NOTES ON THE MANAGEMENT OF VENEREAL DISEASES.

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In all diseases which are liable to chronicity and difficult to cure, new forms of treatment are daily being advocated; this is specially so in the case of venereal disease. It is not the purpose of this article to describe any one new form of treatment, nor is it proposed to discuss the merits of all forms, and no one method is advocated as a panacea in all cases. It is not, in fact, intended to be an exhaustive treatise on the treatment of venereal disease.

We, as military medical officers, are primarily responsible for the health of the serving soldier. There is one great difference in the treatment of military and civil cases in that military cases are invariably treated in hospital, whereas civil cases are treated, as a rule, as out-patients. In the author's experience, civil cases certainly do no worse than military.

The great advantage in having cases in hospital is that they can be observed under various forms of treatment and accurate data compiled; for this reason the author has no hesitation in asserting that the military medical officer is the leading authority in the management of venereal cases. But do we make sufficient use of the material and chances given to us?

The main objection to the treatment of cases in hospital is financial—first the cost of the hospital treatment and secondly the loss in efficiency, training, etc. It is the author's considered opinion that cases, especially of gonorrhoea, are kept in hospital far too long, with detriment both to the State and themselves. This is a condition difficult to alter, as the Army as a whole, especially the lay portion, is so bound down by convention. If cases are kept in hospital only for so long as they have active and acute symptoms and are then discharged to barrack treatment, a great improvement will be seen; these cases do not constitute a grave danger to their comrades, and there is really no necessity for the provision of separate latrine accommodation, etc., for them—except as a sop to public opinion.

The mental aspect of the venereal patient is one of the most important symptoms and one of the most difficult to treat; for this reason, these patients rapidly become hospitalized. It must be remembered that, apart from local disease, they are physically fit men who chafe against the restrictions put upon them and feel the stigma of disgrace which still, in spite of more enlightened present-day opinion, unfortunately exists.

The above remarks chiefly refer to cases of gonorrhoea. Syphilis cases are kept in hospital until all sores have healed, the rash has faded, etc.,
and they have had three weeks' arsenic treatment. This cannot be altered. Soft sore cases must be kept until all sores have healed.

By a judicious combination of various methods of treatment it has been found possible to hasten considerably the cure and consequently to lessen the cost to the State. As proof of this the following figures, taken from the records of the British Military Hospital, Barrackpore, Bengal, India, may be quoted:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of admissions</th>
<th>Average number of days in hospital per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fresh cases</td>
<td>Relapses</td>
</tr>
<tr>
<td>1929</td>
<td>116</td>
<td>9</td>
</tr>
<tr>
<td>1930</td>
<td>70</td>
<td>15</td>
</tr>
<tr>
<td>1931</td>
<td>76</td>
<td>11</td>
</tr>
</tbody>
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Some of the forms of treatment described below are old and, possibly nowadays, out of date, but in certain cases all have their uses. It is thought better to describe these methods under general headings.

**Gonorrhoea.**

*Bed.*—It is the accepted principle that a fresh case when admitted to hospital should immediately be put to bed on a milk diet and given no irrigations; he is then automatically marked "up" on the tenth day. The civil case has to go on working from the first day onwards! A certain amount of rest is essential in most cases, but each must be judged on its merits: some only require one or two days. Of course, if acute complications supervene bed is indicated.

*Diet.*—Milk diet is indicated at first, but it should only be continued for a minimum period as it tends to lower the patient's body resistance—the amount of toxemia in a case of gonorrhoea is not fully realized. Most cases can be put on an ordinary diet at the end of a week. The diet should be as rich as possible in vitamins. Plenty of fluid is necessary and is best given in the form of barley water—at least two and a half pints per patient per diem. That made with Robertson's patent barley is best and, moreover, is very economical in fuel used; it will therefore be found cheapest in the long run.

*Exercise.*—Soldiers are used to taking a considerable amount of exercise and suddenly to curtail this by incarceration in hospital is detrimental both mentally and physically, with consequent reduction in body resistance. Even in acute cases exercise is essential. Walks, graduated P.T. for fifteen to twenty minutes in the early morning, will be found beneficial and, contrary to the usual belief, complications such as epididymitis do not occur if the P.T. is not overdone. Every patient should, however, be made to wear a suspensory bandage, either in the form of a "Jock Strap" or of the pattern illustrated in Colonel Harrison's book;1 the latter can easily be made by the hospital tailor.

1 "Diagnosis and Treatment of Venereal Diseases in General Practice," third edition, Oxford University Press, London.
Mental Treatment.—This depends largely on the temperament of the medical officer treating the case and the mentality of the patient. As previously stated, apart from the local disease and concomitant toxæmia, the patient is a fit man and if he is well fed, has plenty of mild exercise and recreations—i.e., suitable books, games, etc.—he will do far better.

It is the highly-strung, imaginative individual who, physically reduced by insufficient diet and exercise, has had it constantly rubbed into him that he is a criminal and outcast and has been given plenty of time to brood over his sad state, that becomes chronic and extremely difficult to cure. This does not mean that discipline in the venereal ward must be relaxed; it must, on the other hand, be very strictly enforced. A cheerful, sympathetic and optimistic attitude on the part of the medical officer and attendants will often work wonders in a backward and chronic case.

Period in Hospital, etc.—As soon as the acute symptoms have subsided and when smears cease regularly to show gonococci, the patient may be discharged from hospital to barrack treatment; the fact that smears occasionally show gonococci does not matter.

The best method is to arrange with the Officer Commanding a unit in the station to form an Attached Section to which all such cases, to whatever unit they belong, may be sent. When in the Attached Section they are under the command of a N.C.O. and carry out all duties and training, but are barred from the wet canteen and are not allowed "on pass." They are marched to the hospital every day for treatment and are seen by the medical officer once a week, or oftener if required, for special treatment. When they are apparently free from disease they are discharged from the Attached Section and return to their units for full duty, but are kept under surveillance for a further three months.

Should a case, whilst either in the Attached Section or under surveillance, develop symptoms of complications, he is re-admitted to hospital as a relapse.

The mental effect of this form of treatment on the patient is considerable.

A word here would not be out of place regarding the question of "test of cure." In the author's opinion there is not, with the possible exception of the endotoxin test described in a previous article,¹ any reliable test of cure and he does not use one, but depends chiefly on clinical and bacteriological findings. Experience has shown that if the test used is negative there is no certainty in most cases that a cure has been effected, but if the patient breaks down under test the resultant attack is inclined to be very chronic and resistant to treatment. Of course, in the case of contemplated marriage some such test must be done in addition to clinical and bacteriological examinations.

¹ "Recent Advances in the Treatment of Gonorrhœa." By Majors White and Winter, JOURNAL OF THE ROYAL ARMY MEDICAL CORPS, October, 1929, liii, 260.
Medicinal Treatment.—From the commencement of the disease alkalis, together with sedatives such as hyoscyamus and diuretics such as buchu, are given. The amount of alkali is regulated by periodical examination of the urine—a constant pH value of 7.2 is aimed at. Alkaline sodium phosphate is undoubtedly the best alkali for this purpose, but when it cannot be obtained sodium bicarbonate and sodium citrate may be used. In mild or threatened cases of posterior urethritis tincture of belladonna is added.

In more severe cases of posterior urethritis and in vesitis, vesiculitis or acute prostatitis, etc., the alkali is temporarily discontinued and sandalwood oil given as a sedative. This drug has no curative value, but it does have a sedative action on an acutely inflamed and painful urethral mucous membrane. It is stated to cause digestive disturbance, but it has been found that this is less likely to occur if administered as Nesbit's specific (Extra Pharmacopoeia) which is:

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\begin{align*}
\text{Rx} & \quad \text{O1. santal} & \ldots & \ldots & \ldots & 12\tfrac{1}{2} & \text{dr.} \\
& \quad \text{O1. cassia} & \ldots & \ldots & 1 & \text{dr.} \\
& \quad \text{O1. pimento} & \ldots & \ldots & 15 & \text{minims} \\
& \quad \text{Alcohol, 90 per cent} & \ldots & \ldots & 8\tfrac{1}{2} & \text{oz.} \\
\end{align*}
\]

\[\frac{1}{4} \text{dr. to 1 dr. in milk, t.d.s.p.c.}\]

In acute cases of posterior urethritis, etc., suppositories also are used. Either atropine grain \(\frac{1}{2}\) and belladonna grain \(\frac{1}{4}\), atropine grain \(\frac{1}{2}\) and morphia grain \(\frac{1}{4}\), atropine grain \(\frac{1}{2}\) and acetonilide grains 4 or atropine grain \(\frac{1}{2}\) and ichthyol grains 5, or other suitable combinations according to the type of case under treatment. In this connection it is interesting to note that a suppository of atropine and belladonna combined is more effective than either separately, presumably because plain atropine does not contain the other alkaloids in belladonna and belladonna alone does not contain sufficient atropine.

In highly neurotic cases and those with chordee, etc., sedatives are required; bromides are usually used, but are depressant, and it has been found that other drugs, such as camphor monobromate, are preferable. A very excellent prescription is:

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\begin{align*}
\text{Rx} & \quad \text{Luminal} & \ldots & \ldots & \ldots & 12 & \text{gr.} \\
& \quad \text{Camph. monobrom. lupulin} & \ldots & \ldots & \ldots & 2\tfrac{1}{2} & \text{dr.} \\
& \quad \text{Pfr. et Succ. Liq.} & \ldots & \ldots & \ldots & 100 & \text{pills} \\
& \quad \text{(2 pills = luminal 1 gr.)} & \ldots & \ldots & \ldots & 1 \text{ to 2 pills t.d.s.} \\
\end{align*}
\]

Later in treatment it is advisable to discontinue the alkali and to give some form of tonic; syr. of glycerophosphates combined with syr. ferri iodi. has been proved of value.

In spite of careful treatment some patients do not do well and become pale and listless; this usually affects certain types, especially those with auburn hair and clear complexions. In most cases this is apparently due to a calcium deficiency caused primarily by an inefficiency of the parathyroids
and aggravated by the large amount of alkali taken. The administration of calcium in such cases is indicated and it can be given either as calcium lactate or kalzana, or better still as a calcium and parathyroid preparation such as calcinol and endocrene.

Vaccines.—The gonococcal exotoxin of Dimond, prepared in the Central Laboratory at the Royal Herbert Hospital, Woolwich, is still used exclusively with excellent results, and the author sees no reason for making any change. Various types of vaccines, including the courses issued from Kasauli and also German and other preparations, have been tried but discarded in favour of exotoxin.

The routine is one cubic centimetre \((7,000 \times 10^8\) cocci) intradermal into the inner side of the thighs and the dorsum of the penis for four to five weeks at weekly intervals. No advantage has been noted by giving two cubic centimetres as originally advocated. Recently, slightly more local reaction has been noted, especially with batches II and III; there is very little reaction with batches I and V; the author has not received any supply of batch IV.

The exotoxin keeps very well in the tropics, but for the best results it must be kept in the ice-chest. Stocks have been kept at room temperature in the hot weather for six months with only a slightly noticeable decrease in antigenic value but, what is more important, with a distinct increase in toxicity, as evidenced by increased local and general reaction.

Other Forms of General Treatment.—Certain proprietary drugs intended for oral, subcutaneous, and intramuscular administration have been used; amongst them manganese butyrate and collosol manganese are satisfactory, especially in cases with secondary infection; of the two, manganese butyrate gives better results. S.U.M. 36 was tried, but results were uniformly disappointing.

In cases of prostatitis and epididymitis protein shock treatment with sterile fat-free milk has been given intramuscularly and intradermally with excellent results. At first aolan was used, but later a similar and cheaper preparation manufactured by the Bengal Chemical and Pharmaceutical Company, sold under the name of lactumin, was tried. It was found that with this better results were obtained, possibly because this preparation is made from buffalo and not cow milk.

Of other drugs neotropin and pyridium have given disappointing results.

Irrigation.—Potassium permanganate still remains our sheet anchor, but the author is of opinion that it is almost invariably used far too strong. It is now generally accepted that sterilization of the urethra with an antiseptic is not feasible with the drugs at our disposal and mechanical flushing with a non-irritant fluid strong enough to kill the gonococci in the urethra is to be aimed at. Potassium permanganate 1/20,000 is quite strong enough for the purpose, at any rate in the early stages. Irrigations are given right from the commencement and are always posterior, on the assumption that an anterior irrigation only pushes the discharge back into
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the bulb, where it remains a constant source of danger to the posterior urethra, whereas a thorough flushing out of the whole urethra and bladder with large quantities of fluid cleanses the whole tract; as proof of this may be cited the patient who is unable, usually for nervous reasons, to irrigate properly and cannot therefore take more than an anterior irrigation, and who almost invariably develops an acute posterior urethritis.

Gonococcal pus is extremely irritating on account of the large amount of highly concentrated endotoxin it contains—due to autolysis of dead and dying gonococci. Irrigation is therefore an essential form of treatment, cannot be dispensed with and should be commenced at the earliest possible moment. It is unfortunate that pus must collect during the night and various preparations such as soluble bougies and drugs suspended in a gelatine base have from time to time been devised in an endeavour to continue treatment at night, but none of these has proved of any outstanding worth, chiefly, it would appear, because the cause is not removed, e.g., accumulation of endotoxin in contact with inflamed tissue. A possible line of research immediately suggests itself in the direction of an antitoxic serum.

In the more chronic cases the strength of potassium permanganate is sometimes, with advantage, increased to 1/10,000 or 1/8,000. In others which do not appear to be doing well it may be made up in normal saline, or in normal saline with 1 per cent soda bicarb. The use of normal saline alone, as recommended by Major L. B. Clarke, is beneficial in many cases.

In some cases a change over to one of the silver preparations often pays, but these also should be weak—silver nitrate 1/8,000, protargol 10 per cent (protargol granulate is excellent), argyrol 5 per cent, etc.

In some chronic cases it is advantageous to stop irrigations altogether for a time, even if gonococci are still regularly present in the smears.

"Morning gleet" is a bugbear to all who are called upon to treat gonorrhœa. It has a variety of causes; it may be due to active but chronic disease, in which case gonococci appear periodically in the discharge, or acute exacerbations may occur; it may be due to continuance of the lesions—usually in the prostate or vesicles—by intercurrent secondary organisms after the gonococci have disappeared; again it may be due to discharge of mucus from the damaged epithelium; lastly it may even be a simple so-called spermatorrhœa. The treatment of the first is the same as for chronic gonorrhœa; as regards the second it may be stated that if secondary infection occurs in any number of cases the orderly in charge of the irrigation room is to blame, in that proper sterilization of nozzles, cans, etc., is not being attended to, and irrigations are not being properly carried out as regards cleansing the glans penis. Secondary organisms are usually only of very low virulence, but may become more pathogenic. As a rule they commence as saprophytes living on the gonococcal pus, but it would appear that they are largely the cause of chronic arthritis occurring in old cases with prostatitis, in the same manner as a root abscess in a tooth.
Many organisms have been found but one of the commonest is a diphtheroid, *Bacillus coryza segmentosus*.

Irrigation with mercury oxycyanide 1/8000 twice a day for two days is indicated in these cases; it must not be continued for more than two days, as it tends to cause a chemical irritation.

In the third type of case, "no treatment" is the best course, to allow the body to repair the damage and adjust itself. In severe cases, irrigation with alum or zinc sulphate for a few days at the commencement may hurry things on. The last type usually occurs in neurotic individuals, some of whom may never have had gonorrhoea; it is due to secretions from Cowper's, Littré's and Tyson's glands and also possibly from the prostate and vesicles, resulting from constant "milking" to see if there is a discharge. Cases in which this condition occurs are usually confirmed masturbators, and psychotherapy is the only treatment.

*Instrumentation, etc.*—Up till quite recently it was taught that the passing of bougies, preferably rather bigger than the urethra could comfortably stand, was the best treatment for gonorrhoea, and some practitioners still appear to think that they are not doing their best by the patient unless they pass sounds, massage the prostate, etc., with the utmost regularity. The urethral mucous membrane is one of the most, if not the most, sensitive tissues in the body, and no mechanical interference should be advocated except where absolutely necessary. Some years ago stricture was a common complaint, to-day it is comparatively rare. One of the reasons for this is undoubtedly the less heroic methods used in treating the disease.

No instrumental interference should be attempted until the acute symptoms have subsided; then, if the bore of the urethra will allow, a urethroscope should be passed; if there are any follicles, straight sounds will be required for two or three weeks at weekly intervals and the follicles massaged—curved sounds are rarely necessary. If no follicles are seen and the urethra looks moderately healthy, no sounds need be used.

In chronic cases, with hard encysted follicle, it has been found that cauterizing the follicle with silver nitrate by means of the operating urethroscope, followed by massage on a sound a week later, usually has an excellent result. This operation, however, requires very great care.

The author very rarely has recourse to Kholmann's dilator.

As in the case of sounds, prostatic massage is very much overdone. If there are no symptoms, and if the vesicles, prostate, etc., feel normal at the first examination, there is no need to carry out prostatic massage as a routine, and harm may be done by doing so. Massage should only be carried out for so long as symptoms and signs warrant it.

The author was once called to see a high official who had had gonorrhoea and who had been treated for over eighteen months by various doctors. He complained of a constant morning gleet. On going into the history, it was found that for about nine months he had been in the habit of massaging
his own prostate daily! and had been irrigating twice a day since the commencement. By knocking off all treatment, and by persuading him that in massaging his prostate he was doing harm, the patient was rapidly cured. This does not infer that in certain chronic cases, especially those with a secondary infection, prostatic massage may not be required regularly for considerable periods.

One complication which is fairly common and, if slight, is very liable to be overlooked, is tysonitis. This condition may considerably prolong the disease, and every case should be examined periodically. If tysonitis occurs, a good treatment is cauterization with silver nitrate fused on to the end of the stilette of a hypodermic syringe needle.

Periurethral abscess is not uncommon. In this condition it has been found that if, as soon as there is pus formation, the abscess is aspirated and washed out with ten per cent protargol, it is more likely to subside without fistula formation through the skin surface, and that pain is immediately relieved.

Acute epididymitis is a most unpleasant complication for the patient, but it has been found that, although painful at the time, aspiration with a wide bore needle fitted to a hypodermic syringe—and although nothing may be withdrawn—results in immediate relief and rapid recovery.

Diathermy.—From a study of the results obtained by various workers it would appear that the optimum temperature for the growth of the gonococcus is a degree or so below normal, and that growth is inhibited at a temperature of over 101°F. Opinions differ as to the lethal temperature—it may be 102° to 115°F. or more—but from the fact that cases have occurred in which gonorrhoea has been cured by attacks of pyrexia due to malaria, etc., and also from the beneficial results obtained from protein shock therapy, it would appear that in vivo it is not very high.

Numbers of experimenters have studied the temperature of the male urethra and, with a normal body temperature, the average has been found to be between 93° and 94°F. and, even when infected with chronic gonorrhoea, it does not exceed 95°F. Moreover, in patients with an axillary temperature of 104°F, the urethral temperature was 99°F. It seems reasonable, therefore, to suppose that application of heat should be one of our most promising lines of treatment, especially as heat sufficient to inhibit, and even kill the gonococcus, is not sufficient to injure the living tissues. In the treatment of acute urethritis in the male many attempts have been made in this direction, one of the earliest of which was the double-channeled water-heated bougie devised by Mr. Frank Kidd. None, however, has been found uniformly satisfactory and some are even dangerous.

Diathermy would, at first sight, appear to be an ideal method, but here

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again it has not come up to expectations, mainly due to the difficulty experienced in placing the electrodes so as to obtain a uniform heating of the whole urethra. The best method yet devised is that of Cumberbatch and Robinson, in which the penis is doubled back to lie in contact with the perineum; one electrode is applied along the dorsum of the penis and the other is placed in the rectum. It is in the treatment of complications of gonorrhoea and in the treatment of the disease in the female that diathermy is of value, and it should be a part of the routine treatment in all venereal clinics.

In all cases the focal centre of infection should be treated in addition to the local—i.e., in arthritis the prostate and vesicles are treated as well as the affected joint. Excellent results, including rapid relief of pain and swelling, can be obtained by diathermy of the acutely infected epididymis. In this case the prostate, prostatic urethra, vesicles, etc., are dealt with at the same time as the testicle by placing one electrode in the rectum and the other on the testicle.

In view of the insensitiveness to heat of the cervix, etc.—which can stand a temperature of 120° F. without damage or pain—great improvement can be obtained by the treatment of the cervix, pelvic organs, etc., with diathermy.

It is beyond the scope of this article to describe in detail, diathermy technique nor indeed is it necessary. Those who are interested and who have a machine available will possess a textbook on the subject—those by Cumberbatch, and Cumberbatch and Robinson are to be recommended.

**SYphilis.**

Apart from slight modifications in the process of manufacture of the usual drugs used, resulting in improvement in these products, there has been little advance in the technique of the treatment of syphilis in recent years, and such treatment has become practically standardized. In the majority of cases, routine rule-of-thumb methods are all that is required to ensure cure. Certain conditions, however, require special mention.

Much has been written about and a number of courses of treatment devised for so-called "Wassermann fast" syphilis. Management of such cases is a long, tedious and costly proceeding. That continuation of treatment is necessary is a matter for dispute, but the author is of opinion that every effort should be made to reduce the Wassermann reaction to negative.

A method of treatment which has been found efficacious in these cases is, after the completion of the usual long course, to commence a series of short courses of five weekly injections with three monthly intervals between; at the end of each course the drugs are changed—i.e., NAB in place of sulphostab, and mercury in place of bismuth, etc.—and, further, potassium iodide is continued by mouth during the course. Even better
results have been obtained by giving whole blood injections (i.e., autohæmotherapy) weekly at all rest intervals.

A word here will not be out of place regarding the relation of albuminuria to the treatment of syphilis. Most medical officers appear to regard the appearance of albuminuria as an absolute contra-indication to the continuance of treatment and are loth to recommence in fear of causing more serious complications. The procedure in cases with intercurrent albuminuria is entirely dependent on the diagnosis. That albuminuria is not a contra-indication but rather an indication for caution is clearly set forth in most textbooks, especially by Harrison and David Lees. Cases of this nature may be divided into three categories:

1. Those with renal disease showing albuminuria before infection.
2. Those with apparently normal kidneys who develop albuminuria after infection.

In every case the condition of the kidneys should be carefully investigated—heart and optic fundi examined, blood-pressure taken, urea concentration and renal efficiency tests done.

Cases coming under category (1) have obviously damaged kidneys at the outset and these are more likely to become infected with syphilis, which always attacks an already damaged organ. If the previous history be carefully taken in cases coming under (2) it will usually be found that the kidneys have been, if not actually damaged, certainly lowered in resistance by previous disease.

The longer syphilis of the kidney is left untreated, the greater the permanent damage resulting in a worse prognosis. Syphilitic infection may occur either in the secondary or tertiary stages and may be either parenchymatous or interstitial. A diagnostic point is that both are characterized by an enormous quantity of albumin in the urine; casts may or may not be present and the symptoms are not nearly so severe as the quantity of albumin would appear to suggest. Treatment of such cases results in a rapid disappearance of the albumin, either entirely or up to a certain point which is dependent on the amount of permanent damage sustained; it, however, immediately re-appears if treatment is stopped prematurely. It may be laid down that nephritis in a syphilitic patient is not necessarily syphilitic in the first place, but will certainly become so if the syphilis is left untreated.

Remedies used in the treatment of syphilis are admittedly toxic to the human organism, and various symptoms occur in susceptible individuals; such symptoms vary with different patients. It is reasonable to suppose that the toxin will first attack already injured organs—e.g., a patient with a liver damaged by alcohol, etc., may get jaundice, another sensitized by seborrhœa may get dermatitis—it is therefore not unreasonable to suppose that a patient who develops albuminuria during treatment has, at any
rate, a weak kidney. This is, then, no contra-indication for treatment, but only requires care in administration. Treatment of syphilis cases in which albuminuria occurs should be confined to the administration of organic arsenic preparations. Bismuth is liable to cause damage to the kidneys in any case and should not be given. In all cases reduced doses should be given at first but may be increased with advantage, especially in cases coming under categories (1) and (2).

SOFT CHANCRE.

Treatment of this condition is still very unsatisfactory and no important advance has been made in recent years. The author has tried many remedies, oral, intravenous, intramuscular, local, etc., but none has shown promise of universal success; in fact, in a large number of cases, the greatest improvement appears to result from the "cleaning up" given with normal saline for two or three days prior to and during the routine dark ground examinations.

No general treatment appears to exercise any great effect; sodium antimony tartrate, urea stibamin, neostibosan, aolan, whole blood injections and a host of other remedies have been given a trial. Improvement has been noted on certain cases and hopes raised only to be dissipated by trial on other cases.

One line of treatment seems to give more uniform results; this is to wash the sores two or three times daily in eusol and to dress with a wet dressing of urotropine, one drachm to one ounce. The main object of treatment is to keep the parts as surgically clean as possible and prevent, at all costs, the accumulation of discharges.

In uncircumcised cases, free drainage is difficult unless operative interference is resorted to. Circumcision is contra-indicated as the whole wound is liable to infection and a serious condition may result. It is best in all such cases to slit up the prepuce and remove a wide "V" shaped piece from the dorsum. The remainder of the foreskin shrinks after healing, and it is surprising how seldom a further cosmetic operation is required. This operation should be done in every case with a long foreskin. A general anaesthetic should always be given and no attempt made to do it under local anesthesia.

In some cases, especially the rapidly eroding, foul serpiginous variety, two or three applications of camphphenol are excellent.

Some sores are liable to become chronic and no improvement is noted for some time. In these cases cauterization either with copper sulphate, silver nitrate or the actual cautery is often effective. In large sores with exuberant granulations which have come to a standstill, especially those resulting from the opening of buboes, application of scarlet red ointment for twenty-four hours, followed by a mild ointment such as acid boric, often promotes rapid healing.
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As regards buboes, local applications such as antiphlogistine, gentle massage with iodex ointment, etc., are sometimes helpful in the early stages. When broken down, free incision and drainage is the only course to adopt. It will be found, however, that if a day or two before incision the abscess cavity is aspirated and washed out with iodine, 1 in 12 in water, and after incision it is scraped with a spoon and swabbed with camphphenol, healing tends to be less painful and more rapid.

It is hardly necessary to state that, as in the case of most other diseases, nursing and the general management of venereal cases is of paramount importance; an efficient Special Treatment Orderly is invaluable.