

THE VANISHING DISEASES

One of the most spectacular results of the use of penicillin has been the steep decline over the last decade in the incidence of gonorrhoea and syphilis. These diseases have become so rare that in most teaching hospitals it is difficult or impossible to find a sufficient number and diversity of cases to illustrate all the clinical variants and complications for students.

The consequences of this state of affairs are that many young practitioners are unable to recognize disease states which, to their immediate predecessors, were commonplace and tend, in treating venereal diseases, to overestimate the powers of penicillin and to use it indiscriminately for any disease of the genital organs.

In the past, venereologists have insisted on accuracy in diagnosis before beginning specific treatment, and on the most careful checking to ensure that cure was complete. Now that penicillin has made a venereologist of every doctor these high standards are often forgotten.

Penicillin is so effective that it is probable that gonorrhoea and syphilis and the related treponematoses will eventually become extinct. How long this will take depends on how the antibiotic is used. Therefore, we feel it may be helpful to recall briefly what penicillin can and cannot do in the field of venereal disease.

Penicillin is very effective against gonorrhoea and all its complications, and against syphilis, especially in the early stages. In other venereal diseases such as chancroid, non-gonorrhoeal urethritis and lymphogranuloma venereum, penicillin has little or no effect and is not the antibiotic of choice. It is obvious, therefore, that a clinical diagnosis of syphilis or gonorrhoea should be supported by pathological evidence before penicillin is given. It is no excuse in this country to say that there is no pathologist within reach. The pathologist is no further away than the nearest Post Office since all the necessary specimens can be posted to him. If the diagnosis is all but certain, penicillin may be given after the specimens have been taken. It should be remembered that in the event of some legal action no court is likely to accept a diagnosis of venereal disease on clinical grounds alone.

About 90 per cent of cases of early syphilis are cured by a course of penicillin injections (3-6 million units) given over a period of time so short that few patients fail to complete the treatment. The percentage of cases cured when the total dose is given in a single injection is not much less than when a course of injections is given. This method is used for syphilis and other treponematoses in backward peoples

who cannot be trusted to attend regularly even for a short time.

It is apparently not generally realized that positive serum tests in cases of early syphilis do not revert to negative immediately after treatment and that reversal may take six months or even longer. Many patients with seropositive early syphilis are treated anew simply because a serum test, taken a month after treatment, is still positive. The fate of some unfortunates who are found on routine examination to have a positive serum test and who have, in fact, an inactive, Wassermann-fast latent syphilis, may be imagined. Some sufferers from systemic lupus erythematosus, a disease which often causes false positive serum tests, may be equally unfortunate. The importance of the Treponemal Immobilization Test in distinguishing between true and false positive serum tests for syphilis is not always recognized.

Penicillin therapy brings about varying degrees of clinical improvement in cases of late syphilis, but one must not expect that it will always, or even often, reverse positive serum tests in such cases. Experience has shown that the dosage required in treating late syphilis (12 million units or more) is much higher than in treating early syphilis. To avoid the possibility of therapeutic shock or paradox it is advisable to begin treatment of late syphilis (with visual involvement) with small doses of penicillin and to extend the total dose over a period much longer than is usual in early cases.

The results of penicillin therapy in early and late congenital syphilis are comparable to those obtained in the acquired disease, but the ideal is to treat syphilis in pregnant women and avoid congenital syphilis entirely. The use of quantitative serum tests is essential in the post-treatment period in all cases of syphilis. No patient should be discharged as cured without an examination of the cerebrospinal fluid.

Penicillin treatment in gonorrhoea yields even better results than in syphilis, and a single injection of 300,000 units will cure the majority of uncomplicated cases. This dose is, in actual practice, almost always exceeded. In treating gonorrhoea the clinician should always keep in mind a possible coexistent syphilitic infection. A single injection of penicillin, which may cure the gonorrhoea, may serve to mask an undetected syphilitic condition.

Those treating venereal diseases should remember that apart from their obligation to treat the patient their further duty should include an attempt to reach and treat the original source of the infection.

KUNSMATIGE BEVRUGTING

Die vraagstuk van kunsmatige bevrugting en die geboorte van proefbuiskinders het onlangs weer sterk onder die aandag gekom van sowel lede van die mediese professie as lede van die algemene publiek. Daar is baie belangrike

vrae wat in hierdie verband gestel word, en daar is baie belangrike antwoorde wat tot nog toe uit bly. Om hierdie rede is dit dus wenslik om die kern van die saak, soos ons dit sien, hier kortliks te stel.

In die eerste plaas moet ons aanmerk dat die kwessie van kunsmatige bevrugting, hetsy met die vader as skenker of met 'n buitestaande skenker, vandag geen biologiese of tegniese probleem van geneeskundige aard is nie. Besonderhede van die tegniek van kunsmatige bevrugting is in detail uitgewerk en die metode kan met gemak en sukses toegepas word. Ook is daar geen besondere liggaamlike, geneeskundige implikasies vir die ouers of die kinders nie.

Soos ons dit sien, lê die kern van die vraagstuk van kunsmatige bevrugting daarin dat dit in sy wese 'n maatskaplike, 'n etiese en 'n godsdienstige vraagstuk is. Dit gaan om basiese waardes wat aan die grond lê van die intiemste menslike verhoudinge. Dit reik tot in die kern van die probleem van morele verantwoordelikheid—verantwoordelikheid van die een mens tot die ander mens, en ook, en veral, verantwoordelikheid van 'n mens ten opsigte van lewe wat deur hom verwek word.

Om hierdie redes is die vraagstuk van kunsmatige bevrugting 'n vraagstuk wat sulke fundamentele fasette van die

ongeskrewe, universele sedewet blootlê. En, om hierdie redes maak dit ook so 'n unieke aanspraak op die oordeel en sedelike integriteit van die betrokke geneeshere, van die ouers en veral van die anonieme skenkers.

'n Newevraagstuk wat herhaaldelik al opgeduik het, en steeds nog bly opduik, is die vraagstuk van moontlike wetgewing om die saak van kunsmatige bevrugting te beheer. Dit is nie 'n maklike vraagstuk om aan te durf nie en dit is moeilik vir hierdie *Tydskrif* om hom sterk oor die een of ander kant van hierdie aspek van die saak uit te spreek. Wat ons egter tog wil sê, is dat dit, na ons mening, altyd verkieslik is om enige vraagstuk van essensieel morele aard, indien moontlik, langs weë anders as deur wetgewing te benader. En in hierdie land beskik ons deur die Mediese Vereniging van Suid-Afrika en die Suid-Afrikaanse Geneeskundige en Tandheekkundige Raad, oor die nodige masjinerie om leiding te gee in die saak. Ons wag op daardie leiding sodat hierdie saak op die hoogste etiese vlak benader kan word.

ARTIFICIAL INSEMINATION

The problems of artificial insemination and the birth of test-tube babies have recently aroused widespread interest not only among the medical profession but also among the general public. Many important questions arise in this connection and as yet remain unanswered. It is therefore desirable to state briefly the essence of the problem as we see it.

In the first place it must be observed that the process of artificial insemination no longer presents a biological or technical problem from the purely medical point of view, irrespective of whether an anonymous donor is used. Details of the technique of artificial insemination have been perfected and the method can be successfully applied without discomfort to the patient. Moreover, few, if any, risks of a physical or medical nature are incurred by the parents or children.

The problem of artificial insemination is, in our opinion, essentially a social, an ethical and a religious problem. We are here concerned with fundamental values affecting the

most intimate human relationship. At the core of the matter lies the question of moral responsibility—the responsibility of one human being for another and especially the responsibility of man for life brought forth by him.

Considered from the point of view of moral responsibility the question of artificial insemination exhibits some of the most fundamental facets of the unwritten universal moral law. For this reason, too, the problem makes unique demands on the judgment and moral integrity of the doctors, parents and, above all, of the anonymous donors concerned.

A related problem which has arisen repeatedly and still remains unsolved, is the question whether artificial insemination should be controlled by legal measures. This is a difficult question to which we have no ready answer. We would, however, like to state that it is our firm belief that legislation is not the solution in matters of an essentially moral nature. It is clear that a lead should be taken by the Medical Association of South Africa and the South African Medical and Dental Council so that the problem may be solved on the highest possible ethical level.