NOTES ON THE TREATMENT OF SYPHILIS IN 
UGANDA.
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In March, 1910, Government proposed establishing a centre for the treatment of venereal diseases at Masaka on account of their prevalence in this district. The County Chief was called upon to build this hospital and huts for the reception of sick. This he did at his own expense, and expressed great pleasure at the proposed measures for checking the spread of these diseases among his people. Accommodation is now provided for the reception of 300 patients, and food supplied free by the chiefs. As the food is almost as plentiful as grass and of little more market value, this is not a difficult matter. The sick are sent in by the chiefs for treatment. The idea of its being necessary to have the sick brought in may at first sight seem curious. These diseases are extremely common, and the majority of the infected seem to regard the disease very much as children's epidemics used to be regarded in the less enlightened days at home, an inevitable something which had to be endured. It never seems to occur to these people to seek treatment of their own accord; they remain festering in their villages, infecting other adults and children, until they are referred here for treatment by their chiefs. Once arrived they are willing enough to undergo treatment, and often show great interest in their progress. Though no compulsion is employed to retain them here, and they are free to take their departure at any time, they almost invariably remain until they are free from signs. The majority of cases are in the secondary stage of syphilis when they arrive. Owing to ignorance presumably the primary stage of the disease is rarely recognized. The disease seems to find its chief expression in the secondary stage. Tertiary syphilis seems to be relatively uncommon. When it does occur the manifestations are simple and unimportant, mainly cutaneous affections—psoriasis, chronic ulcerations, &c. The severe lesions of the nervous system, so common in Europe, and which make syphilis so dreaded a disease there, are rarely seen in these people. This fact may partly explain the light view taken of syphilis by the native. I believe the opinion is held by some syphilologists that if the secondaries come out well the liability to tertiary
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Hospital Huts.

Interior of Treatment Room and Native Assistants.
symptoms is not so great. This view seems to be borne out in practice here. Congenital syphilis is common and assumes a rather severe type. The clinical features of the cases closely resemble those of secondary syphilis. It is markedly and readily responsive to treatment.

Clinical Signs of Secondary Syphilis.—The clinical features of the cases are almost always identical, though the severity of the signs varies in different individuals. These are (1) the rash, always well-marked, sometimes dry and corresponding with that seen in Europeans, more usually pustular. In severe cases the body is covered with pouting, cauliflower-like excrescences, fetid and discharging; (2) throat affections, mucous patches on the fauces, often a spongy mass of granulations is seen extending down behind the molar teeth; ulcerations of the mucous membrane of the hard and soft palate; (3) arthritic and osteal affections, pain is most commonly complained of in the sternum and the ribs, arthritic effusions appear most usually in the knee-joints; (4) mouth, well-marked condylomata are seen at the angles of the mouth and along the mucous membrane of the cheeks at the points of contact with the teeth; (5) condylomata are seen at all the flexures; they are especially common in the axillae, so much so that the occurrence of flat circular ulcers in the axillae are absolutely diagnostic. The region between the coccyx and the pubis is almost invariably occupied by heaped up masses of sloughing granulations. The accompanying photographs represent the common and every-day type of case.

Treatment.—Complete treatment as we know it, namely twenty-one months, is inexpedient in this country and as will be seen later it is questionable how far it can be said to be necessary from a medical standpoint.

The method of treatment employed in all adult cases is intramuscular injection of Lambkin's mercurial cream. Six injections are administered at intervals of seven days, then follows a rest period of four weeks, then a further four injections at weekly intervals. After this should any sign persist, treatment is carried on with four injections at intervals of a week followed by a month's rest and so on for as long as is necessary. All patients are encouraged to attend as long as possible even if not receiving injections, in order that observations may be made as to progress or recurrence. The average duration of treatment here is fourteen weeks. Congenital syphilis cases are treated by abdominal inunctions of 10 per cent ung. hydrarg. The application to chronic
(A) Secondary and Congenital Syphilis before Treatment.

(B) Same as (A) after Treatment.
tertiary ulcers of Lambkin's calomel cream, thinly smeared on lint, gives remarkable results.

Dosage.—A uniform dose of $\frac{1}{3}$ gr. is given in all cases. Higher doses, as will be shown, are as unjustifiable as they are uncalled for. Salivation is the only notable result. I have six case sheets showing administration of initial doses of $\frac{1}{3}$ gr. followed by five doses of $\frac{1}{5}$ gr. Five of these cases showed marked salivation later.

Results.—The case sheets show that response to this treatment is marked and immediate. Not uncommonly, even in severe cases, all signs have disappeared by the time the first course of six injections is completed. At the conclusion of the second course, if signs have not returned meanwhile and are then absent, I discharge patients, instructing them to attend from time to time for observation. I have numerous records of such cases, and my experience here is that the signs do not as a rule return. I have been engaged for the greater part of three years in the treatment of syphilis in these people and have had opportunities of observing cases continuously for fifteen months. I have records of cases of severe secondary syphilis where the subjects only attended for six injections, on completing which they were free from all signs of the disease and have since to my certain knowledge shown no further symptoms. This result is at variance with recognized views and may be a special feature of this disease in these people. Its obvious bearing on the practical problem of the suppression of the disease here is of immense importance, for such persons are incapable of propagating acquired syphilis, and are presumably immune from re-infection. They may become the subject of tertiary syphilis, but that is a personal matter and not of public concern.

The prevention of congenital syphilis is indirectly ensured inasmuch and in so much as the spread of acquired syphilis is militated against, the occurrence of congenital syphilis in the offspring of tainted parents is not entirely precluded. But, then, as was pointed out by Captain Sparkes, R.A.M.C., that is rather too much to be expected in the present stage of this work.

Conclusion.—There seems to be no doubt that if the treatment of the sick is to be left to the discretion of the infected, and no stronger method is to be used than persuasion through the Chiefs, as is the case at present, syphilis will make still more remarkable ravages throughout the country, and in my opinion, will bid fair to wipe out the race. According to native returns, the general death-rate of this part of the country exceeds the birth-rate, the greatest
loss of population occurring in the first year of life. The infantile mortality rate is rarely below 300 per 1,000, commonly it is 500 per 1,000, and I have been assured that it sometimes assumes even greater proportions. The connexion between syphilis and the wastage of infant life seems too obvious to require further elaboration.

From what has been said it will be seen that from the purely medical or therapeutic point of view, the checking of the spread and the reduction of the incidence of acquired syphilis among the population, is not a problem of great difficulty.

It remains to be seen whether the authorities will insist on the attendance of the sick. The industrial development of the country is undoubtedly making great strides, but is as yet only in its infancy. It is an axiom that the demand for labour increases with the economic development of a new country. Here the demand is increasing, but the supply is actually on the decrease. Venereal disease is mainly responsible for the situation. One would think that from the economic point of view alone the problem is one that presses for a solution.

I wish to express my indebtedness to Capt. E. B. Place, District Commissioner, Masaka, for the accompanying photographs.