OUR PRIZE COMPETITION.

WHAT SHOULD A NURSE KNOW ABOUT VENEREAL DISEASES?

We have pleasure in awarding the prize this week to Miss Alice M. Burns, East Suffolk and Ipswich Hospital, Ipswich.

PRIZE PAPER.

We think that a nurse should know enough about venereal diseases to arouse her warm sympathy with the sufferers, to nurse them intelligently, to prevent the spread of infection, and lastly, to recognise symptoms among those who have not as yet sought advice, and are probably ignorant of their condition, and advise a visit to the doctor.

Now, with regard to the first requirement, we cannot realise too early that we are here to help and not to judge, and that our assumption of that office does nothing better than repel and harden the sufferers, and discourage them from seeking further treatment. Besides, your victim may be suffering because of someone else's wrong-doing, and further, your established case of venereal disease has probably transgressed the moral law no further than the acquaintance whom you regard as respectable, but who has, so far, escaped the consequences of his wrong-doing—a humiliating thought this, but unanswerable. It is impossible for you to judge in these matters; therefore your only rational attitude is a charitable one.

Now, to nurse venereal disease intelligently we must understand something of the nature of the organisms which precede it.

There are two kinds of venereal disease—Syphilis and Gonorrhœa—with an occasional third—Soft Chancre. The two first are known to date back to early Bible times. There is a record of gonorrhœa in Leviticus (Chap. xv.), and again in the Second Book of Samuel, whilst records of syphilis date back to about the same period. Syphilis was first brought to England by the sailors of Christopher Columbus in 1495, after their voyage to the West Indies, and it has been rampant in this country ever since.

In 1905 the bacillus of Syphilis was isolated by Hoffman and Schaudinn, and named the *Spirochæta Pallida*. This bacillus cannot invade the body through the unbroken skin, but abrasions and cracks, too small for the naked eye, are sufficient as channels for infection. The incubation period is from 15 to 20 days or more. Primary sores appear from the seventeenth to the thirty-fifth days. All primary lesions may disappear without treatment. After this there is a second incubation period of forty days, following which the symptoms of secondary syphilis appear. There will be a slight rise of temperature; the patient feels ill; all the symptoms of the primary stage may be duplicated in the second, together with many others, among which are loss of hair, rashes of any size, shape and location, mucous patches in mouth, orchitis, iritis and keratitis. Secondary syphilis lasts from two to four years, according to treatment. Symptoms of the third stage, called tertiary, may come on at any period up to thirty years. The lesions of this stage are always destructive, and may attack any part or organ of the body. They are seen in the skin as ulcers, and are, perhaps, commonest on the legs of old people. This kind of ulcer has a well-defined edge. Cases of tertiary syphilis are frequently to be met with in the wards of our general hospitals, diagnosed under their localisations, as at this stage they are not specially infective.

Sufferers in the early stages who marry are almost certain to transmit the disease to their offspring. Syphilis may be inherited from one or both parents, and the child may be either palpably a physical wreck at birth, or may appear normal and show the signs of congenital syphilis after about six weeks. It will begin to waste away, develop a rash on the buttocks, and snuffles, a sign that the bones of the nose have been attacked, or it may become blind from destructive ulceration of the cornea; in short, a burden to itself, and, if it manages to grow up, to the State. It is very largely the victims of congenital syphilis who fill our crippled children's hospitals, our workhouses and asylums. Again, a syphilitic pregnancy is very liable to end in abortion or still-birth.

Gonorrhœa is a local infection only of the mucous membrane of the genital organs, and its treatment is local. Its most important aspect to the nation is that it produces sterility in both sexes (*a*) by stricture of the *ductus deferens* in the male, and (*b*) by closing the Fallopian tubes by inflammatory thickening in the female.

The discharges of both syphilis and gonorrhœa are infective, and everything which the sufferers use must be disinfected, as every nurse should know. Modern treatment of syphilis is by salvarsan or its equivalents, details of which cannot be given in the space of this article. It is important to know, however, that the *Spirochætes* may show virility even after a test has given a negative result. Thus supervision should extend over a period of at least two years.

HONOURABLE MENTION.

The following competitors receive honorable mention:—Miss Winifred Appleton, Miss E. K. Dickson, Miss F. James, Miss D. Fenton.

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