SEXUALLY TRANSMITTED DISEASES A WASTE OF MILITARY MANPOWER

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Introduction

The very great increase in the incidence of the sexually transmitted diseases (STD) throughout the 1960s has been one of the most disappointing and unexpected medical and social developments of our times. It had been hoped that with the advent of penicillin and other antibiotics in the late 1940s that the number of new patients with these infections would have declined, and that these diseases would have ceased to be a major problem in countries with well organised medical services. There was a marked decrease in the incidence of many of these diseases in the early 1950s, probably as a result of the widespread use of penicillins and other antibiotics. However, by the latter part of the 1950s the tide had begun to turn, and since then there has been a steady increase in the majority of the diseases spread by sexual intercourse in most countries of the world. In Great Britain between 1959 and 1974 the number of cases attending STD clinics more than doubled (Figure 1). There was a 90 per cent increase in incidence of gonorrhoea and syphilis¹.

Gonorrhoea increased more than threefold between 1954 and 1972. Cases of gonorrhoea occurring in England and Wales were, in 1954—17,500, 1961—37,100 and 1972—54,979. In non-specific urethritis (NSU) there showed a fourfold increase between 1952 and 1972, the number of cases were 11,552 in 1952, 46,075 in 1970 and 48,550 in 1972.

A historical perspective

Before consideration of the increase of incidence of STD in the Army which has paralleled that occurring in the civilian community, it is of value to recall some events of the First World War. In 1909 a hospital of one of the Guards Regiments at Rochester Row, London, was converted into a hospital for research and instruction in STD. One of the pathologists posted in was Capt Harrison, who already had considerable experience of the treatment of STD. However, when the British Expeditionary Force (BEF) was sent to France in 1914 the team at Rochester Row was disbanded, no special STD provision being made for the BEF. The military medical units accompanying the BEF had no drugs, even though Salvarsan had been available since 1910, and also had no equipment for STD investigation or treatment. The sole antivenereal disease measure was a leaflet signed by Lord Kitchener, the Secretary of State for War, exhorting the troops to sexual continence. When patients with STD began to report to medical units senior officers raved about unpatriotic conduct and some advocated letting the adjectival patients rot! However, as numbers increased it became clear that something more was required. It was then decided that a whole stationary hospital containing 250 beds should be allotted to this task. The choice of hospital seems to have been determined by the

fact that the Commanding Officer was unpopular with his superiors! There seems no other valid reason for he had no STD training and no specialist staff. Things became chaotic and the hospital became little more than a rest station before repatriation to the United Kingdom (UK). Thus STD became a passport for home, which was militarily unsound. By January 1915, the unit contained over 1,000 patients, and not one syphilitic had received Salvarsan. Major Harrison (he had been promoted in 1911), and his team had to be reassembled and asked to sort out the chaos, a task they performed with considerable panache. The organisation which Col Harrison left behind him on his retirement from the Army Medical Services is still run on the lines he advocated, with special treatment centres in all Commands, and venereologists in British Army of the Rhine (BAOR) and UK².

The current military STD situation

In 1969 in Far East Land Forces (FARELF) and Australian, New Zealand and United Kingdom Forces (ANZUK), the admission rate to military medical units for STD was 3.2 per 1,000 troops. By 1972 it had become 10.1 per 1,000 troops. These figures can only be an indication of trends rather than a true statement of incidence as STDs are usually treated on an out-patient basis rather than as in-patients. Sexually transmitted diseases are now a significant cause of manpower wastage in that admission to a military medical unit or out-patient attendance renders him non-available for military duties. Admission rate per 1,000 troops, British Army Males, in 1972 were for STD — UK 1.2, BAOR 0.3, Land Forces Hong Kong (LFHK) 6.7, Near East Land Forces (NEARELF) 1.2 and ANZUK 4.0. The figure for infectious hepatitis were — UK 0.6, BAOR 0.3, LFHK 2.9, NEARELF 0.8 and ANZUK 3.3.

Infectious Hepatitis is considered separately for two reasons. The first is that only for Hepatitis B, and not for Hepatitis A, is there evidence of sexual transmission, and the Army morbidity returns do not differentiate between types A and B. The second reason is that not all venereologists accept the circumstantial evidence that Hepatitis B is an STD, although the consensus view of the majority accepts this point of view. Whatever the method of transmission of viral hepatitis the disease represents a considerable drain on military personnel.

The admission rates for FARELF Army male troops for Virus Hepatitis in 1972, were by age per 1,000 troops — All 4.7, under 19 13.2, 20 to 24 7.2, 25 to 29 2.9, 35 to 39 3.5 and the duration of admission in days was — All 24.2, under 19 21.8, 20 to 24 27.0, 25 to 29 22.0 and 35 to 39 24.5. Also in 1973 the disease produced a MEDEVAC rate of 0.4 per 1,000 troops from NEARELF.

Table I shows that the increased incidence of STD is borne by all the major

Table I
Admission rates per 1,000 British Army male troops for 1972 in FARELF

	All ages	Less than 19	20-24	25-29	35-39
Early syphilis	2.1	8.8	3.6	0.7	
Other syphilis	0.6		1.8		
Gonorrhoea	0.8		1.2	1.5	
Chancroid	0.4		1.2		
Other	1.9		4.8	1.7	

venereal diseases. However, crude admission rates do not in themselves reflect the true allocation of resources to the problem of coping with STD, and this is better reflected in the duration of admission to military medical units (Table II).

Table II
Duration of admission of British Army male patients to military medical units for STD for 1972 (in days)

	All ages	Less than 19	20-24	25-29	35-39
Early syphilis	7.9	10	7.2	4.0	
Other syphilis	11.7		11.7		
Gonorrhoea	8.8		6.5		
Chancroid	9.5		9.5		
Other	13.9		14.4		17.0

The nature of the manpower problem experienced by force commanders is revealed by Table III. These are the figures for STD experienced by troops sta-

Table III
Treatment figures for STD experienced by troops in Belize

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Gonorrhoea	12	6	7	13	13	7	10	6	8	8	6
NSU	15	14	8	7	11	14	8	9	3	6	5

tioned in Belize at a time of low military activity, over a continuous eight month period. Most of these were treated as out-patients. There were 30 cases of gonorrhoea and 37 cases of NSU. There were no cases of syphilis, chancroid, or lymphogranuloma venereum. The continuous nature of the problem means that at any one time a proportion of a force are militarily non-available because of STD.

These figures hide the true nature of the problem in one sense as they are derived from a garrison with limited Special Treatment Clinic (STC) facilities. A better indication of the true problem is provided by Thin's figures³ quoted in Table IV. These are the figures for one year's work in STC Singapore.

Table IV
Case breakdown for 1970 for STC British Military Hospital, Singapore³

Syphilis	56	Trichomoniasis	1
Gonorrhoea	416	Pediculosis	29
Non-specific urethritis	357	Scabies	16
Warts	94	Genital ulcers	131
Balanitis	51	Miscellaneous	273

It should not be thought that there is a reduced incidence of STD in troops when on active service. Wartime conditions have always been conducive to promiscuity. Gavin Hart⁴ of the 1st Australian Field Hospital in Vietnam found a high STD rate: 27 per cent of those exposed and 65 per cent of the troops he studied had intercourse in Vietnam. In his clinic in the course of a year there were

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Fig. 1. Total patients attending England and Wales STD clinics in thousands.

Fig. 3. The incidence of NSU at STC Munster (Number of cases)

Fig. 2. Annual STD case rate at STC Munster

Fig. 4. The annual gonorrhoea incidence rate at STC Munster (Number of cases)

269 cases of gonorrhoea, five of syphilis, 163 of chancroid, and 246 cases of trauma, herpes and inflammatory diseases.

The current military problem

Figure 1 shows the increase in incidence of STD in the civilian UK figures and is paralleled in BAOR with Figure 2 showing the annual case rate for STC Munster, which has increased from 546 in 1968 to 1894 in 1976. The increase in incidence of NSU (Figure 3) from 52 in 1968 to 233 in 1976 is similar to the British experience. However, there is a cause for concern in the increasing incidence of gonorrhoea (Figure 4) from 30 in 1968 to 257 in 1976. The incidence in the UK in the last five years has not fluctuated by more than 10 per cent⁵.

What is the solution?

It is not proposed to give facile panaceas. The problem cannot be solved overnight by a magic formula. However, it is obvious that the current trends must be reversed, both from the point of view of individual health and of the conservation of expensive and scarce military manpower. The grade of Special Treatment Attendants (STA) has been raised by recruiting them from the ranks of State Registered and State Enrolled Nurses. Medical officers are being trained as Specialist Genito-Urinary Physicians by attachment to busy London teaching hospitals. Newly commissioned medical officers are receiving more intensive tuition on their Post-graduate Medical Officer courses. Contact tracing facilities are being improved. However, there is a need for more suitable volunteers from the ranks of doctors and nurses, both to do the work and provide new ideas, without which the organisation will decay.

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