VENEREAL DISEASES

Notes for the Guidance of the Medical Officers

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PREFACE

THE INSTRUCTIONS given in this pamphlet are intended to guide medical officers in the treatment of Venereal Disease and cancels all previous recommendations.

It is published with the approval of the Director, Health Services

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Office of the Anti-V. D. Campaign,
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With compliments from
THE SUPERINTENDENT
Anti-V. D. Campaign

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EARLY SYPHILIS

EARLY Syphilis is syphilis of less than 4 years' duration. It has the best prognosis for cure, and treatment should be vigorous, Poor treatment in this stage may lead to infectious relapse, late forms of syphilis and serum fastness. Patients with EARLY SYPHILIS should be observed for a minimum period of Two Years after completion of treatment and should not be dismissed until blood tests and spinal tests are negative.

Diagnosis

SERO-NEGATIVE PRIMARY (S1)

Clinical.—Characterized by single or occasionally multiple lesions, which often fail to fit the typical text-book description of a chancre. In addition, there is enlargement of the regional lymph nodes. In this stage the blood test is negative but becomes positive within 4-5 weeks and is then known as Sero-Positive Primary (S2).

SERO-POSITIVE PRIMARY (S2)

Same clinical symptoms as in above stage.

Laboratory.—(S1 & S2) Darkfield examination is practically 100 per cent positive in early lesions, when satisfactory specimens are examined by a competent person. Low titred sero-logical tests should always be checked for a rise in titre before treatment is started if darkfield examination is negative. Suspect all genital lesions in the male or female as being syphilitic until proved otherwise.

SECONDARY (S3)

Clinical.—Usually associated with rash, generalized lymph adenopathy, sore throat, condylomata, mucous patches, headache, malaise. May have a healing chancre or history of recent primary lesion.

Laboratory.—Diagnosis confirmed either by darkfield, blood test, or both. Blood tests always 100 per cent. positive in SECONDARY SYPHILIS.

Latent (S4) (*a*) Early

Clinical.—No lesions present, but history indicates infection of less than 4 years' duration. Patients usually less than 25 years of age.

Laboratory.—Diagnosis made by two positive blood tests. Spinal fluid test is important for correct diagnosis of this stage. SPINAL FLUID IS NEGATIVE.

The above stages are all included in the term *Early Infectious* Syphilis.

LATE SYPHILIS

Latent (S4) (*b*) Late

Clinical.—No lesions present, but history indicates infection of over 4 years' duartion. Patients usually over 25 years of age.

Laboratory.—Diagnosis made by two positive blood tests. Spinal fluid test is important for correct diagnosis of this stage. SPINAL FLUID IS NEGATIVE.

Neuro-Syphilis (S5)

Neuro-syphilis should be treated by the specialist, since accurate neurologic examination, spinal fluid interpretation etc., require considerable skill and experience. Since many physicians in general practice are treating these patients, however, the following general recommendations are made :—

(1) Spinal fluid examination should be done in all cases of late syphilis and neuro-syphilis before any treatment is given, and should consist of an accurate cell-count, protein determination, lange curve, and a quantitative test for syphilis. (V. D. R. L.)

(2) Patients with positive spinal fluids without clinical manifestations of neuro-syphilis should also be diagnosed as neuro-syphilis, i.e. *asymptomatic neuro-syphilis.*

Cardio-Vascular Syphilis (S6)

Cardio-vascular syphilis should also be treated by the Specialist in consultation with a Cardiologist. These cases need general medical care and symptomatic treatment more than anti-syphilitic treatment.

Gummata of bones, skin, viscera, &c.

Treatment for Early Syphilis

(i.e. S1 TO S 4 EARLY)

Out-patient.—Procaine Peni illin in Aluminium Monostearate 2 per cent solution is available for all V. D. pati nts from the Central V. D. Clinic in Colombo. Hence stop treatment with Arsenic and Bismuth. A total dose of 6 million Units of PAM : 600,000 Units (2cc.) being given I.M. daily for 10 days.

Recent information received from various sources and other WHO projects show that 85-90 per cent success has been obtained in the cure-rate by treating early syphilis with 2.4 MEGA units PAM as an initial injection.

In view of the above fact the following alternate treatment schedule is also recommended.

Initial Dose for Early Syphilis.—PAM, 8cc. (2.4 million units), 4cc. intramuscular into each buttock, followed on the 4th or 5th day by further injections of PAM, 2cc. each on alternate days (i.e. 2cc. × 6.) for a sum total of 6 million units PAM.

This is very desirable especially in expectant mothers with syphilis. In this way patients can be rendered non-infectious with the initial injection and even if they default, sufficient treatment has been received by them to control the spread of syphilis.

Where it is not practicable to give PAM on alternative days 4cc. may be given bi-weekly for 5 injections to make up the total of 6 million units.

Follow-up

1. Do a blood test for syphilis at monthly intervals and depend on the change in titre to determine the patients' response to treatment. The blood test may not become negative for 3-6 months following treatment. A conti..uous fall in titre indicates a satisfactory response.

2. Examine patient's marital partner and sexual contacts for signs and symptoms ; take blood tests at time of initial examination and monthly thereafter for four months. Failure to do this often leads to re-infection of your patients and the infection is thus carried backwards and forwards.

3. *Indications for Re-treatment :—*

(*a*) Recurrent syphilitic lesions with darkfield examination positive.

(*b*) Sharply rising titre of 2 tubes or more dilutions. This rise in the titre should be confirmed with repeated blood tests every fortnight and physical examination for any lesions.

Treatment—PAM 2cc. × 15 injections DAILY.

(*c*) When a case of re-infection is diagnosed, re-register the patient as a new case giving him a new number. This procedure should be followed in cases of both Syphilis and Gonorrhoea.

OBTAIN ADVICE OR WRITE TO US WHENEVER IN DOUBT WITH REGARD TO RE-TREATMENT

Treatment for Late Syphilis

(i.e., S4 LATE TO S7)

PAM 2cc. daily to make up a total of 9-12 million units. Where only bi-weekly sessions are held PAM 4cc. × 8 or 10 injections may be given. The higher total dose is preferable for Neuro-syphilis and Cardio-vascular syphilis.

C. S. F. should be examined in all cases before commencing treatment.

All family contacts of cases of Late Syphilis should be examined and treated, if necessary.

False Positive Tests for Syphilis

False positive tests for syphilis are sometimes found in patients suffering from a variety of infectious diseases. Considerable caution should be exercised before diagnosing syphilis on the basis of tests alone in patients with *upper respiratory infections, recent febrile illnesses or immunizations.* Such conditions as *vaccinations, fever, infections mononucleosis, leprosy and malaria* also cause biologic false positive tests for syphilis, False positive reactions are usually of low titre and may show discrepancies when tested by several serologic techniques. Do not hesitate to withhold treatment in patients with recent febrile illnesses, when there is no history of syphilis, or in patients whose marital partners have

no evidence of the disease. Further study of these cases may reveal a false positive test. Whenever a false serologic reaction is suspected, consultations with the laboratory is recommended. Usually a false positive reaction in a patient will become negative if followed up with repeated blood tests for 4-8 Weeks F. T. A. Test will be negative.

Congenital Syphilis (S8)

Congenital Syphilis is usually divided into Early and Late, depending on the age of the patient. Infants under 2 years of age are classified as having EARLY CONGENITAL SYPHILIS and their symptoms, treatment and follow-up are similar to patients with early acquired syphilis. Children over 2 years of age with congenital syphilis are classified as having LATE CONGENITAL SYPHILIS and are somewhat comparable to patients with the late acquired syphilis.

EARLY

Clinical.—The infant is very often acutally ill, needs paediatric care, good nursing, and careful feeding. Therefore these cases, will be best treated in hospital where the mother also can be with the child. The infant may show a rash, snuffles, pseudo-paralysis, swelling of joints, epiphysitis and dactylitis, condylomata and muco-cutaneous lesions.

Laboratory.—Positive darkfield of cutaneous lesions. Serologic tests of high titre or rising titre. X'ray of long bones frequently show osteo-chondritis and periostitis.

LATE

Clinical.—Hutchinson's teeth. saddle nose, interstitial keratitis. Nerve deafness may be found in older children. Antero-posterior thickning of long bones especially marked in the Tibae " Bowing of the Tibae ", gummata, neuro-syphilis.

Laboratory.—Two positive blood tests for syphilis. Spinal fluid examination should be done in all cases to rule out neuro-syphilis. Some are sero-negative.

Serologic tests of the cord blood and low titred quantitative tests in a new born infant are not diagnostic of congenitial syphilis unless associated with definite clinical or X'ray manifestations of the syphilitic infection. In the absence of the latter it may be due to passive transfer of reagin from the mother's blood. On the other hand a positive serologic test may not appear for 2-3 months after delivery. Therefore, children born of syphilitic

mothers should be followed with serological tests every month for a period of four months. If the test is negative at the age of four months it should be repeated at the age of 6 months and again at one year, and if still negative the case dismissed.

Treatment

EARLY

Ambulatory.—PAM 1cc. on alternate days for 10 injections, i.e., a total of about three million units or Crystalline Penicillin 200,000 units per lb. body weight. Some infants with congenital syphilis are often premature and under-nuorished. General paediatric care is essential in these cases.

LATE

The treatment of late manifestations of congenital syphilis such as interstitial keratitis, nerve deafness and juvenile paralysis is, in general, unsatisfactory. These patients require individualized treatment and expert guidance should be sought by the physician in general practice. The treatment of patients with late congenital syphilis is the same as that for latent acquired syphilis except for the difference in dosage of the drug. In general, children of 2-5 years should be given half of the adult dose of PAM. Above 5 years the full dose, i.e. 9-12 million units PAM.

Follow-up

1. Follow-up of blood tests and indications for re-treatment in early congenital syphilis are the same as for early acquired syphilis. The serologic and spinal tests should be negative before the child is dismissed.

2. The follow-up observations and indication for re-treatment in late congenital syphilis are the same as in late acquired syphilis. The serologic tests in these patients may not become negative following treatment. But this does not of itself indicate an unsatisfactory result. Blood tests should be performed every three months for at least two years.

3. When a case of congenital syphilis is discovered, the whole family should be investigated including both parents. Blood tests for syphilis should be done on every case.

SYPHILIS IN PREGNANCY

Adequate treatment of syphilis in pregnancy will prevent infection of the unborn child and will result in a non-syphilitic baby in almost every instance. Early diagnosis of syphilis is essential. Blood tests for syphilis should be taken on EVERY pregnant woman at the FIRST pre-natal visit and again at the 7th or 8th month of pregnancy, if possible.

Diagnosis

The clinical and laboratory criteria for diagnosis of syphilis in pregnant women are the same as in other patients. Clinical manifestations of early syphilis may be suppressed in pregnancy, and the diagnosis of syphilis is usually based on serologic tests. Although patients with syphilis of many years' duration who have already had adeqauate treatment are not likely to have syphilitic children, further treatment of these patients during pregnancy is advisable if their blood tests are still positive.

Treatment

Ambulatory.—PAM, 600,000 units (2cc.) given daily for a total of 6 million units, or PAM 4cc. bi-weekly for 5 injections.

Follow-up

1. The quantitative blood test for syphilis should be taken every month until delivery. These patients should be re-treated during pregnancy if they develop (*a*) re-current syphilitic lesions, or (*b*) a definite rise in quantitative blood tests.

2. All ptaients should have follow-up blood tests after delivery. This follow-up is the same as out-lined on Early and Late Syphilis.

3. A positive blood test for syphilis at the time of delivery does not necessarily indicate that treatment has been inadequate since it may become negative following delivery.

4. All infants born of syphilitic mothers must be followed-up as indicated in the section on congenital syphilis.

TO PREVENT CONGENITAL SYPHILIS TAKE ROUTINE BLOOD TESTS FOR SYPHILIS IN EVERY PREGNANT WOMAN. THE EARLIER TREATMENT IS GIVEN THE BETTER THE PROGNOSIS.

GONORRHOEA

This disease is usually characterized in the male by a purulent discharge per urethra and pain on micturition, and in the female with a purulent discharge per urethra, vagina and cervix.

Before treatment is started ALWAYS examine a smear stained by Gram's method for G. C. and do a blood test for syphilis. Diagnosis could be confirmed by culture Thayer-MartinMedium.

Treatment

When a positive case is detected in the male always treat the marital partner or his sex contact whenever possible even if, on examination, her smear gives a negative report.

Drug : FORTIFIED PROCAINE PENICILLIN IS THE DRUG OF CHOICE. One injection of 1.6 million units for each patient.

FEMALES — 2.4 MILLION UNITS

Follow-up

Every case of Gonorrhoea should be followed-up with routine blood tests for syphilis once a month for at least four months in order to detect any concurrent syphilis.

Non-Gonococcal Urethrits

The cases of Non-gonococcal urethritis may be produced by the following :—

(1) Infection with bacteria, protozoa, viruses.

(2) Chemicals—drugs.

(3) Introduction of foreign bodies.

(4) Sensitization of certain tissues due to some allergy.

(5) Trichomonas Vaginalis

Treatment

Before treatment is commenced examine a smear by Gram's method and do a blood test for syphilis.

Drugs : A single injection of Strepotmycin 1g. with a course of Sulphonamide is given in the first instance.

Should this fail Streptomycin 1g. daily for 5 days with an alkaline mixture should be tried.

If the discharge still persists, Aureomycin, Terramycin or Achromycin 250 mgm. six hourly for 4 days should be given.

Treat T. V. with Flagyl

(Metronidazole)

YAWS

Yaws is usually divided into two groups—Ealry and Late. It occurs in communities of low socio-economic level all over the world in the tropical zone.

EARLY—In children with papules and skin framboesides.

LATE—Older children and in adults with late lesions in bones and joints.

Treatment

Early and Late Yaws :—

Adults over 15 years PAM 4cc. in one injection.

Children under 15 years PAM 2cc. in one injection.

Latent Yaws and Contacts :—

Under 15 years—1cc.

Over 15 years—2cc.

In cases of doubt as to the possibility of the case being one of syphilis a preliminary lumber puncture is done and the case treated as one of latent syphilis.

PROCAINE PENICILLIN IN ALUMINIUM MONOSTEARATE

This is the drug of choice for syphilis and yaws ; especially so as it can be given on an ambulatory basis. This drug is available to all V. D. patients throughout the Island from the Central V. D. Clnic, situated at De Saram Place, Colombo.

QUARTERLY REPORT

A quarterly return has to be sent from all V. D. Clinics and in-patients to the Office of the Superintendent, Anti-V. D. Campaign on form Medical 6 within seven days of the end of the quarter. This quarterly return must be completed by all outstation clinics and hospitals treating V. D. cases. The requirements of penicillin are calculated from the number of cases treated during the previous quarter—the indent for penicillin must be included in the cage allotted in the Quarterly Report Form.

Notes on the completion of Quarterly V. D. Return Form

ANALYSIS OF NEW CASES

Sero-negative primary syphilis.—This diagnosis only applies to patients with a chancre confirmed by Dark Ground Microscopic Examination in whom the blood test is negative.

Other Venereal Diseases.—Include soft-sore, lymphogranuloma venereum and granuloma inguinale

Follow-up of Cases.—The total of the first and second lines should equal the total of lines three, four and five.

Public Education Activities.—This refers to public education outside the clinic.

REPORTING ON V. D. R. L.

The method of reporting on V. D. R. L. (which has now replaced Khan & CL) is as follows :—

Reactive	—	Non-Reactive	—	Weakly Reactive
(*Positive*)		(*Negative*)		(*W R.*)

All reactive sera are tested in serial dilution and the titre recorded within brackets, e.g., V. D. R. L. Reactive (+8).

USE OF HEALTH 406—REQUEST FORM FOR EXAMINATION OF BLOOD FOR V. D. R. L.

The above Request Form is printed in duplicate, i.e., Pink and White. Both forms must be completed and posted to the respective Provincial Laboratory doing the test along with the blood samples when requesting examination of blood for V. D. R. L.

The address of the Clinic or Institution, the numbers of the patients' files or tickets and the signature of the M. O. should be entered legibly. One copy will be retained at the examining laboratory and the other will be despatched to the address given on the form.

Superintendent,
Anti-V. D.Campaign.

Office of the Superintendent,
Anit-V. D. Campaign,
De Saram Place,
Colombo, January 3, 1970

ANNEXURE

HEADINGS OF REGISTERS THAT SHOULD BE MAINTAINED AT A. V. D. CLINIC

1. New Cases Register

V. D. C. No.	Name in full	Address in full, Age, Sex, Marital Status, Nationality, Occupation	Diagnosis	Treatment	Remarks

2. Subsequent Visits Register

			Date					

3. Summary of Attendance (a waste book may be used for this purpose)

Date	First visit	Subsequent visits	Total	Remarks

4. Contact Investigation Register

Serial No.	V.D.C. No. of Patient interviewed or diagnosed	Date of Interview	Patient's Disease	Name of Contact	Address of Contact	Date located	Date attended	V.D.C. No. of Contact	Diagnosis	Remarks

5. Medical Officer's Diary giving day-to-day Examination and Treatment (a waste book may be used for this purpose)

V.D.C. No.	Blood	Smear	T.P.	PAM given

6. Blood Specimen Register (a waste book may be used for this purpose)

Date on which Specimen sent	V.D.C. No. of Patient	Result of Findings—	V.D.R.L

7. **Contact Slip Register**

Date Contact Slip issued	Contact Slip No.	Patient's V.D.C. No.	Diagnosis of Patient	Name, Age and Address of Contact etc.

Relationship to Patient	Clinic referred to	Date Contact attended	Contact's V.D.C. No.	Diagnosis of Contact	Remarks

ANNEXURE II

ANTE-NATAL CLINIC..............

1. **Register—Routine Ante-natal Blood Test**

Serial No. Annually or Ante-natal Ticket No.	Serial No. Monthly	Full Name, Full Address of Husband or Contact, Name, Address and Occupation	Blood Report	Diagnosis	Treatment given PAM in CC	Action taken by M.O.H. or referred to a V.D. Clinic and whether Treatment completed

2. Register of V· D· Epidemiological Work

Serial No.	Date received	Referred by	E. R. No. and Particulars of Contact	Date referred to Field Staff Range P.H.I. or P.H.N. for Investigation	Date reported by P.H.I. or P.H.N.	Action taken regarding Location and Examination of Contact	Date E. R. returned to original Clinic

3. Register of V· D· Defaulters

Serial No.	Date received	Referred by	V.D.C. No. and Particulars of Defaulter	Date referred to Field Staff Range P.H.I. or P.H.N. for Investigation	Date reported by P.H.I. or P.H.N.	Action taken regarding follow-up of Defaulter	Date Defaulter's Report returned to original Clinic