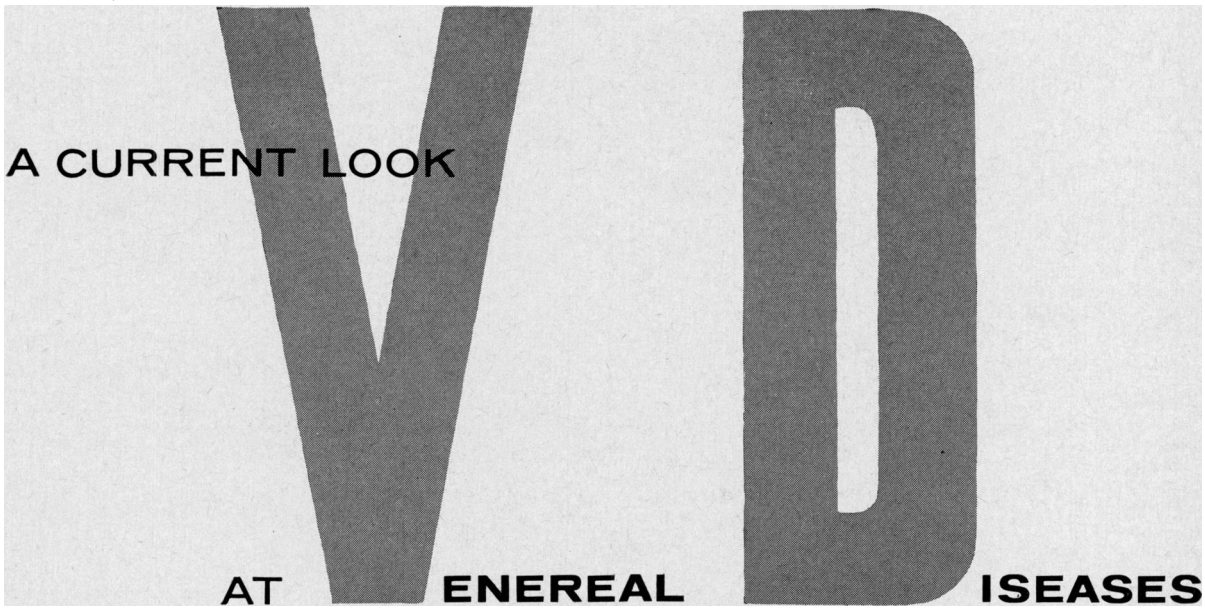


The fight on venereal disease has reached a turning point, according to authorities attending a series of seminars on venereal disease conducted by the Public Health Service in major urban areas during the spring of 1960.

The knowledge and skills are available, they conclude, to reduce syphilis and gonorrhea to the point where public defenses need be only nominal, if strong measures are applied within the next few years. Unless such action is taken promptly, however, they believe the recent increase of venereal disease may become seeded throughout the population. And this increase may be speeded as the microbial agents grow to resist present forms of medication. The public is threatened also by the tendency of each infected patient to expose four others, on the average, and by a modern moral and technological climate which tends to sanction if not encourage such promiscuity.

Granting that a change in the pattern of sexual activity is less likely to occur than a change in public health practice, it was concluded that, until immunization methods are discovered, the best hope of controlling venereal disease is to apply Dr. Thomas Parran's classic formula of diligent and systematic methods of finding persons with infectious syphilis and bringing them to treatment before they expose four others.

For the time being at least, venereal disease can be cured promptly by medical treatment, using simple, painless methods. But except for the development of attitudes which discourage promiscuous sexual habits, the only way to prevent venereal infection today is to find and treat carriers of the germs.

Expedited casefinding using all available community resources is essential to effective control. Much depends on the voluntary appearance of patients for treatment and their willingness to name associates and contacts.

For all the time that goes into locating potential patients, and interviewing, testing, and treating them, casefinding is a small price to pay for preventing the infection from going

to extremes. Major economies in finding cases could be achieved if physicians reported all presumably infected patients to health departments; if courts required tests of all persons arrested; and if hospitals and laboratories routinely reported positive findings in the more than 13 million blood tests performed annually.

Recommendations of the conference in Chicago in April 1960 emphasized the following points:

- With more than 13 million serologic tests processed annually in the United States, reports from all private and public laboratories would help health agencies to check with physicians to assure adequate treatment of all patients and epidemiological investigation of all infectious cases.
- If every patient with infectious syphilis were treated as an emergency and interviewed promptly, contacts, suspects, and associates could be pursued with the greatest possible rapidity. In this procedure, the telephone would be the primary reporting tool followed immediately by an epidemiological report.
- The telephone should be used especially to initiate and expedite investigations of contacts or suspects who are outside the jurisdiction of the primary investigator.
- Hospitals which do not perform routine blood tests upon admission could be encouraged to do so, perhaps by supplying them with tubes, needles, and other necessary equipment at public expense, as necessary for this purpose.
- In the attack on venereal disease, all community resources and all professional skills available are needed and should be used.
- There is a need for serologic screening of ships' crews, arranged by international action, with financial support available to port areas to deal with the threat of infection among the host of mobile and transient visitors. Opening of the St. Lawrence Seaway specifically suggests the opportunity for visitors to seed new chains of infections at inland ports, in the absence of hygiene or sophistication.
- A plea for more effective cooperation by private physicians suggested that physicians order serologic tests for syphilis whenever indicated, give alert attention to early infectious lesions, report all cases diagnosed and treated, report promptly and interview patients with a positive STS recorded on their hospital charts, and refrain from unnecessary treatment of patients with a positive STS and a history of previous STS or treatment. It was observed that although State health departments differ in recommendations for treatment, "none advises total dosages as great as 10 million units of penicillin for asymptomatic syphilis or repeated treatments because of persistent positive STS in patients treated for late syphilis."

It was proposed that medical schools in at least a few hours of didactic instruction provide reasonably uniform information about the importance of histories in syphilis, the interpretation of serologic tests, and general principles of treatment.

A popular view, if not a consensus, was that eradication of syphilis in the United States is a practical goal; that efforts should be concentrated on casefinding for control of infectious syphilis; that participation by private physicians is essential to effective control; that special studies should be directed toward the epidemiology of venereal disease among young people; that informational and educational efforts should be intensified; and that research and demonstration should be encouraged to assist diagnosis of gonorrhea in the female.

Current Status of Syphilis In the United States

WILLIAM J. BROWN, M.D.

Chief, Venereal Disease Branch, Communicable Disease Center, Public Health Service

Syphilis remains a public health problem of major and increasing proportions.

A total of 120,000 cases were reported among civilians alone in 1959, of which 8,200 were in the early infectious stages (fig. 1).

Reported cases of infectious syphilis have been increasing alarmingly since 1957. Moreover, there is no indication that the trend is changing. Almost 42 percent more infectious syphilis was reported from July to December of 1959 than was reported during the same 6 months of the previous year. We estimate the

Figure 1. Primary and secondary syphilis cases reported in the United States, 1950–59

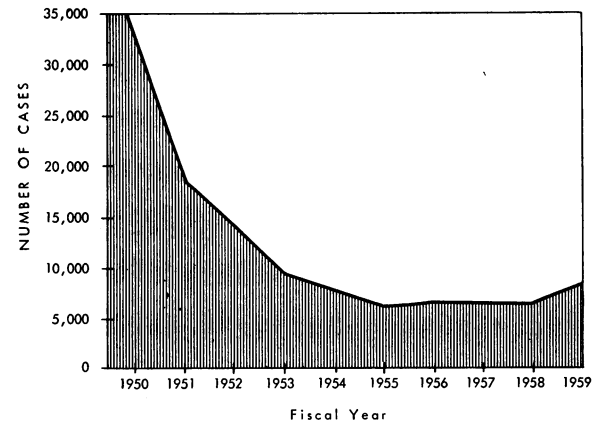
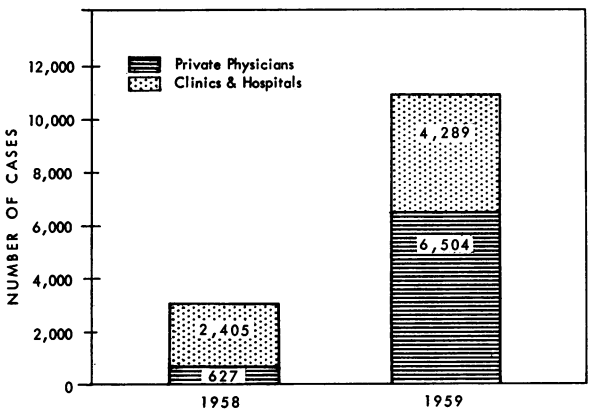


Figure 2. ~~Primary and secondary syphilis~~ cases reported by private physicians and clinics and hospitals, Pennsylvania, 1958–59



reservoir of untreated syphilitics today at 1,200,000 cases and that the true annual incidence is 60,000 cases.

Already the cost of 33,000 paretics in tax-supported mental institutions is $48 million a year. And if we do not find and treat the 1¼ million untreated, we may expect an additional 178,000 to develop late disabling manifestations. This will include 52,800 more cases of paresis and meningovascular syphilis requiring about 530,000 years of hospitalization at a cost of almost a billion dollars. It will also include 23,000 cases of tabes, 6,000 of optic atrophy, and 91,000 of cardiovascular syphilis.

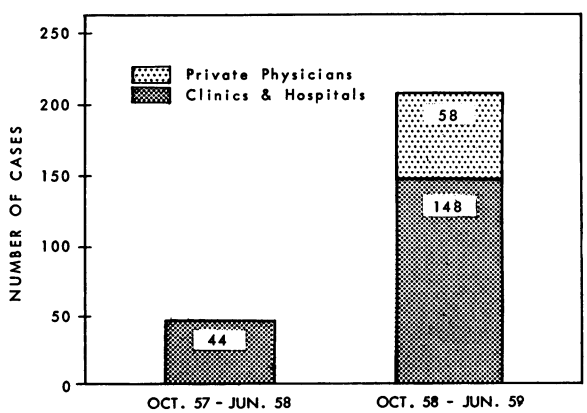
Clearly, at this point syphilis is not under control. This is not to say that we have not made progress against syphilis in this country, because we have. For example, deaths from syphilis have dropped from 14,000 to 4,000 a year, and infant deaths due to syphilis have dropped from 574 to fewer than 1 per 100,000 live births.

Fortunately, syphilis, for several reasons, is not spreading in geometrical progression, but it does seem to be spreading faster than we can find and treat it. A variety of factors, such as environment, economics, and social structure, may influence the spread of syphilis in a population. Some syphilitics, for example, do not have opportunity for further intercourse while they are infected. Moreover, syphilis is not contracted at every exposure to infection. And also, some chains of infection and chains of contact double back on themselves in large part and are contained within certain social groups.

Venereal disease control always has depended upon research to develop techniques of diagnosis and treatment, and upon a vigorous case-finding program to find infected persons and bring them to treatment faster than infection could spread. I believe that the late Dr. Joseph Earl Moore, in paraphrasing Frost on tuberculosis, was correct when he said, ". . . it is not necessary that transmission be immediately and completely prevented. If, in successive periods of time, the number of infectious hosts is continuously reduced, the end result . . . if continued long enough, must be the extermination of the treponeme of syphilis."

Today, techniques of both diagnosis and

Figure 3. Primary and secondary syphilis cases reported by private physicians and clinics and hospitals in Louisiana during two corresponding 9-month periods, 1958–59



treatment have been developed almost to the ultimate. Epidemiology, however, has lagged behind, particularly among patients of private physicians. Consequently, a large part of our national program is now being oriented to the development of working relationships between public health and the private practitioner.

We have had some measure of success in persuading private physicians to report their cases and to have them interviewed by a trained epidemiologist. The Pennsylvania program is a good example. Reporting by private physicians in Pennsylvania increased more than 10 times from 1958 through 1959 (fig. 2).

In 1958, the Louisiana State Health Department began to stimulate reporting among private physicians through personal visits, talks at medical society meetings, and followup of reactive serologies from public and private laboratories and hospitals. The results are shown in figure 3. In two corresponding 9-month periods, cases of primary and secondary syphilis reported by private physicians rose from 0 to 58. During the same two periods, early latent cases reported by private physicians increased from 3 to 417 (fig. 4).

Kansas is another typical example of improved interviewing among primary and secondary syphilis patients of private physicians. Morbidity reporting of early lesion syphilis treated by private physicians in Kansas rose from 11 cases in 1958 to 50 cases in 1959 (fig. 5). Further, the number of privately treated patients with primary and secondary syphilis who were interviewed during the same period increased from 8 to 38. As a result, contacts of private physicians' patients who were interviewed increased from 43, in which there were no cases of infectious syphilis, to 147, which included 14 with primary and secondary syphilis.

Overall improvement has been made in interviewing privately treated primary and secondary syphilis patients across the country as shown in figure 6. In the 5-year period ending in 1958, an average of 17 percent of these patients were interviewed per year by a trained interviewer. During 1959, this percentage was still increasing. Forty-nine percent of all patients with infectious syphilis reported by private physicians were interviewed for sex contacts by a trained interviewer.

Figure 4. Early latent cases of syphilis reported by private physicians and clinics and hospitals in Louisiana during two corresponding 9-month periods, 1958–59

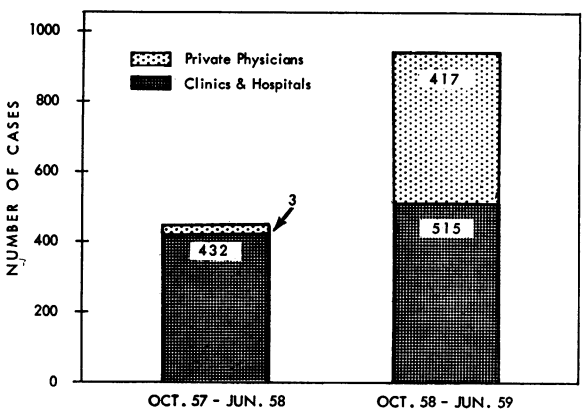


Figure 5. Results of contact interviewing of primary and secondary syphilis patients treated by private physicians, Kansas, 1958 and 1959

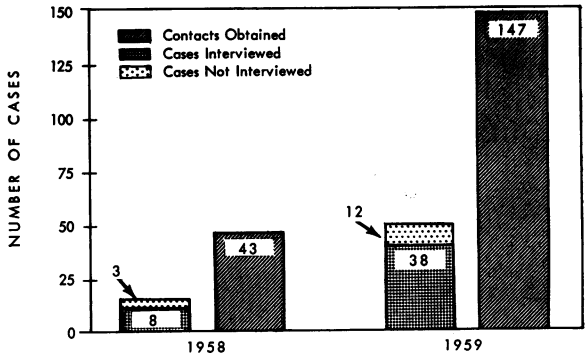
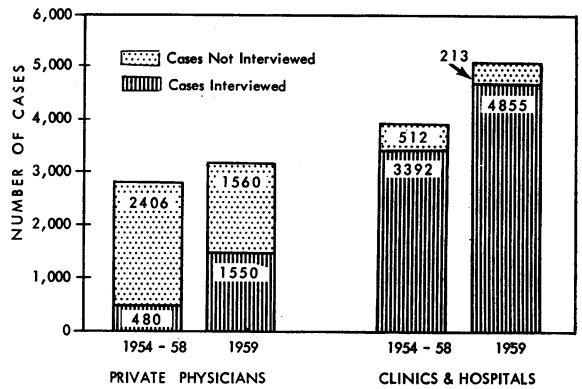


Figure 6. Contact interviewing of primary and secondary syphilis patients treated by private physicians and in clinics and hospitals, United States, yearly average, 1954–58, and 1959



From the standpoint of epidemiology, success with the patient treated by a private physician equals that of the public clinic patient.

One question with respect to syphilis morbidity is raised sooner or later: Are these increases "real" increases in incidence, or are they only the results of improved casefinding and reporting? As we see it, increased morbidity at this point reflects both increased incidence and improved reporting. But we have no way of knowing how much is attributable to either.

However, there is one answer to this question. Regardless of what morbidity reports represent, the patients are real, they need treatment, and their contacts need examination. This cannot be denied.

In fact, it may be expected that if our present efforts continue successfully, as I have every hope that they will, morbidity figures will go a lot higher than they are now. But, sooner or later, a point will be reached after which any amount of epidemiological effort can result only in a plunge toward eradication.

Casefinding in Chicago

PHILIP R. WACTOR, Jr.
Health program representative,
Chicago Board of Health

In Chicago, 27 E. 26th Street is an address of unique reputation. It is the Municipal Social Hygiene Center, under the direction of Dr. K. B. Muir. Since 1938, the center has played host to 3 million or more guests who have entered for diagnosis, interviews, treatment, and checkups. Its files hold records dating back to 1934 of 800,000 male patients and 700,000 females, with medical charts of the histories of victims of syphilis.

In a neighborhood which blends, in Chicago style, the slum in retreat, industrial monuments in transition, and modern public housing projects in progress, a fence of iron spears protects the center's spacious and dignified quarters, declared unsuitable for use as a school building 20 years ago.

Here, with limited facilities and personnel, financed by local, State, and Federal funds, a dedicated staff carries on a running battle with the social and microbial agents of venereal disease.

Not all the patients have venereal disease. Many are negative. They may have almost any form of skin disease. Dr. Seymour Weinstein, chief consultant, has even found a few cases of Hansen's disease among them. Many come in of their own accord. But the bulk of the visitors are invited in through epidemiological investigation.

Consequently, the bearing of most of those who climb the stairs to the registration desk is not happy. Although the receptionist is cheerful and smiling, her brightness touches few of those who wait in the large central reception hall. Thirty or more at a time drape the benches or squat on the hallway stairs. They pay scant attention to the informative exhibit on the south wall. They seldom read leaflets, books, or even papers.

They only sit and wait while the record clerks check their registration cards against the alphabetic file of previous visitors, the phonetic file of names reported by private physicians, and the numerical file of patients with syphilis.

If any are cheerful, they are the few directed to completely separate facilities for receiving, examining, interviewing, diagnosing, and treating expectant mothers, children under 2 years of age, and couples seeking the required premarital examination.

For the patient, the routine of diagnosis, interview, and treatment is an occasion for personal anxiety and relief. For the staff, it is a process which arrests or interrupts the career of agents which, undeterred, could reach from every promiscuous contact to thousands of innocents. The staff sees 5,200 patients in a month. In a year, they treat more than 16,000 cases of gonorrhea. In 1959, this one center reported 7,083 patients with syphilis.

The visitor who brings his chart number is ushered in for a checkup without delay. Others are summoned, by number only, over a loudspeaker system. No names are used.

There are several rooms for diagnostic service, containing private dressing booths and examination facilities. Before treatment, patients diagnosed as positive are called to the second floor for an interview. Each interview

is held behind closed doors. Although the booths are open at the top and far from soundproof, so much conversation goes on at once that the only distinguishable remarks are those within a booth.

All interviewers are male. It is found that patients are likely to be more responsive to questions from a man. Women as a rule hesitate to admit promiscuity to another woman.

The attitude of the patients varies. Men as a rule are uncommunicative as to female contacts in relation to gonorrhea. They show little or no concern as to those they may have infected. No effort is made to interview women with gonorrhea, as it is felt little is to be gained: the men infected will show up for treatment in any event, soon after they are infected. In 1959, the center treated 16,000 patients, mostly men, for gonorrhea.

Dr. Weinstein is hopeful that the use of fluorescent antibodies may facilitate the prompt diagnosis of gonorrhea in women, with the possibility of detecting and arresting most of the social foci of that infection. There will remain, however, the present difficulties of finding female patients with gonorrhea and bringing them to treatment, since the woman is usually unaware of the infection in its early stages.

More Cases and Greater Efforts

While scholars hope to reduce venereal disease to the point where it is no more of a public health threat in America than malaria, the center's physicians, epidemiologists, investigators, and aides are dismayed at the rise in the incidence of syphilis.

While the rise in the reported cases of syphilis is in part a result of the superior epidemiology performed at the center, the staff is certain that the increase is also real. This conclusion is based on an increase in the rise of early infectious syphilis and on an increase in the number of positive reports in routine serologies from sources where there has been no special effort at casefinding and reporting.

Dr. Muir takes special pride in the industry, enthusiasm, and proficiency of the epidemiological staff, the "peppy epi" boys, detailed to the city by the Public Health Service. There are four on duty now.

In one year, despite a reduction in staff, the investigators, by improvements in the technique of cluster testing (the contacts, the suspected contacts, and the associates of patients with infectious syphilis), scored impressive gains in the number of infectious cases found and treated.

For the first 6 months of fiscal year 1959, they had 48 source patients with infectious syphilis. In 6 months of the following fiscal year, there were 169 source patients (table 1).

With the increased range of investigation, they found 25 cases of primary and secondary syphilis in the 1959 period, and 116 in 1960. Moreover, 41 of the cases in 1960 were in suspects or associates, cases which would not have been discovered in the infectious stages were it not for the technique of cluster investigation.

The epidemiological service has lost no opportunity to turn up unsuspected cases. A house-to-house survey in a high-incidence neighborhood has succeeded in bringing in 465 patients for treatment, out of 4,338 reactors. Of this number, 23 were infectious syphilitics.

Two other members of the staff are assigned to encourage physicians to report positive diagnoses promptly to the center. One of their special duties is to explain the need for prompt confirmation of a diagnosis reported as positive by hospital or laboratory tests.

Efforts to obtain reports from hospitals and laboratories have succeeded in bringing in reports on 94 percent of the tests administered in the city. In the event that a dark-field examination reveals the spirochetal organism from a lesion, the center is notified immediately. Otherwise, reports of positive diagnoses for the most part are filed monthly.

Hot pursuit of infectious patients is cooled somewhat by an arrangement which obliges the center to defer investigation of private patients reported as positive by laboratories or hospitals. None are interviewed until the patient's physician confirms the diagnosis, and such confirmation waits as long as 2 months. A less significant cooling effect results from the tendency of hospitals, for administrative reasons, to send reports of positive reactors to the center only once a month rather than daily.

Since in the normal course of events a patient may not appear for diagnosis and treatment

until weeks or months after infection, the search for fresh contacts of infectious syphilis begins with a handicap.

Other factors also interfere with detection of infectious syphilis in the early stages. A few patients develop no apparent symptoms. Often the lesions are not in an obvious location. Some develop internally or in obscure positions where even the patient may ignore them. If the lesions are less than classic, the diagnosis may be missed by physicians who have had little or no experience with the disease in recent years.

With the decline in the incidence of syphilis, the staff finds that not all physicians are appreciative of the implications of a positive blood test, or alert to the nature of a rash or sore which may disappear. Leaning with assurance on the efficacy of antibiotics, a physician may be inclined to develop a low index of suspicion, in the opinion of some authorities. During several interviews concerning cases of congenital syphilis, the mothers asserted, "I told the doctor I had this sore, but he said it would go away."

An experienced syphilologist, Dr. Muir is concerned also with the possibility that treated cases of syphilis may relapse. The center physicians seek to persuade patients to return for a checkup at least once a month for 6 months, and to call again, at wider intervals, for at least a year. Recrudescence of the infection was a characteristic of the disease under earlier forms of treatment, and Dr. Muir feels that this characteristic may persist even under antibiotic treatment.

Her fingers are crossed also lest the incidence of anaphylactic reactions to treatment increase before the disease is eradicated.

Still another obstacle to eradication of the disease is its appearance among men and boys who associate mainly with their own sex, although they compose a major reservoir of infection for both sexes. The relations of such deviates are characteristically promiscuous; one 13-year-old boy named 40 contacts. Another who kept a diary named 38 in one year, and in a succeeding year named 44 others, with no repetition of any of the earlier names. Such contacts, many from the privileged ranks of society, now contribute the majority of those investigated. They lead at the same time to many heterosexual infections.

It is not certain that such patients have a higher incidence of infection than in the past, but the staff believes that the increase in reported cases to a great extent represents a true rise in the incidence.

Table 1. Cluster test progress report, Chicago, Ill.

Item	48 source patients, first 6 months fiscal year 1959			169 source patients, first 6 months fiscal year 1960		
	Contact	Suspect	Associate	Contact	Suspect	Associate
Names obtained	220	153	279	909	396	421
Located and examined	161	125	275	701	336	421
Positives	50	28	32	234	85	27
Infected with syphilis	49	28	20	234	85	27
Brought to treatment	32	16	7	118	41	17
Primary and secondary	19	5	1	75	26	15
Early latent	11	7	1	37	13	1
Other syphilis	2	4	5	6	1	1
Returned to treatment	0	2	1	2	1	0
Adequately treated	17	10	12	114	14	10
Not infected with syphilis	112	97	255	467	251	394
Not examined	59	28	4	208	60	0
Indices:						
Contact index	4. 58	3. 19	5. 81	5. 38	2. 34	2. 49
Epidemiological index	1. 02	. 58	. 42	1. 38	. 50	. 16
Brought to treatment	. 67	. 33	. 15	. 70	. 24	. 10
Brought and returned to treatment	. 67	. 38	. 17	. 71	. 24	. 10
Lesion to lesion	. 40	. 10	. 02	. 44	. 15	. 09
Percent reactive	31. 05	22. 40	11. 64	33. 38	25. 29	. 06
Percent located	73. 18	81. 69	98. 57	77. 11	84. 84	100. 00

Ordinarily, deviates are loath to report a venereal infection or to admit the source. The result is that they are more likely than heterosexual patients to go untreated and to seed infection widely. Apart from the dread of social contumely, they are fearful of criminal penalties. The Chicago investigators, however, by studiously disassociating themselves from police activity, have succeeded in winning their confidence to the extent that most cooperate willingly in reporting contacts and in helping investigators to find suspected contacts.

The Routine and Some Findings

Typically, an investigator interviews 100 patients a month, all diagnosed as having infections.

If a patient has syphilis, the first step is a field trip by the investigator to the home of the contact, to locate and identify those who may live in the same place.

Ordinarily, except for the importance of a field visit to learn the associates of an infectious syphilitic, investigators pursue their leads by telephone or, if that does not avail, by telegram, for those over the age of 18. By these methods, they succeeded in bringing to examination more than 6,000 of 10,134 persons named in 6 months.

This record is scored despite the notorious reluctance or inability of patients to identify casual consorts. "A jane on Cottage Grove" is typical of the identification offered. Often the contact's name is unknown to the informant, or it is a false name. On the other hand, the telephone number, if it is recent, will be correct, and the contact will answer to whatever name was given. The name itself, given in good faith, may need translation, as Scott may sound like Skort, Marion like Mann, and Terril like Tull. The spelling of such names also may be as free as the pronunciation.

The center does not deny treatment to patients who offer no personal identification. Any name and address they give is accepted, and it is purely a matter of conjecture how many are duplicates.

Patients use six or more aliases, sometimes without regard to gender. When patients are recorded by the Cook County jail, which tests and, if necessary, treats anyone arrested and detained for as little as 2 days, all the names by which a patient is known are recorded, and this information is used for the center's records. Such checks help an investigator to know whether a patient is a recidivist with established associations, or a fresh contact.

A technician at the county jail tests 50 to 100 a day, by the rapid plasma reagin method, relying on the patients for aid. Of the lot, 8.5 percent are found positive for syphilis. A similar arrangement for testing and treating is planned for the city jail.

There is no special category of crime associated with venereal disease except for the women who are arrested on narcotics charges. Most of these have resorted to prostitution in order to earn money for drugs, according to the staff. The investigators have the impression that, on the other hand, organized prostitutes use antibiotics liberally to cure or prevent infection.

The number of examinations for venereal disease at the center increased from 43,787 in 1956 to 122,169 in 1959, including the house-to-

Syphilis Diagnosis

"Recent publicity emphasizing the frequency of biologic false-positive reactions has made this diagnosis medically 'fashionable.' We join Perry, Kierland, and Magath in their insistence that a positive serologic test for syphilis should suggest a diagnosis of syphilis until proved otherwise."—DRS. GEORGE SCIPLE, C. HUNTER MONTGOMERY, and JOHN M. KNOX, *New England Journal of Medicine, July 14, 1960, pp. 84–85.*

Table 2. Syphilis distribution in Chicago, 1959

Type of case	Private patients	Hospital, clinic, or institutional patients	Total
Primary and secondary	209	537	746
Early latent	335	819	1, 154
Latent	1, 111	3, 732	4, 843
Congenital	46	294	340
Total	1, 701	5, 382	7, 083

house survey. The number given preventive or curative treatment at the center increased from 5,951 to 7,608 in 1959. The number of infections found in Chicago increased from 21,635 in 1956 to 23,361 in 1959. Of this number, as noted, 16,102 were gonorrhea, 7,083 were syphilis, and 61, other venereal infections.

Of the syphilis cases, most in 1959 were latent, indicating failure of earlier diagnostic efforts (table 2). Most of the primary, secondary, and early latent syphilis patients were men.

The future of control of venereal disease in Chicago is under shadow of the seaway development. All of the ports on the Great Lakes for that matter will see an increase in visitors, including seamen, many of whom will come from lands where the incidence of venereal disease is still relatively high.

New Haven's Court Clinic: A Casefinding Source

GUNAR N. BOHAN, M.D., M.P.H.
Director of medical services,
New Haven (Conn.) Health Department

In New Haven, Conn., the chief method of finding sources of venereal disease is the followup of all positive laboratory findings for syphilis, gonococcal infection, lymphogranuloma venereum, granuloma inguinale, and chancroid.

The Sanitary Code of the State of Connecticut, regulation 32, requires all laboratories to report promptly positive findings to the director of health of the municipality where the person affected normally resides, giving the name and address of the patient and the physician, with a duplicate copy going to the bureau of venereal disease, Connecticut State Department of Health.

The sources of these reports are premarital blood tests for syphilis of both partners; prenatal blood tests, mandatory in Connecticut since July 1, 1941; hospitals, where serologic tests for syphilis are performed on all patients on admission, many of which are given in emergency rooms; preemployment medical examinations, which although not required in Connecticut, include serologic tests in some instances; private physicians; contact investigations; the health department's venereal disease clinic, including voluntary patients; and the New Haven court clinic.

The court clinic proved to be a fertile source of new patients with syphilis or gonorrhea and old patients needing treatment again. New Haven is the only municipality in Connecticut where persons arrested on vice charges are examined for venereal disease by the health department as a routine.

History

The court clinic began July 13, 1942, at a meeting initiated by the Federal Bureau of Investigation, which was conducting a survey of vice conditions in Connecticut specifically pertaining to organized prostitution. Several conferences were held with public officials, medical authorities, and law enforcement officers.

On July 29, 1942, the health officer of New Haven, Dr. Joseph I. Linde, met with the local representatives of the judiciary, the police department, the county jail's staff, and members of the bureau of venereal disease of the health department to set up more effective machinery for the repression of prostitution and the control of venereal disease in New Haven.

Establishment by the health department of a diagnostic venereal disease court clinic was decided upon, and on September 17, 1942, the court clinic opened its doors. At that time, the law, in connection with court orders for venereal disease examinations, held that if there was no conviction, there would be no court order for examination. The health officer, however, could issue an order for examination if he had reasonable grounds. The clinic operated under this law for about a year with the full cooperation of the city court, the police department, the war council, and the council of social agencies.

Early in 1943, the State legislature made it mandatory, effective October 1943, for every individual arrested for an alleged morals offense, to be examined for venereal disease (section 739–g). This section of the statute was passed more or less as a war measure with

the approval and sponsorship of the Connecticut State Department of Health. At that particular time, as the courts were quite concerned about venereal disease, the law was adopted promptly. This court examination requirement has worked out quite satisfactorily.

Procedures in Court Clinic

All persons arrested on a morals charge are examined by the court clinic doctor for evidence of a venereal disease prior to trial. On the morning following their arrest, they are brought to the court clinic for that purpose by a probation officer. Persons released on bond are told by the arresting officer or the desk officer to report to the clinic. If they fail to appear, the trial is postponed.

A blood test for syphilis is taken for both men and women. Cultures and smears for gonorrhea are done routinely on women, and on men if indicated. A physical examination is given with attention to the genitalia, mucous membranes, and skin for clinical signs of these diseases.

Records kept in detail show results of examination, charge on arrest, other pertinent history, results of contact investigation, and disposition of case.

Results of examination of court cases for venereal diseases, 1943–59, New Haven (Conn.) Health Department

Year	Number persons examined	Positive for syphilis		Positive for gonorrhea	
		Number	Percent	Number	Percent
1943	229	26	11.4	15	6.6
1944	221	38	17.2	30	13.6
1945	177	34	19.2	13	7.3
1946	172	29	16.9	23	13.4
1947	181	18	9.9	13	7.2
1949	257	22	8.6	21	8.2
1950	256	18	7.0	14	5.5
1951	269	17	6.3	7	2.6
1952	331	41	12.4	7	2.1
1953	369	25	6.8	17	4.6
1954	363	21	5.8	14	3.9
1955	426	32	7.5	13	3.0
1956	423	18	4.3	9	2.1
1957	382	41	10.7	42	11.0
1958	293	10	3.4	26	8.9
1959	384	23	6.0	16	4.2
Total	4,733	413	8.7	280	5.9

NOTE: 1948 data not available.

In addition, a report form (VD–13), in duplicate, is filled in by the clinic nurse and physician stating the history, laboratory findings, and recommendations. One copy is sent to court as part of the prisoner's packet through the city attorney's office, and after the case is terminated, filed at the city court clerk's office as part of the permanent file. Another copy is sent to the bureau of venereal disease of the State department of health.

The clinic interview usually provides the only opportunity for the nurse and physician to talk with the patient. At this time, information regarding contacts, previous history of venereal disease, and any other pertinent facts are taken in as much detail as the patient is willing to give.

If the laboratory findings are negative, the patient is notified and discharged from the clinic. When laboratory findings are positive, arrangements are made for treatment.

When a patient is found to have venereal disease, the report is given to the city attorney. This information is given so that the judge may place the person on probation or commit him, if requested by the clinic physician, in order that treatment may be administered. Patients are usually cooperative.

All contacts to cases of venereal disease found by the court clinic are followed in the same manner as other contacts. The court clinic is for diagnostic purposes only. The individual is afforded the choice of treatment either in the health department venereal disease clinic or by a private physician.

Statistics

During the period 1943–59, excluding 1948 on which no data are available, a total of 4,733 persons were examined at the New Haven court clinic. Of this number, 413 (8.7 percent) were positive for syphilis and 280 (5.9 percent) had gonorrhea. All were placed under treatment.

Compared with the other two compulsory examinations, premarital and prenatal, the court clinic is proving to be an economical casefinding measure. A total of 400,392 premarital blood tests, performed by the State

department of health laboratories, yielded for the corresponding years only 3,679, or 0.9 percent, positive results. A total of 361,538 prenatal blood tests gave a positive percentage of only 0.4 percent.

These two blood-testing laws have definitely contributed to syphilis control, but examination of persons arrested on vice charges has brought to treatment more patients not only with syphilis but with gonorrhea.

The results of the court clinic clearly indicate that casefinding should be directed to those who are promiscuous.

The law dealing with premarital and prenatal examinations requires only a serologic test. Although a complete physical examination is recommended, the main emphasis is placed on the control of syphilis. The reservoir of undiagnosed gonorrhea in the female is one of the reasons why this venereal disease ranks second among reported infectious diseases in the United States. The court clinic, nevertheless, has been valuable in the detection of gonorrhea.

Establishment of the New Haven court clinic has also demonstrated that a health department with good leadership can, with the cooperation and joint effort of different agencies, provide the community with effective venereal disease control facilities.

In all other municipalities throughout Connecticut, the court refers persons arrested on vice charges to private physicians for venereal disease examinations. Each physician is paid on a fee basis by the State department of health, as required by law.

The New Haven plan, with the health department primarily responsible for finding venereal disease, has the advantage of facilities necessary to follow up positive cases and possible contacts.

Summary

The New Haven court clinic has proved to be a valuable venereal disease casefinding source.

There should be more emphasis on sustained venereal disease programs directed to groups of individuals who are known to be promiscuous.

All physicians should be aware of the fact that gonorrhea in females may be present and undetected unless vaginal smears and cultures are carried out.

Local health departments should take the leadership with cooperation of others in venereal disease control.

National Water Pollution Conference

A vigorous discussion of water pollution problems was recommended by Arthur S. Flemming, Secretary of Health, Education, and Welfare, for the National Conference on Water Pollution to be held in Washington, D.C., December 12–14, 1960. The conference, which is receiving support of civic, industrial, and labor groups throughout the country, is expected to be attended by more than 1,000 of the Nation's leading professional and technical people in the field as well as by representatives of national organizations.

At a meeting of the conference's steering committee held in August, Secretary Flemming set two objectives for the conference: substantial agreement on national goals for water pollution control and the specific programs needed to reach these goals.

Surgeon General Leroy E. Burney pointed out that the United States is headed for a water crisis in the current decade unless the American people do a much better job of cleaning up the country's resources. The need for water supply and pollution control facilities "will continue to grow during the 1960's," he said, "as a result of population increases, the further concentration of people in metropolitan centers, and sharp increases in the use of water by households, farms, and industry."

Partly because of public apathy, the United States has accumulated a huge national deficit in these facilities, he said, warning that "we can no longer neglect this vital segment of the national economy without storing up serious trouble for the future. We need to apply more sanity to sanitation."