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PRESENT PATTERN OF EARLY SYPHILIS IN THE MANCHESTER REGION

III. HOMOSEXUAL INFECTIONS*

BY

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The significant social, economic, and geographic features of the area served by the Manchester Regional Hospital Board were described by Laird (1957a), when it was reported that, in this area, early acquired syphilis had ceased to be an endemic infection; by 1955, syphilis occurred only sporadically or in the form of small localized epidemics. The influence of imported infection and the part of the prostitute in the chain of syphilitic infection during 1955 and 1956 were reported separately (Laird, 1957b). The pattern of early syphilis continues to show these features, but in recent years homosexual infection has become of importance; this latter factor is considered in the present paper.

Early Syphilis in Males, 1957–61

The numbers of males with primary or secondary syphilis seen during the years 1957–61 inclusive in the V.D. clinics of the Manchester Regional Hospital Board area, have been classified according to geographical place of infection and the sex of the source of infection (Table I). The few male cases diagnosed as latent acquired syphilis of less than one year's duration have been excluded, as in such cases the time and place of infection are often uncertain.

TABLE I

ALL MALE CASES OF PRIMARY OR SECONDARY SYPHILIS, BY PLACE OF INFECTION AND SEX OF SOURCE OF INFECTION, 1957–61

Year	Heterosexual Infections			Homosexual Infections		
	Local	Rest of United Kingdom	Overseas	Local	Rest of United Kingdom	Overseas
1957	2	2	2	—	—	—
1958	4	1	5	4	—	—
1959	2	4	7	2	2	—
1960	3	1	6	2	—	—
1961	9	2	18	3	3	1
Total	20	10	38	11	5	1

These male cases of primary or secondary syphilis (Table I) include 23 seamen all infected heterosexually overseas and usually by a prostitute. These seamen being excluded, a total of 62 cases remains (Table II, opposite), of which twenty (32·3 per cent.) were infected locally, ten (16·1 per cent.) in the United Kingdom but outside our local area, fifteen (24·2 per cent.) overseas (usually on holiday or business trip), and seventeen (27·4 per cent.) were infected homosexually.

Table III (opposite) shows that homosexual infection was responsible for about one-third of the male cases of early syphilis acquired locally or elsewhere in the United Kingdom.

Discussion

The marked reduction in the incidence of early acquired syphilis in the last decade has made it easier to discern the epidemiological links between cases (Laird, 1957a). The present study of primary and secondary syphilis in males seen in the clinics of the Manchester region shows that, since 1958, homosexual infection has been admitted in about one-third of cases infected locally or elsewhere in the United Kingdom. These figures for admitted homosexual infection are minimal; it is possible that some cases of those infected homosexually give a false story of heterosexual exposure and this suspicion gains support if the infected male gives a very vague account of his sexual exposure. It is difficult to know whether homosexual infection is increasing or merely receiving increased recognition. One's impression is that more homosexual cases of gonorrhoea have been seen in recent years, and that, while some homosexual partnerships are stable and long-lasting, some homosexuals are very promiscuous.

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TABLE II

MALE CASES OF PRIMARY OR SECONDARY SYPHILIS, EXCLUDING SEAMEN, 1957–61

Year	Heterosexual Infections			Homosexual Infections			Annual Totals	Percentage Homosexual Infections
	Local	Rest of United Kingdom	Overseas	Local	Rest of United Kingdom	Overseas		
1957	2	2	—	—	—	—	4	—
1958	4	1	—	4	—	—	9	44·4
1959	2	4	4	2	2	—	14	28·6
1960	3	1	1	2	—	—	7	28·6
1961	9	2	10	3	3	1	28	25
Total	20	10	15	11	5	1	62	27·4

TABLE III

MALE CASES ACQUIRING PRIMARY OR SECONDARY SYPHILIS *LOCALLY* COMPARED WITH THOSE IN THE REST OF THE UNITED KINGDOM

Year	Local				Rest of United Kingdom				Total United Kingdom			
	Heterosexual Infections		Homosexual Infections		Heterosexual Infections		Homosexual Infections		Heterosexual Infections		Homosexual Infections	
	No.	Per cent.	No.	Per cent.	No.	Per cent.	No.	Per cent.	No.	Per cent.	No.	Per cent.
1957	2	—	Nil	—	2	—	Nil	—	4	—	Nil	—
1958	4	50	4	50	1	—	Nil	—	5	56	4	44
1959	2	50	2	50	4	66	2	33	6	60	4	40
1960	3	60	2	40	1	—	Nil	—	5	71	2	29
1961	9	69	4	31	2	40	3	60	11	61	7	39
Totals	20	62	12	38	10	66	5	33	31	65	17	35

The incidence of infectious syphilis has shown a rising trend in England and Wales in 1959 and 1960 (C.M.O.'s Report, Appendix C, Table VIII), and the figures for males in the Manchester area (excluding seafarers infected abroad) have increased 7-fold between 1957 and 1961 (Table II). Although the number of homosexual infections increased in the Manchester area in 1960 and 1961, their *percentage* of all male infections was constant during 1959, 1960, and 1961 (Table II). This Manchester study, therefore, provides no evidence to suggest that the rising incidence of infectious syphilis, which has been noted in many other countries, is directly due to the homosexual infection of males. However, early syphilis in the passive homosexual often remains undiagnosed until the secondary or early latent stage has been reached, thus increasing the opportunities for homosexual transmission.

The male who is sometimes actively homosexual and at other times heterosexual in his contacts could be a significant factor in the spread of syphilis in both sexes, although the increase in early syphilis in England and Wales (C.M.O.'s Report, p. 56) and in the Manchester Regional Hospital Board area so far remains confined to male cases. In fact, the number of female cases with syphilis of less than one year's duration in England and Wales in 1960 (175) was less than in 1959 (209), while the male cases in 1961 (819) showed a relatively large increase over the 564 cases in 1959 (C.M.O.'s Report, Appendix C, Table B). Commenting on these opposite trends, the C.M.O.'s Report (p. 56) states, "The increase has affected only males and is greater than can be accounted for by the minor fluctuations which occur from time to time. The fact that there is some reduction in cases in females is not reassuring, because it suggests difficulty in tracing infectious contacts rather than diminished incidence of infection." An increasing number of infections amongst male homosexuals would provide an alternative explanation, and such an increase would have a 2-fold effect on the male/female ratio as the source of infection and other contacts, if traced, would swell the number of male cases at the expense of the total for female cases.

The totals for male and female cases of acquired

syphilis of less than one year's duration are shown for England and Wales and for the Manchester Region in Table IV, together with the male/female ratios. This ratio shows a considerable increase in 1960 and 1961 for England and Wales and in 1961 for the Manchester region. It seems unlikely that the energy and success of tracing female sources of infection should suddenly diminish in 1960 and 1961, and it is more probable that some new factor is at work. Increased syphilitic infection amongst homosexuals could be such a new factor.

With seafarers and others infected abroad, the female source of infection will not be diagnosed in the same clinic as the male case. Again, the prostitute with infectious syphilis may be responsible for several male cases. Both these factors militate against a good male/female ratio. As mentioned above, syphilis amongst homosexuals will have a 2-fold effect in increasing the male/female ratio.

Male cases of primary and secondary syphilis seen during 1961 in the V.D. clinics of the City of Manchester are shown in Table V, where they are classified by place of infection and the result of contact tracing. In eleven cases, infection was acquired overseas, and one homosexual was infected in London; no contact tracing was possible in these twelve cases.

Two homosexuals were infected in Manchester and in both cases their male sources of infection were brought under treatment; the wife of one of these two homosexuals was kept under observation and developed primary syphilis. Thus, although three contacts with early syphilis were brought under treatment as a result of epidemiologic effort in the two original male cases, the resulting male/female ratio is 4:1.

Of the six males claiming heterosexual infection in Manchester, one was a West Indian who had a short-lived, common-law arrangement with a fellow-countrywoman recently arrived in England who disappeared from Manchester just before his chancre developed. The other five men were white, four

TABLE V

EARLY ACQUIRED SYPHILIS DIAGNOSED IN MALES DURING 1961 IN THE V.D. CLINICS OF THE CITY OF MANCHESTER

Place of Infection			Source of Infection Brought to Treatment
Overseas	Manchester	Elsewhere in United Kingdom	
6 Seamen	—	—	No
4 Civilians	—	—	No
1 Homosexual	—	1 Homosexual	No
—	2 Homosexuals	—	Yes in both cases; also the wife infected by one homosexual
—	6 Cases – 4 claiming infection by prostitute	—	One prostitute traced and found to have had recent secondary syphilis

TABLE IV

ACQUIRED SYPHILIS OF LESS THAN ONE YEAR'S DURATION AND RATIO OF MALE TO FEMALE PATIENTS, 1948-61

Year	Manchester Region			England and Wales		
	No. of Male Patients	No. of Female Patients	Male/Female Ratio	Males	Females	Male/Female Ratio
1948	1,023	670	1·5	6,603	4,034	1·6
1949	717	448	1·6	4,392	2,420	1·8
1950	402	240	1·7	2,678	1,465	1·8
1951	175	114	1·5	1,498	774	1·9
1952	72	38	1·9	891	462	1·9
1953	47	26	1·8	755	319	2·4
1954	30	20	1·5	600	208	2·9
1955	31	16	1·9	609	228	2·6
1956	29	13	2·2	587	257	2·3
1957	7	4	1·7	555	192	2·9
1958	15	2	7·5	522	182	2·9
1959	19	9	2·1	564	209	2·7
1960	15	7	2·1	819	175	4·7
1961	40	8	5·0	678*	162*	4·2

* Estimated figures for first three-quarters of 1961.

claiming to have been infected by a prostitute and the fifth giving a very vague account which aroused the suspicion that his infection might have been homosexual in origin. Only one of the four men gave a helpful description of the prostitute he blamed for infection—her nickname, colour of hair, approximate age, height and build, and the public house outside which he had met her. This description fitted three women recorded in our epidemiological files and our social worker was able to persuade all three to attend for examination. Two were free from syphilis but the third was found to have late secondary syphilis. While it is possible that this prostitute was responsible for some of the other male cases, the male/female ratio for these six males infected in Manchester must be recorded as 6:1.

It seems, therefore, that where syphilis has ceased to be endemic, as in the Manchester region, infection overseas or local infection by a prostitute or homosexual assumes increasing significance in the sporadic cases or localized epidemics which still arise at intervals. These three factors also contribute to a high male/female ratio in the figures of individual clinics and for the country as a whole.

Summary

Study of epidemiological details of male cases of primary or secondary syphilis diagnosed in the V.D. clinics of the Manchester Regional Hospital Board area during the years 1957–61 inclusive confirms that syphilis is no longer an endemic infection.

One-third of the male cases infected in the United Kingdom admitted homosexual infection and this proportion is probably a minimal one.

It is suggested that increasing homosexual infection in males may be the new factor which could explain the recent increase in male cases and decrease in female cases recorded in England and Wales.

Infection overseas, or local infection by a prostitute or homosexual, favours a high male/female ratio of cases of early syphilis in the figures of individual clinics and for the country as a whole.

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L'incidence actuelle de la syphilis primaire aux environs de Manchester
III. Infections homosexuelles

Résumé

L'étude de l'epidémiologique des cas masculins atteints de syphilis primaire et secondaire qui ont été vus dans les cliniques vénériennes du Manchester Regional Hospital Board, de 1957 à 1961, donne des preuves incontestables que la syphilis n'est guère endémique dans cette région.

Un tiers des hommes infectés au Royaume-Uni ont avoué avoir des relations homosexuelles et ce pourcentage est sans doute au-dessous de la vraie proportion.

Il se peut que l'incidence croissante d'infection homosexuelle chez les hommes soit le fait nouveau qui explique l'augmentation récente de cas masculins et la diminution de cas féminins qui ont été remarqués en Angleterre et au Pays de Galles.

L'infection contractée à l'étranger ou l'infection locale par une prostituée ou un homosexuel, explique pourquoi la syphilis primaire est plus fréquemment observée chez les hommes dans les cliniques individuelles et dans l'ensemble du pays.