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bncdoc.id	ARH
bncdoc.author	Barlow, David
bncdoc.year	1979
bncdoc.title	Sexually transmitted diseases: the facts.
bncdoc.info	Sexually transmitted diseases: the facts. Sample containing about 44200 words from a book (domain: natural sciences)
Text availability	Worldwide rights cleared
Publication date	1975-1984
Text type	Written books and periodicals
David Lee's classification	W_non_ac_medicine

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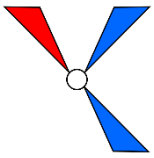

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so inclined, though the premiums for third-party insurance might be prohibitively high. Following the National Health Service Act of 1946, all the clinics were brought under the control of the Regional Hospital Boards and the Boards of Governors of the Teaching Hospitals. Thus, for over sixty years, there have been specially equipped and staffed clinics throughout the country, where patients can be seen without direct referral by their general practitioners. When prescription charges were introduced, the special clinics were exempted, and treatment continues to be free. The other single most important factor responsible for raising the standard of care was the recognition of venereology as a clinical specialty in its own right. This meant that the clinics were run, in the main, by trained medical officers whose special interest and expertise could be concentrated on **the sexually transmitted diseases**. Apart from Southern Ireland, there is no country in the world that has an equivalent specialty, and, as a result, standards of diagnosis, treatment, and care abroad vary from the inadequate to the unbelievably bad in most cases. The scope of the specialty of venereology has widened over the years, and following recommendations from the Royal College of Physicians has now been renamed 'genito-urinary medicine' to take into account the small proportion of patients attending the clinics who have a **'venereal disease'**. It is felt that fewer people would be put off attending with **other genital or sexual problems** if the stigma of going to a 'VD' clinic could be dispensed with. Rather sadly, the sites allotted to these clinics were often away from the main hospital departments and were either to be found in dungeon-like basements or else in prefabricated huts. In the last ten or fifteen years there has been a trend away from this geographical separation of the clinic, and there are now several purpose-built departments above ground designed as integral parts of new hospital complexes. Apart from a specialist service second to none, **the importance of accurate figures** relating to **the incidence of the various conditions** has not been overlooked, and, again, Great Britain leads the world. Perhaps because of the long-standing provision of special clinics, **the large majority of cases of sexually transmitted disease** are seen in such clinics, in contrast to other countries, where **less than 20 per cent of cases** are seen in hospitals. This has meant that elsewhere it has been very difficult to **assess** **the extent of the problem**, which has therefore been underestimated. Every clinic in the United Kingdom has to **collect figures on the total attendance and the diagnoses and submit them quarterly to the Department of Health**. With **syphilis** and **gonorrhoea**, the ages are also recorded, and this means that

an accurate map of disease prevalence

can be drawn and any trends or changes can be recognized very quickly. It is accepted that some **10 to 15 per cent of cases** are seen outside the clinics by private or general practitioners, and it is unusual for these cases to be reported to the Department of Health. The development of the service for the diagnosis and treatment of **the**

	sexually transmitted diseases in Great Britain stems largely from the efforts of one man, Colonel L. W. Harrison, who, somewhat unwillingly, was posted to a Guards Regiment Hospital in Rochester Row, London, in 1909 as pathologist. This hospital had been converted to a centre for research and instruction in **the venereal diseases**, and, by a happy coincidence, this was a time of great advances in the field. It had become possible to demonstrate the causative organism of **syphilis**, Treponema pallidum, under the microscope; there was soon to be available a blood test, the Wasserman Reaction (WR), which enabled **syphilis** to be diagnosed in the absence of any signs of **the disease**; and finally, a new **syphilitic** treatment, Salvarsan, an arsenic compound, had become available. Until this time, the mainstay of treatment for **syphilis** had been mercury in some form or other, either by internal administration or in the form of unctions. The Special Advisory Board for the Army Medical Service had laid down as a basis for treatment 'a more or less continuous course of mercury by mouth for 1½ to 2 years' combined with mercurial ointment rubbed into the skin for 20 to 30 minutes daily over a six-week period. Other regimens involved treatment with iodine compounds. Although Salvarsan was a considerable advance on previous treatments, it was not itself without risks and side-effects, and it was considered important to ensure that the 'C/T' ratio was 'propitious'. This ratio was derived by dividing the 'dose sufficient to destroy all parasites' by the 'maximum dose which will not kill the patient'! Notwithstanding the risks associated with this treatment, the discovery of Salvarsan was greeted throughout the world with great enthusiasm. One Russian paper, described as 'highly conservative', contained a piece, some of which, it was said at the time, was barely capable of being rendered into printable English. Having exalted over the 'liberation of whoredom' it went on to say,' 'No more danger! Down with the family! No need to toil in the sweat of one's brow to support it! Long live prostitution - the like of which has not been seen since the downfall of Rome …' Harrison and his team at Rochester Row did much of the pioneer work on Salvarsan