Geneva	14,648	2								
Glens Falls	16,633	4								
Ithaca	17,004	7							1	
Jamestown	38,917	13	1	1	82				6	1
Lackawanna	17,918	2	1				1		3	
Lockport	21,308	7	2						1	
Middletown	18,420	1			1		1		1	
Mount Vernon	42,726	6	6		2				2	1
Newburgh	30,366	9	3						2	
New York	5,621,151	1,147	340	21	186	4	209	6	[1] 346	[1] 96
Niagara Falls	50,760	18	6				6			
North Tonawanda	15,452	3			3		1			1
Ogdensburg	14,609	5								
Olean	20,506	6								
Peekskill	15,868	3			5					
Poughkeepsie	35,060	10	1	1			3			

[1] Pulmonary tuberculosis only.

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

DIPHTHERIA, MEASLES, SCARLET FEVER, AND TUBERCULOSIS—Continued.

City.	Population January 1, 1920, subject to correction.	Total deaths from all causes.	Diphtheria.		Measles.		Scarlet fever.		Tuberculosis.	
			Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
New York—Continued.										
Rochester	295,750	47	27	1	2	.....	12	.....	11	1
Rome	26,341	.....	2	.....	4	.....	.....	.....	.....	1
Saratoga Springs	13,181	3	.....	.....	1	.....	.....	.....	1	.....
Schenectady	88,723	17	4	1	6	.....	.....	.....	.....	1
Syracuse	171,717	39	5	1	24	.....	2	.....	3	3
Troy	72,013	27	1	.....	.....	.....	.....	.....	.....	1
Watervliet	16,073	5	.....	.....	.....	.....	.....	.....	.....	.....
White Plains	21,031	7	.....	.....	.....	.....	1	.....	.....	.....
Yonkers	100,226	13	1	.....	4	.....	5	.....	.....	1
North Carolina:										
Charlotte	46,338	18	.....	.....	.....	.....	1	.....	4	2
Durham	21,719	5	.....	.....	1	.....	.....	.....	.....	.....
Greensboro	19,861	10	.....	.....	.....	.....	.....	.....	.....	.....
Raleigh	24,418	10	.....	.....	2	.....	.....	.....	1	.....
Rocky Mount	12,742	7	.....	.....	.....	.....	.....	.....	.....	.....
Salisbury	13,884	6	.....	.....	.....	.....	.....	.....	.....	1
Wilmington	33,372	12	.....	.....	.....	.....	1	.....	1	1
Winston-Salem	48,395	23	1	.....	.....	.....	.....	.....	10	3
North Dakota:										
Fargo	21,961	.....	2	.....	.....	.....	1	.....	.....	.....
Grand Forks	14,010	.....	.....	.....	1	.....	.....	.....	.....	.....
Ohio:										
Akron	208,435	25	1	.....	4	.....	3	.....	7	.....
Barberton	18,811	2	.....	.....	.....	.....	.....	.....	.....	.....
Bucyrus	10,425	5	.....	.....	.....	.....	.....	.....	.....	.....
Canton	87,091	10	4	.....	.....	.....	5	.....	2	.....
Cincinnati	401,247	121	8	.....	14	.....	5	.....	20	14
Cleveland	796,836	.....	25	.....	45	.....	49	.....	.....	.....
Columbus	237,031	59	5	.....	.....	.....	5	.....	3	5
Coshocton	10,847	.....	1	.....	.....	.....	.....	.....	.....	.....
Cuyhoga Falls	10,200	4	.....	.....	1	.....	.....	.....	.....	.....
Dayton	152,559	31	.....	.....	1	.....	2	.....	1	.....
East Cleveland	27,292	4	.....	.....	1	.....	.....	.....	1	.....
Findlay	17,021	5	.....	.....	.....	.....	.....	.....	2	.....
Fremont	12,468	3	.....	.....	.....	.....	.....	.....	.....	.....
Hamilton	39,675	9	.....	.....	.....	.....	5	.....	2	1
Kenmore	12,683	.....	.....	.....	1	.....	.....	.....	1	.....
Lancaster	14,706	6	.....	.....	.....	.....	.....	.....	.....	2
Lima	41,306	5	.....	.....	1	.....	.....	.....	.....	.....
Mansfield	27,824	6	2	.....	.....	.....	.....	.....	.....	1
Marion	27,891	.....	1	.....	.....	.....	1	.....	.....	.....
Middletown	23,594	6	1	.....	.....	.....	1	.....	.....	1
Newark	26,718	5	.....	.....	.....	.....	.....	.....	.....	.....
Niles	13,080	1	.....	.....	.....	.....	4	1	.....	.....
Norwood	24,966	3	.....	.....	.....	.....	.....	.....	.....	.....
Piqua	15,044	4	.....	.....	.....	.....	.....	.....	.....	1
Salem	10,395	3	.....	.....	.....	.....	.....	.....	.....	.....
Sandusky	22,897	4	.....	.....	.....	.....	.....	.....	1	.....
Springfield	60,840	17	9	.....	1	.....	3	.....	2	1
Steubenville	28,508	11	.....	.....	.....	.....	.....	.....	.....	.....
Toledo	243,109	52	7	.....	.....	.....	3	.....	8	11
Youngstown	132,358	26	1	.....	13	.....	1	.....	3	2
Zanesville	29,569	9	.....	.....	.....	.....	.....	.....	.....	.....
Oklahoma:										
Muskogee	30,277	.....	.....	.....	3	.....	.....	.....	.....	.....
Oklahoma City	91,258	25	4	.....	.....	.....	1	.....	2	.....
Oregon:										
Portland	258,288	58	6	.....	11	.....	3	.....	7	3
Pennsylvania:										
Philadelphia	1,823,158	380	69	15	30	.....	103	1	71	29
Rhode Island:										
Cranston	29,407	5	1	.....	6	.....	1	.....	.....	1
Newport	30,255	3	1	.....	.....	.....	2	.....	.....	.....
Pawtucket	64,248	14	1	.....	.....	.....	.....	.....	.....	.....
Providence	237,595	57	4	.....	9	1	5	.....	.....	2
South Carolina:										
Charleston	67,957	21	.....	.....	.....	.....	.....	.....	.....	3
Columbia	37,524	.....	.....	.....	6	.....	.....	.....	2	.....
South Dakota:										
Sioux Falls	25,176	5	1	.....	2	.....	.....	.....	.....	.....
Tennessee:										
Memphis	162,351	73	.....	.....	11	.....	.....	.....	15	10
Nashville	118,342	41	1	.....	12	.....	2	.....	4	4

CITY REPORTS FOR WEEK ENDED JUNE 25, 1921—Continued.

DIPHTHERIA, MEASLES, SCARLET FEVER, AND TUBERCULOSIS—Continued.

City.	Population January 1, 1920, subject to correction.	Total deaths from all causes.	Diphtheria.		Measles.		Scarlet fever.		Tuberculosis.	
			Cases.	Deaths	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Texas:										
Austin	34,876	4	3							
Beaumont	40,422	15								
Corpus Christi	10,522	2								
Dallas	158,976	21			21				1	3
El Paso	77,543	38	1		3		4			10
Fort Worth	106,482	3	3		2		1			
Galveston	44,255	11								1
Port Arthur	22,251	9							1	1
Waco	38,500	4							1	
Utah:										
Salt Lake City	118,110	16	11	1	2		4		1	2
Vermont:										
Burlington	22,779	4	2		1					
Rutland	14,954	3					1			
Virginia:										
Danville	21,539	7	2		4				1	
Lynchburg	29,956	10			19		1			
Norfolk	115,777				1		1		5	2
Petersburg	31,002	14	1		1				3	1
Portsmouth	54,387	18								1
Richmond	171,667	58	3		36				13	9
Roanoke	50,842	9	2		1					
Washington:										
Bellingham	25,570						1			
Everett	27,644				3					
Seattle	315,652		14		2		3		7	
Spokane	104,437		2		26		2			
Tacoma	96,965		1		3					
Yakima	18,539				6					
West Virginia:										
Charleston	39,608	13	3				1			
Huntington	50,177	25	1							5
Martinsburg	12,515	3								
Moundsville	10,669	1								
Parkersburg	20,050	4								
Wheeling	54,322	11	12		8		3			1
Wisconsin:										
Appleton	19,561		1		1		2			
Beloit	21,284	3					1		1	
Eau Claire	20,890				1		3			
Fond du Lac	23,427	4								
Green Bay	31,017	5	2		1		1			
Janesville	18,293	4	1							
Kenosha	40,472	4			4				2	1
La Crosse	30,363								1	
Madison	38,378	4			1				1	
Milwaukee	457,147		15		8		12		17	
Oshkosh	33,162	12	1							
Racine	58,593	10	4	1	2		4	1	2	
Sheboygan	30,955		1				1			
Superior	39,624	7	1		1		3		1	
Wausau	18,661						1		2	
Wyoming:										
Cheyenne	13,829	6								

FOREIGN AND INSULAR.

PLAGUE ON VESSEL.

Steamship "Kishenev"—At Chefoo, China.[1]

On May 2, 1921, the Russian Fleet steamship *Kishenev* from Vladivostok, Siberia, arrived at Chefoo, China, with a history of a fatal case of plague occurring en route and with a second case of plague on board. The vessel was sent to quarantine at Kentucky Island, where 10 deaths occurred on board. On May 5, 1921, 108 contacts escaped on shore and were reported, May 13, as still at large. To May 6, 1921, 16 deaths were reported as having occurred on the vessel and the island.

BRAZIL.

Plague—Maranhao.

A fatal case of plague was reported at Maranhao, Brazil, June 28, 1921. On the same date the finding of many dead rats was reported.

INDO-CHINA.

Cholera—Plague—Smallpox—January, 1921.

During the month of January, 1921, cholera, plague, and smallpox were reported in Indo-China as follows:

Cholera.—Cases, 80; deaths, 15, as against 178 cases with 119 deaths in December, 1920, and 40 cases with 24 deaths in January, 1920. The occurrence was reported in the Provinces of Anam, Cambodia, Cochin-China, and Tonkin.

Plague.—Cases, 57; deaths, 51. The occurrence was reported in the Provinces of Anam, Cambodia, and Cochin-China.

Smallpox.—Cases, 102; deaths, 15, as against 78 cases with 37 deaths during December, 1920, and 387 cases with 101 deaths during the month of January, 1920. The occurrence was reported in the Provinces of Anam, Cambodia, Cochin-China, and Tonkin.

Influenza—January, 1921.

During the month of January, 1921, 63 cases of influenza with 10 deaths were reported in Indo-China as against 131 cases with 5 deaths in January, 1920. The occurrence was reported in the Provinces of Anam and Tonkin. No cases were reported in December, 1920.

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[1] Public Health Reports, July 1, 1921, p. 1534.

MEXICO.

Yellow Fever—Alamo, State of Vera Cruz.

An outbreak of yellow fever, with 10 cases, was reported at Alamo, State of Vera Cruz, Mexico, during the month of June, 1921.

Further Relative to Yellow Fever—Vera Cruz.[1]

Information received under date of July 1, 1921, shows that the four cases of yellow fever reported at Vera Cruz occurred in soldiers, who arrived June 25, 1921, from Cosamaloapam, via Tierra Blanca, State of Vera Cruz. One of the cases terminated fatally 12 hours after arrival. The patients were stated to be natives of high altitudes and to have been in garrison at Cosamaloapam one month.

PANAMA.

Smallpox—January 1–June 10, 1921.

The occurrence of smallpox in Panama, Colon, and the Canal Zone during the period January 1 to June 10, 1921, has been reported as follows: Panama, 47 cases; Colon, 111 cases; Canal Zone, 2 cases; nonresidents, 32 cases; total, 192 cases. The distribution of cases by months was as follows: January, 50; February, 66; March, 21; April, 39; May, 15; June 1–10, 1.

PORTO RICO.

Plague-Infected Rat—Santurce.

During the week ended June 25, 1921, the finding of a plague-infected rat was reported at Santurce, Porto Rico, making a total of 87 cases of rodent plague reported in Porto Rico from the beginning of the outbreak. The total number of human cases of plague reported is 25. The last reported case terminated fatally June 22, 1921.

RUMANIA.

Typhus Fever—March–April, 1921.

Typhus fever has been reported in Rumania as follows: Month of March, 1921, 80 cases occurring in the district of Orhei; month of April, 1921, 107 cases with 10 deaths occurring in the district of Hotin.

RUSSIA.

Typhus Fever—Esthonia—April, 1921.

During the month of April, 1921, 57 cases of typhus fever were reported in the Province of Esthonia, Russia.

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[1] Public Health Reports, July 8, 1921, p. 1585.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER.

Reports Received During Week Ended July 15, 1921.[1]

CHOLERA.

Place.	Date.	Cases.	Deaths.	Remarks.
India				Mar. 13–19, 1921: Deaths, 1,744.
Calcutta	May 15–21	159	138	
Indo-China				Jan. 1–31, 1921: Cases, 80; deaths, 15.
Provinces—				
Anam	Jan. 1–31	42		In January, 1920: No cases.
Cambodia	do	8	2	January, 1920: Cases, 27; deaths, 14.
Cochin-China	do	18	9	January, 1920: Cases, 13, deaths, 10.
Tonkin	do	12	4	January, 1920: No cases.
Siam:				
Bangkok	Apr. 24–May 7	4	1	

PLAGUE.

Brazil:				
Maranhao	June 28	1	1	
British East Africa:				
Kenya Colony—				
Kisumu	Apr. 24–May 21			Present.
Ecuador:				
Guayaquil	May 1–31	9	1	
Egypt				Jan. 1–June 2, 1921: Cases, 142; deaths, 68.
Cities—				
Alexandria	May 27–June 1	6	1	
Suez	May 28–June 2	1	1	
Provinces—				
Assiout	May 27		1	
Gharbieh	June 2	1		
Minieh	May 28	1	1	
India				May 8–14, 1921: Cases, 450; deaths, 360.
Calcutta	May 15–21	7	7	
Karachi	May 22–28	2	1	
Indo-China				Jan. 1–31, 1921: Cases, 57; deaths, 51.
Siam:				
Bangkok	Apr. 24–30	1	1	
Straits Settlements:				
Singapore	May 8–14	1	1	
On vessel:				
S. S. Kishenev	May 2	1		At Chefoo, China. Plague death en route. Vessel sent to quarantine, Kentucky Island. To May 6, a total of 16 deaths was reported. (Public Health Reports, July 1, 1921, p. 1534.)

SMALLPOX.

Algeria:				
Algiers	May 1–31	2		
British East Africa:				
Kenya Colony—				
Zanzibar	May 8–14	12	4	Origin India.
Canada:				
Nova Scotia—				
Sydney	June 12–18	1		
Ontario—				
London	June 19–25	1		
Ottawa	June 19–25	13		
Toronto	do	1		
Saskatchewan—				
Moose Jaw	do	1		
Saskatoon	June 21–27	1		
Chile:				
Antofagasta	May 30–June 5	55	15	
Mejillones	do			Present. Also at interior nitrate plants.
China:				
Antung	May 16–29	6		

[1] From medical officers of the Public Health Service, American consuls, and other sources.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued.

Reports Received During Week Ended July 15, 1921—Continued.

SMALLPOX—Continued.

Place.	Date.	Cases.	Deaths.	Remarks.
Colombia:				
Santa Marta	June 12-18			Present.
Cuba:				
Antilla	June 12-25	8		
Matanzas	June 12-18	1	1	
Santiago	June 1-20	10	1	
Ecuador:				
Guayaquil	May 1-31	20		
France:				
Rouen	May 1-29	2		
Germany				Apr. 24-May 13, 1921: Cases, 8. Additional, Apr. 17-May 7, 1921: Cases, 57; deaths, 7.
Haiti:				
Cape Haitien	June 12-18	32		
India				Mar. 13-19, 1921: Deaths, 587.
Calcutta	Mar. 15-21	5	5	
Indo-China				Jan. 1-31, 1921: Cases, 162; deaths, 15.
Provinces—				
Anam	Jan 1-31	35		January, 1920: Cases, 16; deaths, 3.
Cambodia	do	21	3	January, 1920: Cases, 139; deaths, 54.
Cochin-China	do	19	12	January, 1929: Cases, 8; deaths, 1.
Tonkin	do	27		January, 1929: Cases, 224; deaths, 43.
Italy:				
Catania				Province: June 6-13, 1921: Cases, 2.
Palermo	May 18-31	4	1	
Japan:				
Nagasaki	May 23-June 5	4	1	
Java:				
West Java—				
Krawang	May 13-19	9		
Mexico:				
Chihuahua	June 5-11		1	
Vera Cruz	June 13-19		1	
Panama				Jan. 1-June 10, 1921: Cases, 192, of which 32 were in non-residents.
Canal Zone	Jan. 1-June 10	2		
Colon	do	111		
Panama	do	47		
Portugal:				
Lisbon	May 15-June 4		22	
Portuguese East Africa:				
Lourenco Marques	May 8-21	6		
Rumania:				
Districts—				
Hotin	Apr. 1-30	40	9	
Orhei	Mar. 1-31	2		
Russia:				
Province—				
Esthonia	Apr. 1-30	6		
Spain:				
Barcelona	May 12-June 8		11	
Malaga	May 1-31		34	
Switzerland:				
Zurich	May 22-28	5		
Tunis:				
Tunis	June 4-10		1	
Union of South Africa:				
Cape Province	Apr. 24-May 7			Outbreaks.
Natal	do			Do.
Orange Free State	do			Do.

TYPHUS FEVER.

Algeria:				
Algiers	May 1-31	56	8	
Oran	June 1-10	12	10	
China:				
Hankow	May 22-28	2		
Egypt:				
Alexandria	May 28-June 3	5	3	
Cairo	Mar. 26-Apr. 1	12	5	

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued.

Reports Received During Week Ended July 15, 1921—Continued.

TYPHUS FEVER—Continued.

Place.	Date.	Cases.	Deaths.	Remarks.
Germany				Apr. 21-May 7, 1921: Cases, 6.
Japan:				
Nagasaki	May 23-June 5	7	2	
Jugoslavia				Jan. 30-Feb. 5, 1921: Cases, 39; deaths, 8.
Belgrade	May 1-14	6		
Rumania:				
Districts—				
Hotin	Apr. 1-30	107	10	
Orhei	Mar. 1-31	80		
Russia:				
Province—				
Esthonia	Apr. 1-30	57		
Syria:				
Beirut	May 20-30		1	
Turkey:				
Constantinople	May 23-June 4	2		
Union of South Africa:				
Cape Province	Apr. 24-May 14			Outbreaks.
Orange Free State	do			Do.

YELLOW FEVER.

Mexico:				
Alamo	June 1-30	10		State of Vera Cruz.

Reports Received from July 2 to 8, 1921.[1]

CHOLERA.

Place.	Date.	Cases.	Deaths.	Remarks.
India				Mar. 6-12, 1921: Deaths, 1,902.
Bombay	May 1-7	1	1	
Calcutta	May 8-14	75	66	
Madras	May 15-21	1		
Rangoon	Apr. 24-May 7	11	9	

PLAGUE.

Ceylon:				
Colombo	May 8-14	1	1	
China:				
Manchuria—				
Harbin	May 3-16	40		
Egypt				Jan. 1-May 26, 1921: Cases, 122; deaths, 64.
Cities—				
Alexandria	May 21-27	1	1	
Suez	May 20-25	2	2	
Provinces—				
Assiout	May 24-25	7	5	
India				May 1-7, 1921: Cases, 494; deaths, 387.
Bombay	May 1-7	73	54	
Calcutta	May 8-21	7	7	
Karachi	do	8	7	
Rangoon	Apr. 24-May 7	22	23	
Mexico:				
Tampico	June 11-20	26		Last case, June 18, 1921. Total from Jan. 1 to June 18, 1921: Cases: 145.

[1] From medical officers of the Public Health Service, American consuls, and other sources. For reports received from Jan. 1 to July 1, 1921, see Public Health Reports for July 1, 1921. The tables of epidemic diseases are terminated semiannually and new tables begun.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued.

Reports Received from July 2 to 8, 1921—Continued.

PLAGUE—Continued.

Place.	Date.	Cases.	Deaths.	Remarks.
Peru				Mar. 1–31, 1921: Cases, 76; deaths, 44. Apr. 1–30, 1921: Cases, 43; deaths, 20.
Department—				
Arequipa	Mar. 1–31	2		At Mollendo.
Callao	do	7	1	At Callao.
Lambayeque	do	2	1	At Chiclayo.
Libertad	do	12	7	In 5 localities.
Lima	do	32	16	At Lima city, 20 cases, 13 deaths.
Piura	do	21	19	At Payta, Piura and Sullana.
Ancachs	Apr. 1–30	4	1	At Huarmey.
Arequipa	do	3	3	At Mollendo.
Callao	Apr. 1–30	8		At Callao.
Lambayeque	do	1	1	At Chiclayo.
Libertad	do	16	5	In 5 localities.
Lima	do	6	3	In Lima city, 3 cases, 2 deaths.
Piura	do	5	7	At Payta, Sullana, and Talara.
On vessel:				
S. S. Oreland				At Genoa, Italy, June 12, 1921, from La Plata, Argentina. Two fatal cases plague in crew en route.

SMALLPOX.

Asia Minor:				
Smyrna	May 22–28	1		On the s. s. Nicholas.
Australia:				
Melbourne	Apr. 9–23	4	1	Mild epidemic.
Bolivia:				
La Paz	Apr. 1–30	5	4	
Brazil:				
Rio de Janeiro	May 8–14	1	1	
Bulgaria:				
Sofia	May 15–31	6		
Canada:				
Alberta—				
Calgary	May 26–June 18	3		
British Columbia—				
Vancouver	May 28–June 11	5		
Manitoba—				
Winnipeg	May 28–June 18		5	
New Brunswick—				
Westmoreland County	June 5–11	1		
Nova Scotia—				
Sydney	do	1		
Ontario—				
Hamilton	June 12–18	3		
Kingston	June 5–11	1		At two localities in vicinity, 2 cases.
London	do	1		
Montreal	June 12–18	1		
Ottawa	do	8		
Toronto	do	4		
Saskatchewan—				
Regina	June 5–11	2		
Saskatoon	June 7–13	2		
Chile:				
Antofagasta	May 16–29	91	46	
China:				
Amoy	May 8–14		1	
Canton	Apr. 1–30			Present.
Chungking	May 1–14			Present.
Foochow	May 8–14			Present.
Hankow	May 15–21	4	1	
Manchuria—				
Dairen	May 9–22	18	2	
Nanking	May 8–21			Present.
Tientsin	May 8–14	1		Mission hospital.
Tsingtau	May 9–15	1		
Colombia:				
Santa Marta	June 5–11			Present.
Cuba:				
Antilla	do	7		
Egypt:				
Cairo	Mar. 19–25	1		
Finland	May 1–15	1		

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued.

Reports Received from July 2 to 8, 1921—Continued.

SMALLPOX—Continued.

Place.	Date.	Cases.	Deaths.	Remarks.
Haiti:				
Cape Haitien	May 29-June 11	142		
India:				
Bombay	May 1-7	32	20	
Calcutta	May 8-21	5	5	
Madras	do	11	4	
Rangoon	Apr. 24-May 7	10	2	
Japan:				
Kobe	May 24-30	1		
Java:				
West Java—				
Buitenzorg	Apr. 29-May 5	10	2	
Krawang	do	2		
Lebak	do	3	1	
Mexico:				
Chihuahua	May 23-29		1	
Mexico City	May 15-21	37		Including Federal municipalities.
Panama:				
Colon	May 18-24	2		
Poland				Mar. 1-Apr. 30, 1921: Cases, 1,117; deaths, 142.
Bialystok	Mar. 1-Apr. 30	3		
Cracovia	do	56	6	
Kielce	do	189	26	
Leopol	do	52	16	
Lodz	do	72	9	
Lublin	do	397	30	
Posen	do	26	2	
Silesia	do	10		In Teschen.
Stanislawow	do	30	5	
Tarnopol	do	156	31	
Warsaw	do	36	4	
Warsaw city	do	90	13	
Spain:				
Tarragona	May 9-15		1	
Valencia	May 22-28	1		
Syria:				
Aleppo	Apr. 9-16			Present.
Beirut	May 10-20	1		
Tunis:				
Tunis	May 30-June 5	1	1	

TYPHUS FEVER.

Algeria:				
Oran	May 22-31	10	8	
Bolivia:				
La Paz	Apr. 1-30	32	39	
Egypt:				
Alexandria	May 21-27	1	2	
Cairo	Mar. 19-25	9	4	
Finland	May 1-15	5		
Germany				May 1-7, 1921: Cases, 3. Additional for previous week, 3 cases.
Great Britain:				
Dublin	May 29-June 4	1		
Mexico:				
Mexico City	May 15-21	15		
Poland				Mar. 1-Apr. 30, 1921: Cases, 11,489; deaths, 1,131.
District—				
Bialystok	Mar. 1-Apr. 30	853	45	
Cracovia	do	603	90	
Kielce	do	848	62	
Leopol	do	2,503	277	
Lodz	do	521	53	
Lublin	do	1,446	83	
Posen	do	77	5	
Silesia	do	26		In Teschen.
Stanislawow	do	1,557	232	
Tarnopol	do	1,855	194	
Warsaw	do	972	61	
Warsaw city	do	223	29	

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued.

Reports Received from July 2 to 8, 1921—Continued.

TYPHUS FEVER—Continued.

Place.	Date.	Cases.	Deaths.	Remarks.
Russia:				
Siberia—				
Vladivostok	do	4	1	
Turkey:				
Constantinople	May 22-28	5		
Union of South Africa:				
Cape Province—				
Cape Town	May 13-19	10	3	At native cantonment in vicinity.

YELLOW FEVER.

Mexico:				
Vera Cruz	June 13-27	7		
Peru				Mar. 1-31, 1921: Cases, 66; deaths, 25.
Departments—				Apr. 1-30, 1921: Cases, 106; deaths, 32. In 13 localities.
Lambayeque—				
Chiclayo	Mar. 1-31	20	10	
Chongollape	do	2	2	
Ferrenafe	do		1	
Lambayeque	do	15	5	
Monsefu	do	18	4	
Motupe	do	1	1	
Pomalca	do	5	1	
Villa Eten	do	5	1	
Callao—				
Callao	Apr. 1-30	1		At quarantine station. From Chiclayo.
Lambayeque—				
Chiclayo	do	23	5	
Chongollape	do	10	1	
Jayanca	do	5	2	
Lambayeque	do	5	2	
Monsefu	do	8	5	
Motupe	do	45	11	
Olmos	do	2	4	
Villa Eten	do	2		
Zana	do	1		
Libertad—				
Guadalupe	do	2		
Pueblo Nuevo	do	1	1	
Trujillo	do	1	1	Country.