PROVINCE OF BRITISH COLUMBIA

Division of Venereal Disease Control

Department of Health and Welfare

ANNUAL REPORT

For the Year 1955

VICTORIA, B.C.
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1956

VICTORIA, B.C., July 10th, 1956.

To His Honour FRANK MACKENZIE ROSS, C.M.G., M.C.,
Lieutenant-Governor of the Province of British Columbia.

MAY IT PLEASE YOUR HONOUR:

The undersigned has the honour to present the Report on Venereal Disease in the Province of British Columbia for the year 1955.

ERIC MARTIN,
Minister of Health and Welfare.

DEPARTMENT OF HEALTH AND WELFARE (HEALTH BRANCH),
VICTORIA, B.C., July 10th, 1956.

The Honourable Eric Martin,
Minister of Health and Welfare, Victoria, B.C.

SIR,—I beg to submit the Annual Report on the work of the Division of Venereal Disease Control of the Department of Health and Welfare for the year January 1st to December 31st, 1955.

I have the honour to be,
Sir,
Your obedient servant,

G. F. AMYOT, M.D., D.P.H.,
Deputy Minister of Health.

DEPARTMENT OF HEALTH AND WELFARE (HEALTH BRANCH),
DIVISION OF VENEREAL DISEASE CONTROL,
828 WEST TENTH AVENUE,
VANCOUVER 9, B.C., July 10th, 1956.

G. F. Amyot, Esq., M.D., D.P.H.,
Deputy Minister of Health, Victoria, B.C.

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I have the honour to be,
Sir,
Your obedient servant,

A. A. LARSEN, B.A., M.D., D.P.H.,
Director, Division of Venereal Disease Control.

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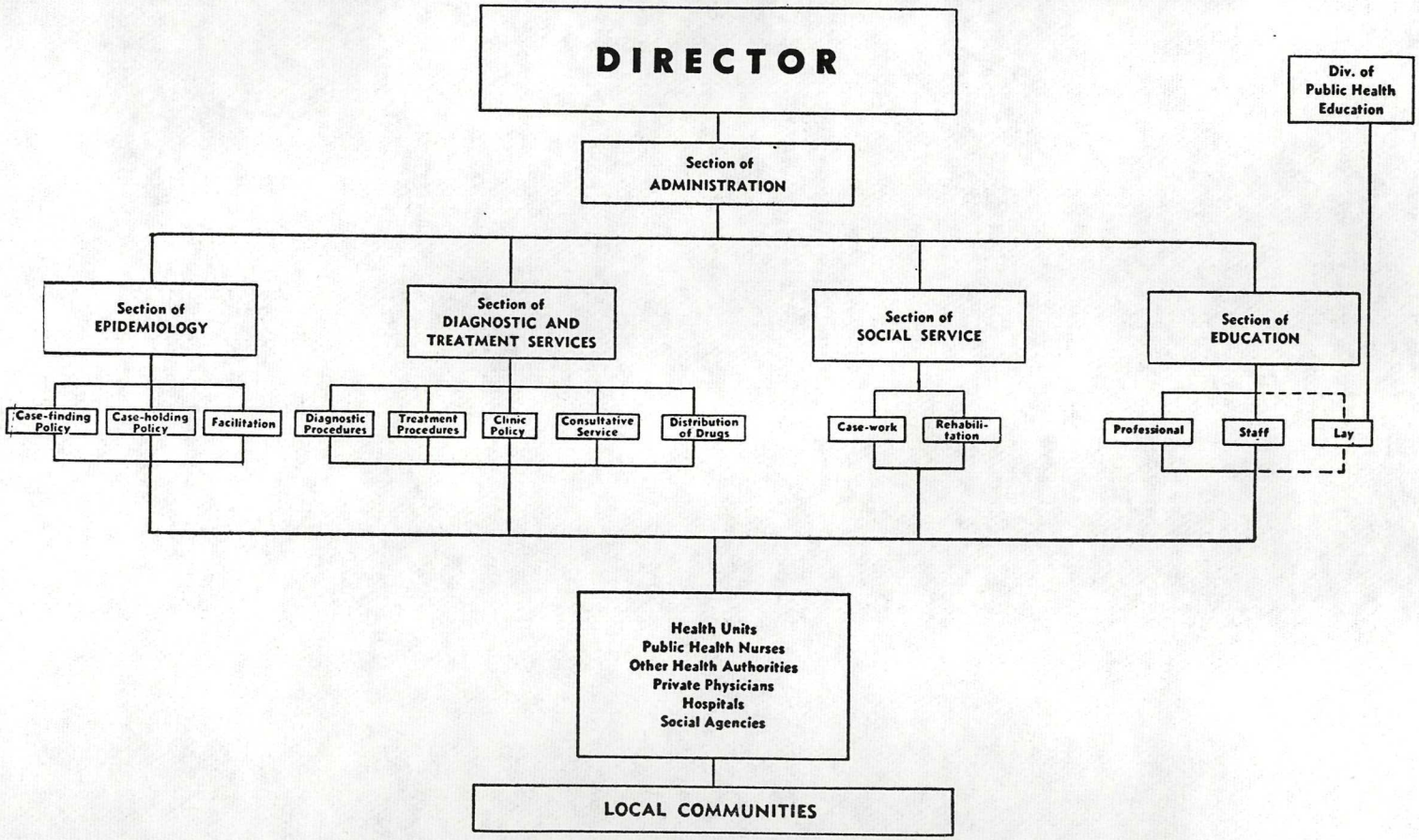
DIVISION OF VENEREAL DISEASE CONTROL



DIVISION OF VENEREAL DISEASE CONTROL

ANNUAL REPORT FOR THE YEAR 1955

A. LARSEN, DIRECTOR

The decline in the total number of venereal-disease cases reported in British Columbia, which first became evident in 1947, has continued through 1955. In contrast to previous years, the reduction this year is due solely to a decrease of about 170 in the number of cases of gonorrhœa reported. Though much remains to be done in the control of gonorrhœa, it is gratifying to find that the yearly improvement now appears to be a steady one. It appears that the approach presently in use by this Division, to which reference will be made later, has now proved its value and should be continued and, if possible, further refined. For the first time in nine years the number of infectious syphilis cases reported and treated has not changed appreciably from the year before. This year thirteen new cases have been found. A review of these cases would appear to indicate that there is still a small but definite reservoir of infection in British Columbia, probably centred in Vancouver.

Six cases of late congenital syphilis were reported this year. Although this is a marked decline from five years ago, it is also a reminder that prenatal blood tests serve a very real purpose and should be done on every expectant mother.

The number of cases of latent or symptomless syphilis brought to light this year has increased by over one-third. This is an indication that there are still many people in our Province infected with syphilis who are quite unaware that they have the disease. Venereal disease other than gonorrhœa and syphilis reported this year includes only eight cases of chancroid, and these, it would appear, were all contracted outside of this Province.

EPIDEMIOLOGY

As the problem of infectious venereal disease in British Columbia declines, the role of the epidemiologist, in tracing sources of infection and tracing contacts to infected patients, becomes more important year by year.

Studies recently completed by Dr. A. J. Nelson, a former Director of this Division, show conclusively the value of carefully interviewing every patient regarding the source of infection and other possible contacts, and of making every effort to bring in everyone named, particularly females, for examination as quickly as possible. With this in mind, efforts are being continued to improve the techniques employed in patient-interviewing and in contact-tracing. The success or failure of this epidemiological approach to the control of venereal disease hinges on the Division's receiving the fullest co-operation from private physicians and the many other agencies with whom it has to deal. The assistance that the Division has received from the Indian Health Service, the Canadian and American armed forces medical services, Vancouver City Police, the Greater Vancouver Metropolitan Health Committee, the British Columbia Hotels' Association, the Liquor Control Board, the Department of Citizenship and Immigration, the Washington State Department of Health, and the American Social Hygiene Association is acknowledged with pleasure.

Health units throughout the Province in the Bureau of Local Health Services have continued to act as the local representatives of this Division, and their staff members have spent a great deal of time tracing contacts and acting as consultants within their areas.

The information that is being obtained from private physicians treating cases of venereal disease appears to be improving yearly, and the Division is now able to trace many more of the contacts of these patients than it could formerly.

The supervisor of the Epidemiological Section has been made responsible for tabulating all information given by patients relating to place of meeting and place of exposure. From the information secured in this way in the current year, it would appear that no bawdy-houses are now in operation in British Columbia, and that most hotel and restaurant owners are co-operating very well and are making sincere efforts to prevent their premises from being used to facilitate the spread of venereal disease.

It was not felt necessary this year to hold the customary meetings with the armed services, police, and hotel association to discuss problems relating to facilitation as they affected hotels, restaurants, and beer-parlours.

The " call girl " system, which has arisen in recent years, has continued to exist to some degree and has made the work of the epidemiologists, in tracing sources of infection, more difficult. The splendid co-operation received from the Vancouver City Police has enabled the Division to locate most of the contacts reported who fall into this group.

At the present time over 65 per cent of the contacts to new infections treated at the Vancouver clinic are located in less than one day. Eighty-three per cent of all contacts reported are brought to treatment in less than three days, and fully 94 per cent have been found, examined, and treated within two weeks. These figures, it is felt, compare favourably with other national or international results where the speed-zone method of tracing is employed.

The blood-testing survey instituted some years ago, as a summer project of this Department amongst the Indians of this Province, was continued again in the early summer of the year. A member of the epidemiological staff spent some time at a large cannery along the west coast and took blood samples from many of the Indians and their families working there.

During 1955 requests were made for two field-visits from the staff for the purpose of studying the problem of veneral disease as related to homosexual practices in the area.

During the past year over 100 nursing-school undergraduates and approximately 40 university and metropolitan health service nurses were given instruction at the Vancouver clinic in patient-interviewing and case-finding.

TREATMENT

Since 1949 the policy of the Division has been to deliberately overtreat patients diagnosed as having gonorrhœa in order to prevent the development of concomitantly acquired syphilis. Though it is generally expected that about 3 per cent of the patients will develop syphilis at the same time that they acquire a gonorrhœal infection, no such cases have been reported in British Columbia in patients treated for gonorrhœa with the 1.2 million units of penicillin which have been used since this programme began. During this past summer a clinical survey was completed comparing the penicillin presently in use by this Division with one of the very long acting penicillins, in the hope that a product could be found that would not only require fewer injections for the treatment of syphilis, but that would also be easier to inject into the patient. The study, including penicillin blood level assays, was carried out by a senior medical student attached to this Division for summer relief work and will be reported shortly in a separate paper. At the present time several of the newer medium-acting penicillins are being tested in an attempt to determine whether a product can be found that is easier to give than the ones presently in use.

During the past year several changes have been made in the clinics maintained by this Division. Night hours have been discontinued at the main Vancouver clinic due to lack of attendance, and the weekly visit by members of the staff to the Girls' Industrial

School has been discontinued as of November 1st, at which time the Industrial School established its own part-time medical service. Inmates of this School will now be examined by their own medical staff, and problem cases will be referred to the Vancouver clinic on a consultative basis.

The number of patients attending the clinic at Health Unit No. 1 on Abbott Street, Vancouver, has increased by more than 50 per cent over the past year. The geographic situation of this clinic in the centre of the down-town area probably accounts for this increase. Clinics are timed to run through the noon hour at Health Unit No. 1 in order to accommodate those patients who are unable to get time off from work. A physician is now in attendance from 11 a.m. to 1 p.m. two days a week. Negotiations are now under way toward improving the physical arrangements of the clinic, and some thought is being given to increasing the number of days that a doctor will be in attendance.

The new City Gaol, which is to be opened early in the new year, will very much improve facilities for the Division's diagnostic and treatment clinic that has been in operation there for a number of years. Clinics at Oakalla Prison Farm, Juvenile Detention Home, Prince George and Prince Rupert Gaols, the Simon Fraser Health Unit in New Westminster, and Victoria have continued unchanged throughout the year.

A public health nurse from our epidemiological staff has been seconded to the Cariboo Health Unit at Prince George to assist that health unit in its venereal-disease control programme because of the large number of cases being reported from that area.

In order that no person in British Columbia may be deprived of the proper treatment for any venereal disease that he might have contracted, due to his inability to pay for the necessary drugs, this Division still supplies free drugs to all private physicians for the treatment of any patient whom they report as having a venereal disease. The drugs are made available through the Vancouver clinic in the metropolitan area and through the health units in the rest of the Province. In addition, depots are maintained in some of the isolated hospitals for the convenience of the physicians practising there.

SOCIAL SERVICE

The Social Welfare Department has continued its policy of previous years of assigning a trained social worker to the Vancouver clinic, though, due to staff shortages, no worker was available for the first five months of the year. The social worker's role at the Vancouver clinic is to give a direct but short-term service to those patients who appear to need his assistance and to refer patients to other community agencies for help with whatever problems they have presented. As venereal disease is seldom the major problem but is merely symptomatic of other difficulties, it is not possible to carry on a lengthy casework type of treatment service at the Vancouver clinic. The direct short-term service is focused on the patient's immediate problems which have necessitated a visit to the clinic for medical treatment. Many patients are found to require help with their feelings about their infection and about the general implications of their behaviour. This type of treatment is designed to support the patient and to ascertain what the immediate and underlying problems might be and what plans might be made to assist the patient so that he may make a start at seeking a solution to them.

During the seven-month period in which a social worker was available, 609 patient-interviews were held. More than three-quarters of the patients seen were thought to have the capacity to gain some insight into the reasons why they have acquired a venereal disease. The remainder were mainly patients who came within the repeater category, whose promiscuous behaviour was a reflection of their casual way of life, which was unlikely to be changed by anything that the Division could do. The experience of the social worker at the Vancouver clinic has demonstrated the need for expanding the community services giving aid to people in the 15- to 30-year age-group. In British Columbia single men between 20 and 34 years of age and single women between 15 and 24 years

constitute the greatest problem. To be helpful to these patients, such a community agency would have to have evening hours, since most of the patients in this age-group are working. In referring patients to existing agencies, the Division has at times experienced difficulty because of a prejudice against the patient when the referral came from a venereal-disease clinic. This prejudice, it is felt, is inappropriate and calls for continued interpretation to social workers and workers in allied agencies in the community. In every instance it was very apparent that the community out-patient resources for psychiatric referrals were far too limited.

With the increase in effectiveness of both the medical treatment and the epidemiological control over venereal disease, it has become increasingly apparent that the social and psychological aspects of venereal disease are of primary importance in any control programme. The real roots of venereal disease lie in the patient's lack of social or personal adjustment, and whatever can be done toward alleviating those conditions which predispose the individual toward promiscuity will affect positively the total venereal-disease control programme.

As in previous years, the clinic social worker took part in the Division's training programme and lectured to undergraduate nurses, public health nurses, and social-work students. In addition, he has now undertaken to spend some time with each new member of the clerical staff of this Division explaining the purposes and implications of the total venereal-disease control programme.

EDUCATION

Patient and public education about venereal diseases and their control is considered an important part of the work of this Division. Responsibility in this field is shared between the Divisions of Venereal Disease Control and Public Health Education and the health units, who act as the local representatives of both Divisions throughout the Province. Professional education in the field of venereal disease has been the main activity of this Division. A total of forty lectures were presented during this past year by members of the staff to student-nurses in the six nursing schools of the Province, as well as instructions to psychiatric nursing students at Essondale and to selected groups of similar students from the Vancouver Vocational School. A one-day symposium was presented to a senior class of nursing students at the University of British Columbia in June, in which an outline of the processes involved in an effective venereal-disease control programme were presented. Nursing students from the Vancouver General Hospital are given an intensive three-day course which takes them through all the sections of the Division. Three students are received each week throughout the year. The programme now includes a series of lectures on the medical aspects, epidemiology, social-work processes, and public health nursing aspects of venereal disease. Clinical experience is provided by having the nurse assist in treatment procedures and in contact-tracing.

A period of orientation is provided for new nurses coming on to the staff of the Metropolitan Health Committee and for nurses joining the World Health Organization, as well as for new Provincial public health personnel. Medical students from the University of British Columbia spent some time in the Division, as in former years.

As always, patient education played a prominent part in the Division's programme through individual interviews and the supplying of pamphlets and booklets dealing with venereal disease to the patients attending clinics.

These same pamphlets and booklets were also provided on request to individuals and groups who were interested in the control of venereal disease. A quantity of the new pamphlet entitled " Syphilis, the Invader " was purchased this year for distribution, and a very excellent and up-to-date film of the same name is being purchased and will be used as part of the lay educational programme.

A reorganization of the educational section of the Division took place in August of this year. At that time the responsibility for the educational programme was given to a well-qualified nurse who had just returned from a year's postgraduate work at the University of British Columbia, where she received her certificate in teaching and supervision.

ADMINISTRATION

The most outstanding event of the year was, of course, the move of this Division from its previous temporary headquarters, where it had been located for thirty-five years, to modern permanent quarters in the new Provincial Health Building on Tenth Avenue, Vancouver. In October of this year Dr. W. S. Maddin resigned as Director of the Division to enter private practice and is now acting as a consultant to the Division in dermatology and venereology. The position of Director has now been combined with that of Consultant in Epidemiology.

Federal health grants continued to assist the operation of this Division greatly. As well as being used to purchase drugs, this year funds were made available for the employment of a third-year medical student to act as a relief epidemiologist and laboratory technician. In addition to his regular work, this medical student carried out the blood-testing survey of Indians up the coast and the experimental work on the new longer-acting penicillins previously mentioned. The Division was also able to assist in the maintenance of the University of British Columbia Bio-medical Library through the allocation of funds for the purpose of up-to-date literature on venereal disease. The special study being conducted by Dr. D. K. Ford at the British Columbia Research Institute on the etiology of non-specific urethritis continued throughout this year.

At the present time this Division has arranged with the Provincial laboratories in Ontario and the laboratories of the Federal department of health in Ottawa to do approximately 80 T.P.I. tests per month free of charge. These tests are proving very valuable in the diagnostic problems relating to syphilis that so frequently occur. It is hoped that before too long arrangements may be made to have the test done in the Division of Laboratories. As a first move toward this, it is hoped that early in the new year the Provincial laboratories will take over the handling of the tests and the reporting of the results to private physicians. The assistance that has been given to the Division up to this time by the Federal and Ontario health departments is gratefully acknowledged.

Two members of the staff were granted leave of absence during the year to continue their education. The nursing instructress attended the University of British Columbia to take the course in teaching and supervision. The senior epidemiology-worker was granted leave of absence to take the short-term course in the techniques of epidemiology offered by the United States Department of Health, Education and Welfare in Los Angeles, Calif. In December Dr. W. S. Maddin attended the conference of the American Academy of Dermatology and Syphilology at Chicago for the purpose of studying recent developments in the techniques and management of syphilis. In May Dr. A. J. Nelson attended the Ottawa conference of Directors of the Divisions of Venereal Disease Control for the Canadian Provinces. The Division has received the usual excellent co-operation from the Divisions of Laboratories, Vital Statistics, and Public Health Education, and would like at this time to express deep appreciation for the help and assistance provided.

STATISTICAL SECTION

TABLE I.—NEW NOTIFICATIONS OF VENEREAL INFECTION AND RATE PER 100,000 POPULATION, 1941–55

Year	Gonorrhœa[1]			Syphilis									Other Venereal Disease			Total Venereal Disease	
				Primary			Secondary			Other							
	Number	Rate	Per Cent of Total	Number	Rate	Per Cent of Total	Number	Rate	Per Cent of Total	Number	Rate	Per Cent of Total	Number	Rate	Per Cent of Total	Number	Rate
1941	1,747	213.6	63.6	92	11.3	3.4	43	5.3	1.6	863	105.5	31.4	.....	.....	.....	2,745	335.7
1942	2,409	276.9	70.6	99	11.4	2.9	45	5.2	1.3	858	98.6	25.2	.....	.....	.....	3,411	392.1
1943	2,555	283.9	68.4	155	17.2	4.1	67	7.4	1.8	961	106.8	25.7	.....	.....	.....	3,738	415.3
1944	3,358	360.3	70.9	254	27.3	5.4	126	13.5	2.6	999	107.2	21.1	.....	.....	.....	4,737	508.3
1945	3,711	391.0	70.7	450	47.4	8.6	195	20.6	3.7	889	93.7	17.0	.....	.....	.....	5,245	552.7
1946	4,618	460.4	68.0	628	62.6	9.3	206	20.5	3.0	1,292	128.8	19.0	46	4.6	0.7	6,790	677.0
1947	4,056	388.6	67.6	408	39.1	6.8	167	16.0	2.8	1,195	114.5	19.9	173	16.6	2.9	5,999	574.6
1948	3,608	333.5	79.6	162	15.0	3.6	77	7.1	1.7	657	60.7	14.5	30	2.8	0.6	4,534	419.0
1949	3,694	331.6	82.1	100	9.0	2.2	39	3.5	0.9	632	56.7	14.1	30	2.7	0.7	4,495	403.8
1950	3,627	318.7	85.5	42	3.7	1.0	19	1.6	0.5	541	47.5	12.7	11	1.0	0.3	4,240	372.9
1951	3,336	286.4	87.1	27	2.3	0.7	9	0.8	0.2	445	38.2	11.6	17	1.5	0.4	3,834	329.0
1952	3,098	258.6	90.4	22	2.3	0.6	11	0.9	0.3	276	23.0	8.1	20	1.7	0.6	3,427	286.1
1953	2,968	241.3	92.5	19	1.5	0.6	7	0.6	0.2	203	16.5	6.3	11	0.9	0.4	3,208	260.8
1954	2,668	210.7	92.3	14	1.1	0.5	3	0.2	0.1	171	13.5	5.9	36	2.8	1.2	2,892	228.4
1955	2,494	191.1	90.7	13	1.0	0.5	1	0.1	0.0[2]	234	17.9	8.5	8	0.6	0.3	2,750	210.7

[1] Excludes gonorrhœa epidemiological and non-specific urethritis.
[2] Less than 0.1 per cent.

The downward trend in the total number of reported cases of venereal disease in British Columbia has continued through 1955 though at a reduced rate. This year the decrease is only 5 per cent, compared with a 10-per-cent drop in 1954. The rate per 100,000 population has also continued its decline, being 210.7. This compares with a high of 677 per 100,000 in 1946.

Gonorrhœa, as always, has been the main venereal-disease problem, accounting this year for 90.7 per cent of all cases reported, though again the rate of 191 per 100,000 of population continues the steady decline first begun in 1946.

Only 13 cases of infectious syphilis were reported to us, as compared to 645 cases ten years ago. This is a striking conquest of a very serious communicable disease. The number of cases of latent or symptomless syphilis discovered increased this year by approximately 25 per cent, indicating that present case-finding methods are effective and that our efforts should not be relaxed.

CHART I.—NEW NOTIFICATIONS OF VENEREAL INFECTION, BRITISH COLUMBIA, 1955

(Rates per 100,000 population.)

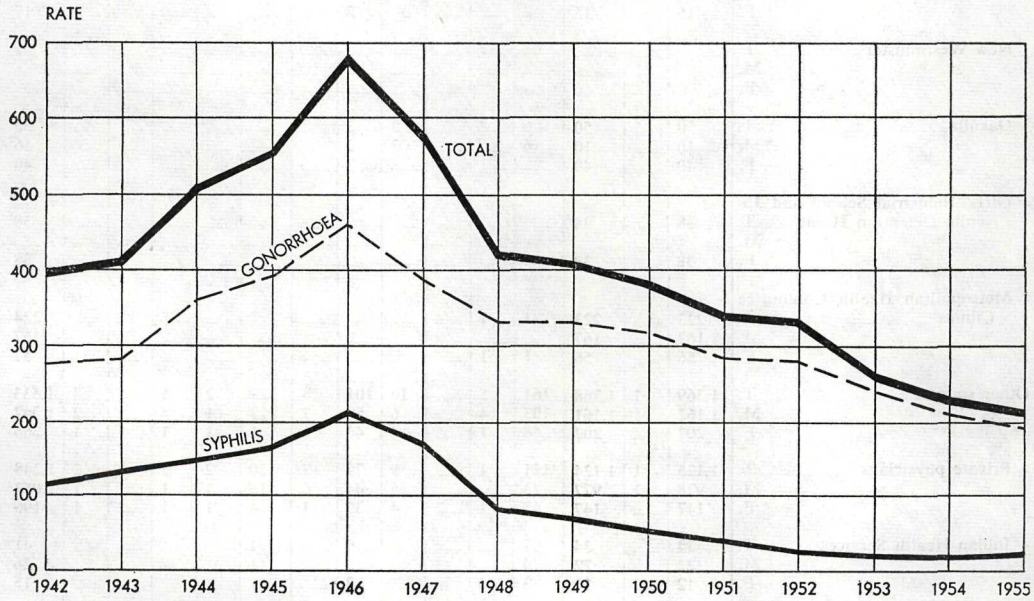


TABLE II.—NEW NOTIFICATIONS OF VENEREAL INFECTION CLASSIFIED ACCORDING TO REPORTING AGENCY, SEX, AND DIAGNOSIS, BRITISH COLUMBIA, 1955.

Reporting Agency		Gonorrhœa			Syphilis											
						Acquired										
		Total	Ophthalmia Neonatorum	Genito-urinary	Total	Primary	Secondary	Latent—Early	Latent—Late	Cardio-vascular	Neuro-syphilis	Other	Prenatal	Type Undetermined	Other Venereal Disease	Total
Totals	T.	2,494	1	2,493	248	13	1	23	145	13	42	3	6	2	8	2,750
	M.	1,878	1	1,877	175	11	1	18	94	12	32	2	4	1	7	2,060
	F.	616	.....	616	73	2	.....	5	51	1	10	1	2	1	1	690
Clinics, total	T.	1,125	.....	1,125	87	8	1	13	44	5	13	1	1	1	5	1,217
	M.	716	.....	716	72	7	1	12	36	5	9	1	.....	1	5	793
	F.	409	.....	409	15	1	.....	1	8	.....	4	.....	1	.....	.....	424
Vancouver	T.	775	.....	775	71	6	.....	9	37	4	12	1	1	1	3	849
	M.	515	.....	515	59	6	.....	8	31	4	8	1	.....	1	3	577
	F.	260	.....	260	12	.....	.....	1	6	.....	4	.....	1	.....	.....	272
Victoria	T.	39	.....	39	9	1	1	1	4	1	1	.....	.....	.....	2	50
	M.	24	.....	24	7	1	1	1	2	1	1	.....	.....	.....	2	33
	F.	15	.....	15	2	.....	.....	.....	2	.....	.....	.....	.....	.....	.....	17
New Westminster	T.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	M.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	F.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Oakalla	T.	50	.....	50	6	.....	.....	3	3	.....	.....	.....	.....	.....	.....	56
	M.	10	.....	10	6	.....	.....	3	3	.....	.....	.....	.....	.....	.....	16
	F.	40	.....	40	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	40
Girls' Industrial School and Juvenile Detention Home	T.	38	.....	38	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	38
	M.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	F.	38	.....	38	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	38
Metropolitan Health Committee Clinics	T.	223	.....	223	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	224
	M.	167	.....	167	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	167
	F.	56	.....	56	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	57
Other sources	T.	1,369	1	1,368	161	5	.....	10	101	8	29	2	5	1	3	1,533
	M.	1,162	1	1,161	103	4	.....	6	58	7	23	1	4	.....	2	1,267
	F.	207	.....	207	58	1	.....	4	43	1	6	1	1	1	1	266
Private physicians	T.	1,125	1	1,124	121	1	.....	9	79	7	20	2	2	1	2	1,248
	M.	978	1	977	73	.....	.....	5	44	6	16	1	1	.....	1	1,052
	F.	147	.....	147	48	1	.....	4	35	1	4	1	1	1	1	196
Indian Health Services	T.	34	.....	34	7	.....	.....	.....	6	.....	1	.....	.....	.....	.....	41
	M.	22	.....	22	4	.....	.....	.....	3	.....	1	.....	.....	.....	.....	26
	F.	12	.....	12	3	.....	.....	.....	3	.....	.....	.....	.....	.....	.....	15
Department of National Defence	T.	64	.....	64	6	4	.....	.....	1	.....	1	.....	.....	.....	1	70
	M.	63	.....	63	6	4	.....	.....	1	.....	1	.....	.....	.....	1	69
	F.	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
Hospitals	T.	.....	.....	.....	8	.....	.....	1	3	1	2	.....	1	.....	.....	8
	M.	.....	.....	.....	8	.....	.....	1	3	1	2	.....	1	.....	.....	8
	F.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Other	T.	146	.....	146	19	.....	.....	.....	12	.....	5	.....	2	.....	.....	165
	M.	99	.....	99	12	.....	.....	.....	7	.....	3	.....	2	.....	.....	111
	F.	47	.....	47	7	.....	.....	.....	5	.....	2	.....	.....	.....	.....	54

When one classifies the new notifications of gonorrhœa according to reporting agency, it can be seen that the clinics of the Division and all the private physicians in the Province reported an equal number of cases in 1955, each accounting for 44.9 per cent of new cases discovered. The remainder were reported for the most part by the various Federal Government health agencies.

Private physicians also reported 49 per cent of the total number of new cases of syphilis discovered during the year. Of these, only 1 case was in the infectious stage. The clinics of the Division first saw 9 out of the 14 cases of infectious syphilis discovered and reported 28 per cent of the total number of newly found cases of syphilis. The clinic maintained at Health Unit No. 1 continues to be a fruitful source of new cases of gonorrhœa. This year 223 cases were diagnosed there, which is an increase of 70 over 1954. An increase of over 400 per cent is recorded in the number of cases of gonorrhœa revealed at the Girls' Industrial School and Juvenile Detention Home, 39 cases being found in 1955, as compared with only 9 in 1954, in these two institutions. The ratio of male to female cases reported this year is 1.8 to 1 for the clinics of the Division and 5.3 to 1 for the private physicians. The difference in these ratios shows that females are not being brought to treatment in the way that they should be, and shows where increased effort could be directed with advantage. One key to the control of gonorrhœa in this Province would appear to lie in the locating and treating of more female contacts to male patients reported by private physicians.

TABLE III. — NEW NOTIFICATIONS OF VENEREAL INFECTION CLASSIFIED ACCORDING TO AGE-GROUPS, SEX, AND DIAGNOSIS, BRITISH COLUMBIA, 1955.

Age-group		Gonorrhœa			Syphilis											
						Acquired										
		Total	Ophthalmia Neonatorum	Genito-urinary	Total	Primary	Secondary	Latent—Early	Latent—Late	Cardiovascular	Neurosyphilis	Other	Prenatal	Type Undetermined	Other Venereal Disease	Total
Totals	T.	2,494	1	2,493	248	13	1	23	145	13	42	3	6	2	8	2,750
	M.	1,878	1	1,877	175	11	1	18	94	12	32	2	4	1	7	2,060
	F.	616		616	73	2		5	51	1	10	1	2	1	1	690
Under 1 year	T.	1	1													1
	M.	1	1													1
	F.															
1– 4 years	T.	2		2												2
	M.															
	F.	2		2												2
5– 9 ,,	T.	6		6												6
	M.															
	F.	6		6												6
10–14 ,,	T.	10		10	1								1			11
	M.				1								1			1
	F.	10		10												10
15–19 ,,	T.	221		221	3	1		1					1		1	225
	M.	97		97	1								1			98
	F.	124		124	2	1		1							1	127
20–24 ,,	T.	647		647	16	4		7	5						3	666
	M.	481		481	12	4		5	3						3	496
	F.	166		166	4			2	2							170
25–29 ,,	T.	610		610	27	3		9	13		2				1	638
	M.	479		479	14	2		7	4		1				1	494
	F.	131		131	13	1		2	9		1					144
30–34 ,,	T.	378		378	14	1		2	7		2		1	1		392
	M.	306		306	8	1		2	4		1					314
	F.	72		72	6				3		1		1	1		78
35–39 ,,	T.	186		186	21	2	1	3	14				1		1	208
	M.	153		153	14	2	1	3	8						1	168
	F.	33		33	7				6				1			40
40–44 ,,	T.	141		141	15				12		3					156
	M.	120		120	10				7		3					130
	F.	21		21	5				5							26
45–49 ,,	T.	83		83	25				15	1	8		1		2	110
	M.	59		59	14				8	1	4		1		2	75
	F.	24		24	11				7		4					35
50–59 ,,	T.	86		86	50	1			29	5	13	1	1			136
	M.	76		76	34	1			18	4	9	1	1			110
	F.	10		10	16				11	1	4					26
60–69 ,,	T.	17		17	52	1			33	5	11	1		1		69
	M.	17		17	48	1			30	5	11			1		65
	F.				4				3			1				4
70–79 ,,	T.	2		2	16			1	12	1	2					18
	M.	2		2	13			1	9	1	2					15
	F.				3				3							3
80 years and over	T.	1		1	4				2		1	1				5
	M.	1		1	3				1		1	1				4
	F.				1				1							1
Not stated	T.	103		103	4				3	1						107
	M.	86		86	3				2	1						89
	F.	17		17	1				1							18

As in previous years, the greatest number of cases of venereal disease continued to be reported in the 20–24-year age-group. One quarter of all cases reported to us occurred in this five-year group. In the age-group 10–20 years there were 231 cases of gonorrhœa reported, of which 134 were in the female.

Ninety-three per cent of all syphilis reported was diagnosed as non-infectious. Half of these cases occurred in the over 50-year age-group and are considered to have come from the reservoir of undiscovered cases built up before Venereal Disease Control services became as active as they are now. Twenty-seven per cent of the late and non-infectious cases of syphilis had already developed symptoms of heart or brain damage at the time of diagnosis.

TABLE IV.—NEW NOTIFICATIONS OF GONORRHŒA BY AGE-GROUPS AND SEX, BRITISH COLUMBIA, 1946–55

(Rates per 100,000 population.)

Age-group		1946	1947	1948	1949	1950	1951	1952	1953	1954	1955
0– 4 years	T.	21	3	6	.....	5	6	4	1	4	2
	M.	13	4	5	.....	.....	2	.....	.....	.....	1
	F.	29	2	8	.....	10	10	7	3	9	3
5– 9 ,,	T.	18	15	9	6	9	2	2	4	4	5
	M.	3	2	2	.....	.....	.....	.....	2	.....	.....
	F.	33	28	16	12	18	4	4	7	9	10
10–14 ,,	T.	22	4	7	7	29	15	5	2	5	10
	M.	9	3	6	3	3	2	.....	.....	2	.....
	F.	36	6	9	11	58	28	10	5	9	20
15–19 ,,	T.	583	533	446	407	480	412	359	280	267	273
	M.	515	474	354	309	377	436	304	266	267	235
	F.	650	590	539	507	585	386	415	293	266	313
20–24 ,,	T.	1,677	1,545	1,270	1,346	1,305	1,196	1,259	1,062	975	829
	M.	2,338	2,197	1,765	1,759	1,686	1,697	1,652	1,545	1,497	1,240
	F.	1,058	950	796	956	939	708	873	579	460	423
25–29 ,,	T.	1,127	978	914	927	894	845	827	797	639	669
	M.	1,722	1,541	1,427	1,355	1,281	1,335	1,281	1,301	1,067	1,071
	F.	557	441	423	517	532	399	407	329	232	282
30–34 ,,	T.	651	487	476	457	487	526	502	462	432	395
	M.	1,005	793	755	717	751	872	795	737	741	671
	F.	299	181	203	200	241	217	239	216	153	144
35–39 ,,	T.	443	399	377	368	353	290	277	252	213	192
	M.	690	625	596	544	549	459	451	440	361	326
	F.	168	155	153	190	165	124	108	72	73	66
40–44 ,,	T.	331	261	250	282	232	236	235	173	167	155
	M.	489	418	379	398	352	366	359	290	286	263
	F.	141	76	103	153	104	94	102	53	46	46
45–49 ,,	T.	223	199	190	188	212	164	170	141	126	109
	M.	355	300	299	292	343	273	271	213	207	147
	F.	69	79	65	70	58	33	51	58	35	66
50–54 ,,	T.	104	107	102	118	107	110	121	105	81	66
	M.	181	190	164	193	167	174	207	172	139	104
	F.	16	12	30	33	40	39	25	27	17	23
55–59 ,,	T.	66	61	49	61	78	69	41	40	55	75
	M.	107	107	76	102	132	120	64	59	92	134
	F.	12	4	15	11	16	16	15	18	15	11
60–64 ,,	T.	57	50	30	49	36	36	50	46	47	9
	M.	92	83	54	82	62	63	89	80	89	18
	F.	10	5	.....	8	4	4	4	8	.....	.....
65–69 ,,	T.	23	24	31	19	26	21	17	17	31	23
	M.	40	38	53	33	42	37	30	31	46	43
	F.	.....	6	.....	.....	5	.....	.....	.....	13	.....
70 years and over	T.	8	14	11	13	9	7	15	7	3	3
	M.	10	23	20	21	16	12	28	13	6	6
	F.	.....	4	.....	3	.....	.....	.....	.....	.....	.....
All ages	T.	404	388	333	332	319	286	266	241	211	191
	M.	561	539	458	435	416	412	368	356	325	203
	F.	235	225	199	220	217	154	160	121	92	96

This table shows that the total rate per 100,000 of population for all age-groups has continued to decline. For the first time in a number of years though there is evidence of an increased rate in four of the age-groups. The fact that the rate in the 15–19-year age-group has not declined as rapidly as in the 20–29-year age-group, and has indeed increased in 1955 in the face of the general downward trend, has given us cause for some concern. It is worthy of note also that only among those under 20 years of age is the rate for females higher than that for males.

TABLE V.—NEW CASES OF GONORRHŒA REPORTED IN BRITISH COLUMBIA, BY AGE-GROUPS AND MARITAL STATUS, 1955

Age-group	Single		Widowed and Divorced		Married[1]	
	Male	Female	Male	Female	Male	Female
15–19 years	96	109	.....	1	1	10
20–24 ,,	422	110	.....	4	49	49
25–34 ,,	582	85	15	4	168	105
35–44 ,,	165	8	13	7	88	39
45–54 ,,	54	5	6	9	31	16
55–64 ,,	26	2	1	.....	17	1
65–69 ,,	6	.....	2	.....	3	.....

[1] Includes separated.

As in previous years, this table shows that the major venereal-disease problem presents itself in the 20–34-year age-group of single males and in the 15–24-year age-group of single females.

TABLE VI.—PATIENT-VISITS AT ALL CLINICS OF THE DIVISION OF VENEREAL DISEASE CONTROL CLASSIFIED ACCORDING TO DIAGNOSIS, 1946–55.

Year	Total		Syphilis		Gonorrhœa		Other Venereal Disease		Not Yet Diagnosed	
	All Clinics	Vancouver Clinic	All Clinics	Vancouver Clinic	All Clinics	Vancouver Clinic	All Clinics	Vancouver Clinic	All Clinics	Vancouver Clinic
1946	56,385	41,856	30,047	23,158	11,382	9,297	.....	.....	14,956	9,401
1947	51,129	38,180	28,291	21,986	9,799	8,051	.....	.....	13,039	8,143
1948	43,897	32,495	24,894	19,166	8,480	7,014	26	23	10,497	6,292
1949	36,685	27,970	16,425	13,139	9,102	7,858	44	36	11,114	6,937
1950	31,107	21,976	11,685	9,301	8,548	7,418	43	31	10,831	5,226
1951	24,315	15,943	8,109	6,606	5,904	4,964	124	122	10,178	4,251
1952	20,721	11,798	5,754	4,314	4,511	3,606	125	114	10,331	3,764
1953	18,307	9,732	4,503	3,494	3,551	2,758	88	88	10,165	3,392
1954	16,792	8,779	3,432	2,831	2,279	1,848	121	115	10,960	3,985
1955	13,308	7,094	1,992	2,137	1,529	1,254	34	33	9,753	3,670

Again this year there has been a decrease in the number of patient-visits to the clinics of the Division. As mentioned in previous Reports, this is due to the decrease in the total number of cases of venereal disease reported and to our ability to effect a cure with a much shorter course of treatment.

TABLE VII.—MALE CONTACTS NAMED BY FEMALE GONORRHŒA CASES ACCORDING TO REPORTING AGENCY, 1949–55

(Rate per 100 male cases.)

Year	Clinics of Division of Venereal Disease Control							Private Physicians						
	New Cases of Gonorrhœa	Contacts		Infected Contacts		Infected Contacts Brought in for Treatment		New Cases of Gonorrhœa	Contacts		Infected Contacts		Infected Contacts Brought in for Treatment	
		Number	Rate	Number	Rate	Number	Rate		Number	Rate	Number	Rate	Number	Rate
1949	846	822	97	322	38	47	6	310	245	79	95	31	12	4
1950	852	798	94	344	40	61	7	277	242	87	111	40	20	7
1951	594	709	119	290	49	40	7	256	255	100	130	51	17	7
1952	459	571	124	235	51	25	5	210	240	114	129	61	12	6
1953	369	524	142	250	68	11	3	261	305	117	222	85	23	9
1954	304	606	199	203	67	9	3	175	270	154	169	97	11	6
1955	336	356	106	116	34	3	1	148	264	178	171	116	7	5

TABLE VIII.—FEMALE CONTACTS NAMED BY MALE GONORRHŒA CASES ACCORDING TO REPORTING AGENCY, 1949–55

(Rate per 100 female cases.)

Year	Clinics of Division of Venereal Disease Control							Private Physicians						
	New Cases of Gonorrhœa	Contacts		Infected Contacts		Infected Contacts Brought in for Treatment		New Cases of Gonorrhœa	Contacts		Infected Contacts		Infected Contacts Brought in for Treatment	
		Number	Rate	Number	Rate	Number	Rate		Number	Rate	Number	Rate	Number	Rate
1949	1,391	1,397	100	520	37	294	21	1,043	904	87	225	22	129	12
1950	1,363	1,406	103	544	40	389	29	954	858	90	206	22	127	13
1951	1,236	1,385	112	515	42	384	31	1,056	1,000	95	278	26	175	17
1952	972	1,149	118	397	41	297	31	1,218	1,129	93	306	25	197	16
1953	868	1,045	120	440	51	314	36	1,184	1,162	98	418	35	260	22
1954	721	899	125	413	57	295	41	1,084	1,063	98	401	37	255	24
1955	549	799	146	355	65	247	45	980	882	90	316	32	212	22

These tables and the accompanying chart show the results obtained by interviewing patients with newly diagnosed cases of gonorrhœa. The purpose of these interviews was to elicit from the patients information about the source of their infection and the names of others that they might have given their disease to.

For each sex, indices have been derived for patients reported by private physicians and for patients reported by the clinics of the Division of Venereal Disease Control. These indices are:—

(*a*) *A Contact Index,* which shows the ratio between the number of contacts named and the number of newly diagnosed cases of gonorrhœa, expressed in terms of the number of contacts per 100 new cases of gonorrhœa.

(*b*) *An Epidemiologic Index,* which shows the ratio between the named contacts who were found to be infected and the number of newly diagnosed cases of gonorrhœa, expressed in terms of the number of infected contacts per 100 new cases of gonorrhœa.

(*c*) *A Brought-to-treatment Index,* which shows the ratio between those infected contacts who had to be located and brought in for examination because they did not seek treatment of their own accord and the number of newly diagnosed cases of gonorrhœa, expressed in terms of the number of contacts it was possible to bring in to treatment and who were found to be infected per 100 newly diagnosed cases of gonorrhœa.

These indices, when properly interpreted, measure the effectiveness of contact-tracing as a method of control of gonorrhœa, and measure also the effectiveness of the work being done by the investigating staff of the Division.

Both Tables VII and VIII and the accompanying chart show the number of contacts named per 100 cases of gonorrhœa reported by the clinics of the Division as opposed to the number reported by private physicians. The arrow on the chart indicates the introduction of the speed-zone technique in the clinics as a method of increasing our contact-tracing efficiency. It can be seen that for male cases the contact index has been increasing considerably faster for the clinics than for the private physicians since the speed-zone technique was introduced.

This does not hold true for female cases because the clinics have, to a degree, relaxed their efforts to locate their male contacts, as it is known that most males take treatment if they develop symptoms. In contrast, experience has shown us that many females can be infected and yet have no symptoms.

It can be seen that the total number of contacts found to be infected rises as the number of contacts named per 100 cases of gonorrhœa increases. The ratio of named contacts infected to newly diagnosed cases is called by us the epidemiologic index, and also has been rising since the introduction of speed-zone technique. This same trend is not apparent for private physicians as far as female contacts named by their male patients are concerned. However, the private physicians have far surpassed the clinics in relation to male contacts found to be infected who were named by their female patients. Because of this the Division is now endeavouring to elicit more contact information from its female cases.

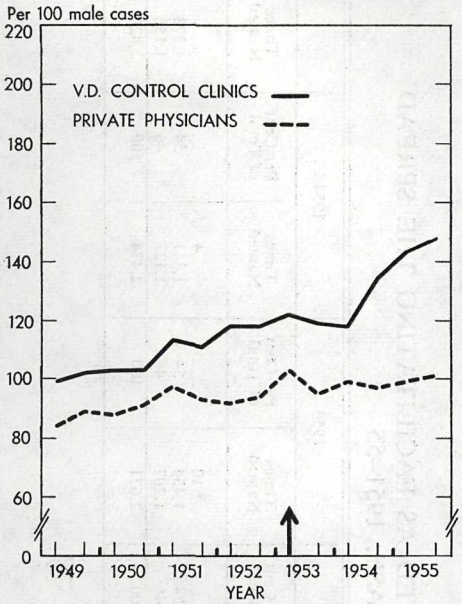
The brought-to-treatment index measures the accomplishments of the Division's investigating staff, and in addition measures the adequacy of the information about the contacts supplied to them by private physicians as compared to the information that the Division is able to elicit from its patients. If we assume that the investigators pursue their contacts named by the patients of private physicians with a zeal equal to that used for pursuing contacts of clinic patients, a comparison between the two groups of the number it is possible to bring in for treatment will give an idea of the relative adequacy of the contact information supplied.

It is interesting also to note that the brought-to-treatment index for male contacts to female cases has always been below 10 per 100. This, of course, is to be expected because most men usually seek treatment of their own volition.

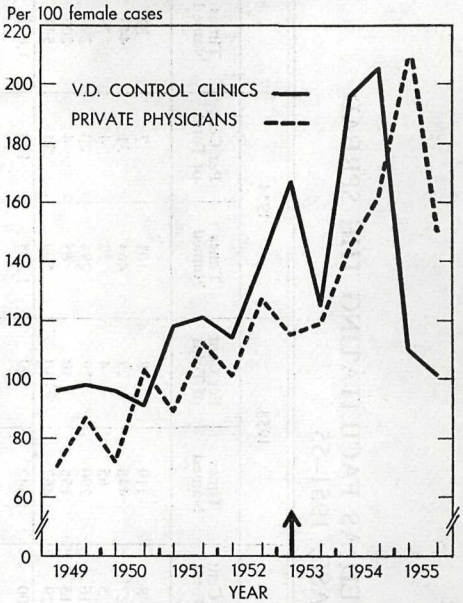
For the clinics of the Division there is reassuring evidence that investigation of female contacts to male cases is continuing to be successful. This information is important because it is a major factor in the success of the Division's control programme. It is known that a small group of infected females are responsible for a high percentage of the cases of gonorrhœa. Our ability to locate these females and to treat them is a major factor in the Division's control programme.

CHART II.—SEMI-ANNUAL GONORRHŒA INDICES BY SEX AND REPORTING AGENCY, BRITISH COLUMBIA, 1949–55

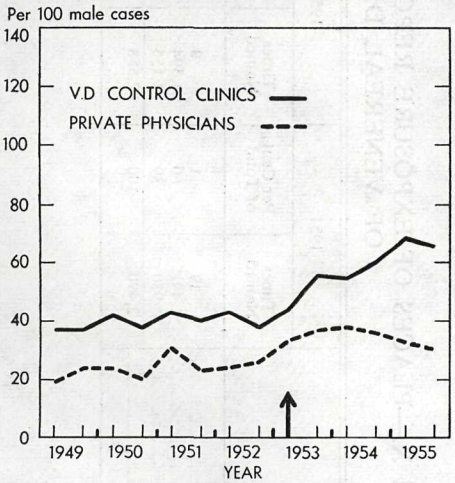
SEMI-ANNUAL GONORRHOEA CONTACT INDEX - MALE
By REPORTING AGENCY, BRITISH COLUMBIA, 1949-55



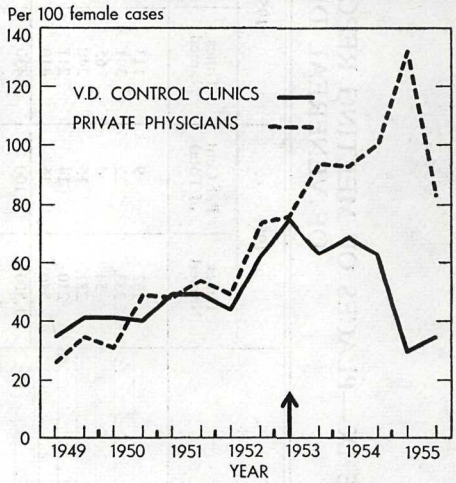
SEMI-ANNUAL GONORRHOEA CONTACT INDEX - FEMALE
By REPORTING AGENCY, BRITISH COLUMBIA, 1949-55



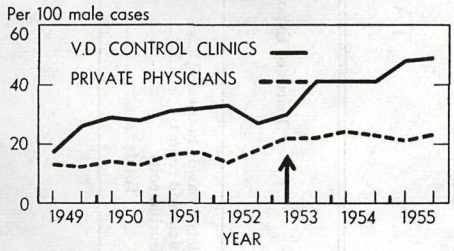
SEMI-ANNUAL GONORRHOEA EPIDEMIOLOGIC INDEX - MALE
By REPORTING AGENCY, BRITISH COLUMBIA, 1949-55



SEMI-ANNUAL GONORRHOEA EPIDEMIOLOGIC INDEX - FEMALE
By REPORTING AGENCY, BRITISH COLUMBIA, 1949-55



SEMI-ANNUAL GONORRHOEA BROUGHT TO TREATMENT INDEX MALE
By REPORTING AGENCY, BRITISH COLUMBIA, 1949-55



SEMI-ANNUAL GONORRHOEA BROUGHT TO TREATMENT INDEX - FEMALE
By REPORTING AGENCY, BRITISH COLUMBIA, 1949-55

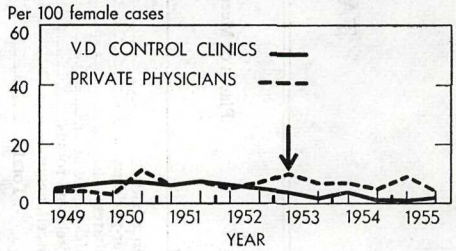


TABLE IX.—PLACES OF MEETING REPORTED AS FACILITATING THE SPREAD OF VENEREAL DISEASE, 1951–55

Places of Meeting	1951		1952		1953		1954		1955	
	Times Named	Per Cent of Total	Times Named	Per Cent of Total	Times Named	Per Cent of Total	Times Named	Per Cent of Total	Times Named	Per Cent of Total
Dance-halls	132	9	113	8	119	8	101	7	82	5
Beer-parlours	333	22	391	27	448	29	464	31	443	27
Cabarets	54	4	65	5	65	4	52	4	79	5
Cafés	231	15	240	16	290	19	294	20	294	18
Hotels and rooms	210	14	211	15	158	10	65	4	206	12
Miscellaneous	540	36	410	29	462	30	509	34	539	33
Totals	1,500	100	1,430	100	1,542	100	1,485	100	1,643	100

TABLE X.—PLACES OF EXPOSURE REPORTED AS FACILITATING THE SPREAD OF VENEREAL DISEASE, 1951–55

Places of Exposure	1951		1952		1953		1954		1955	
	Times Named	Per Cent of Total	Times Named	Per Cent of Total	Times Named	Per Cent of Total	Times Named	Per Cent of Total	Times Named	Per Cent of Total
Alleged bawdy-houses	19	1	9	----	10	----	4	----	------	----
Hotels and rooms	1,491	60	1,394	54	1,454	54	1,341	54	1,273	52
Miscellaneous	980	39	1,155	46	1,207	46	1,127	46	1,156	48
Totals	2,490	100	2,558	100	2,671	100	2,474	100	2,429	100

The figures given in Tables IX and X show the place of meeting and place of exposure given by patients diagnosed as having a venereal infection. It is apparent that the places which are most often named as facilitating the spread of venereal disease are beer-parlours, cafés, hotels, and rooms.

Control of venereal disease through control of places of meeting and of exposure is carried out on a co-operative basis with the owners of the premises concerned, the police, the Hotels' Association, and Liquor Control Board officials.

It is felt that further attempts at control over establishments which facilitate the spread of venereal disease would be fruitful. Increased activity along this line is planned for 1956.

TABLE XI.—CONTACT TO VENEREAL INFECTION CLASSIFIED ACCORDING TO RESULT OF EXAMINATION AND REPORTING AGENCY, BRITISH COLUMBIA, 1955.

Result of Examination	Total	Reported by—							
		Division of Venereal Disease Control Clinic	Private Physicians	Hospitals	Canadian Armed Forces	Other in British Columbia	Health Departments of Other Canadian Provinces and Territories	United States Armed Forces	United States Health Departments
Infected with primary syphilis	1	1	------	------	------	------	------	------	------
Infected with secondary syphilis	1	1	------	------	------	------	------	------	------
Infected with other syphilis	33	7	22	1	------	1	------	------	2
Infected with gonorrhœa	1,392	576	488	19	36	182	22	60	9
Infected with chancroid	------	------	------	------	------	------	------	------	------
Incomplete examination	------	------	------	------	------	------	------	------	------
Negative	323	105	148	15	12	29	3	3	8
Investigation not indicated	1,570	706	496	8	169	146	21	18	6
Infected with non-specific urethritis	39	36	3	------	------	------	------	------	------
Not stated	662	175	357	11	53	24	23	14	5
Totals	4,021	1,607	1,514	54	270	382	69	95	30

This table reports the results of examinations made by various agencies as part of their investigation of alleged contacts of venereal disease. There has been an 11-per-cent decrease in the number of contacts investigated in 1955 as compared with 1954. The reason for this is that during the past two years major emphasis has been placed on locating female contacts named by male patients with gonorrhœa. Though this has resulted in an increase in the average time required to locate a contact and a decrease in the number of contacts located, the results as indicated elsewhere have been worth while.

TABLE XII.—REPORT OF LABORATORY WORK DONE BY THE DIVISION OF LABORATORIES RELATING TO THE DIAGNOSIS AND TREATMENT OF VENEREAL DISEASE FOR ALL AGENCIES IN BRITISH COLUMBIA, 1955.

Examination	1951	1952	1953	1954	1955
Gonococcus cultures	6,797	6,582	7,080	8,228	8,563
Gonococcus microscopic examinations	28,510	28,656	27,349	26,005	25,445
Treponema pallidum microscopic examinations	370	283	257	448	319
Serological tests for syphilis	228,547	232,270	253,756	211,634	198,890

During the past year the trend toward fewer microscopic examinations and more cultural examinations for the diagnosis of gonorrhœa continued. Again this year there was a moderate decrease in the number of serologic tests done for the diagnosis of syphilis. There was also a decrease in the number of microscopic examinations done for the diagnosis of infectious syphilis.

TABLE XIII.—NEW NOTIFICATIONS OF SYPHILIS AND GONORRHŒA[1] BY HEALTH UNITS AND SCHOOL DISTRICTS, BRITISH COLUMBIA, 1951–55

Health Unit and School District (As at Dec. 31, 1955)	1951			1952			1953			1954			1955		
	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total
East Kootenay	10	58	68	4	73	77	5	24	29	3	17	20	3	28	31
School District No. 1	1	5	6	2	7	9	.....	5	5	.....	3	3	.....	1	1
,, ,, No. 2	1	24	25	1	42	43	2	7	9	1	6	7	1	14	15
,, ,, No. 3	4	9	13	1	9	10	2	4	6	.....	2	2	.....	1	1
,, ,, No. 4	.....	9	9	.....	13	13	1	3	4	2	5	7	2	11	13
,, ,, No. 5	3	7	10	.....	1	1	.....	4	4	.....	1	1	.....	1	1
,, ,, No. 18	1	4	5	.....	1	1	.....	1	1	.....	.....	.....	.....	.....	.....
Selkirk	10	34	44	2	52	54	5	22	27	.....	12	12	2	15	17
School District No. 6	1	4	5	.....	2	2	.....	3	3	.....	1	1	.....	1	1
,, ,, No. 7	4	20	24	1	38	39	4	14	18	.....	11	11	.....	13	13
,, ,, No. 8	4	10	14	.....	11	11	1	4	5	.....	.....	.....	2	1	3
,, ,, No. 10	1	.....	1	1	1	2	.....	1	1	.....	.....	.....	.....	.....	.....
West Kootenay	7	34	41	4	23	27	5	27	32	.....	3	3	1	8	9
School District No. 9	.....	4	4	2	2	4	.....	3	3	.....	2	2	1	2	3
,, ,, No. 11	7	25	32	2	18	20	3	23	26	.....	1	1	.....	6	6
,, ,, No. 12	.....	3	3	.....	.....	.....	1	1	2	.....	.....	.....	.....	.....	.....
,, ,, No. 13	.....	2	2	.....	3	3	1	.....	1	.....	.....	.....	.....	.....	.....
South Okanagan	6	30	36	7	17	24	2	22	24	3	17	20	4	26	30
School District No. 14	.....	9	9	.....	3	3	.....	2	2	.....	1	1	1	3	4
,, ,, No. 15	3	8	11	3	8	11	2	10	12	1	3	4	1	4	5
,, ,, No. 16	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
,, ,, No. 17	.....	4	4	.....	1	1	.....	1	1	.....	1	1	.....	3	3
,, ,, No. 23	2	9	11	4	5	9	.....	9	9	2	12	14	2	15	17
,, ,, No. 77	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	1
North Okanagan	6	38	44	7	30	37	4	42	46	2	36	38	2	28	30
School District No. 19	.....	4	4	2	1	3	.....	2	2	.....	1	1	.....	2	2
,, ,, No. 20	3	9	12	2	7	9	1	12	13	.....	3	3	.....	5	5
,, ,, No. 21	1	10	11	.....	10	10	.....	.....	.....	.....	3	3	.....	.....	.....
,, ,, No. 22	2	15	17	3	12	15	3	21	24	2	22	24	1	15	16
,, ,, No. 78[2]	.....	.....	.....	.....	.....	.....	.....	7	7	.....	7	7	1	6	7
South Central	19	81	100	21	117	138	12	118	130	9	112	121	10	133	143
School District No. 24	9	35	44	14	63	77	8	74	82	4	58	62	7	49	56
,, ,, No. 25	.....	1	1	.....	2	2	.....	5	5	.....	5	5	.....	4	4
,, ,, No. 26	.....	1	1	1	3	4	.....	1	1	.....	2	2	.....	4	4
,, ,, No. 29	5	27	32	.....	30	30	2	14	16	1	18	19	1	22	23
,, ,, No. 30	4	13	17	4	13	17	.....	16	16	1	19	20	2	36	38
,, ,, No. 31	1	4	5	2	6	8	2	8	10	3	10	13	.....	18	18

[1] Non-specific urethritis and gonorrhœa epidemiological excluded.
[2] Part of School District No. 21 until January 21st, 1953.

TABLE XIII.—NEW NOTIFICATIONS OF SYPHILIS AND GONORRHŒA[1] BY HEALTH UNITS AND SCHOOL DISTRICTS, BRITISH COLUMBIA, 1951–55—*Continued*

Health Unit and School District (As at Dec. 31, 1955)	1951			1952			1953			1954			1955		
	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total	Syphilis	Gonorrhœa	Total
Upper Island	4	46	50	10	51	61	4	42	46	2	31	33	10	60	70
School District No. 47	1	13	14	2	16	18	2	9	11	2	7	9	5	27	32
" " No. 71	1	10	11	2	13	15	.....	8	8	.....	8	8	2	10	12
" " No. 72	2	23	25	6	22	28	2	25	27	.....	16	16	3	23	26
Skeena	38	192	230	27	301	328	9	336	345	11	216	227	20	151	171
School District No. 50	2	22	24	2	22	24	2	18	20	.....	14	14	1	13	14
" " No. 51	3	3	6	6	26	32	.....	8	8	.....	5	5	.....	4	4
" " No. 52	13	117	130	13	185	198	3	217	220	9	157	166	10	94	104
" " No. 53	19	35	54	6	46	52	3	64	67	2	21	23	8	25	33
" " No. 54	1	15	16	.....	22	22	1	29	30	.....	19	19	1	15	16
Peace River	2	17	19	2	18	20	4	7	11	2	35	37	4	31	35
School District No. 59	2	5	7	1	18	19	4	5	9	2	24	26	3	22	25
" " No. 60	.....	12	12	1	.....	1	.....	2	2	.....	11	11	1	9	10
" " No. 81[3]	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	3	3
Victoria-Esquimalt Union Board of Health	36	136	172	39	128	167	22	128	150	16	126	142	19	75	94
School District No. 61[4]	36	136	172	39	128	167	22	128	150	16	126	142	19	75	94
Saanich and South Vancouver Island	9	28	37	8	23	31	3	15	18	.....	6	6	3	16	19
School District No. 61[5]	3	18	21	2	14	16	.....	4	4	.....	2	2	2	5	7
" " No. 62	2	3	5	3	4	7	1	4	5	.....	2	2	.....	1	1
" " No. 63	3	5	8	2	5	7	.....	7	7	.....	2	2	1	7	8
" " No. 64	1	2	3	1	.....	1	2	.....	2	.....	.....	.....	.....	3	3
Central Vancouver Island	39	83	122	6	68	74	8	73	81	4	40	44	9	38	47
School District No. 65	14	12	26	2	14	16	.....	11	11	2	8	10	1	8	9
" " No. 66	3	17	20	.....	14	14	2	20	22	.....	15	15	.....	7	7
" " No. 67	6	2	8	.....	4	4	.....	4	4	.....	.....	.....	.....	2	2
" " No. 68	8	21	29	2	18	20	3	13	16	.....	3	3	1	7	8
" " No. 69	2	1	3	.....	5	5	.....	3	3	1	.....	1	1	.....	1
" " No. 70	6	30	36	2	13	15	3	20	23	1	13	14	4	13	17
" " No. 79[6]	.....	.....	.....	.....	.....	.....	.....	2	2	.....	1	1	2	1	3
Cariboo	20	140	160	16	232	248	5	339	344	10	317	327	4	303	307
School District No. 27	1	7	8	4	10	14	1	15	16	4	20	24	.....	35	35
" " No. 28	2	10	12	1	24	25	1	18	19	1	40	41	.....	33	33
" " No. 55	1	16	17	1	28	29	1	73	74	3	23	26	.....	16	16
" " No. 56	1	25	26	.....	32	32	.....	24	24	.....	17	17	1	28	29
" " No. 57	14	82	96	10	137	147	2	209	211	2	214	216	3	189	192
" " No. 58	1	.....	1	.....	1	1	.....	.....	.....	.....	3	3	.....	2	2

Upper Fraser Valley	13	71	84	7	90	97	4	72	76	1	47	48	7	29	36
School District No. 32	6	24	30	2	23	25	2	22	24	1	23	24	1	13	14
,, ,, No. 33	5	36	41	3	51	54	2	33	35	.....	20	20	5	12	17
,, ,, No. 34	2	11	13	2	16	18	.....	17	17	.....	4	4	1	4	5
Boundary	8	27	35	4	26	30	4	24	28	6	20	26	4	21	25
School District No. 35	1	13	14	1	11	12	1	7	8	1	4	5	1	5	6
,, ,, No. 36	5	13	18	2	13	15	1	16	17	5	16	21	2	15	17
,, ,, No. 37	2	1	3	1	2	3	2	1	3	.....	.....	.....	1	1	2
Metropolitan Health Committee	192	2,089	2,281	119	1,614	1,733	116	1,474	1,590	104	1,435	1,539	120	1,357	1,477
School District No. 38	4	35	39	1	21	22	3	25	28	1	16	17	2	13	15
,, ,, No. 39	177	1,999	2,176	112	1,537	1,649	101	1,406	1,507	99	1,364	1,463	110	1,287	1,397
,, ,, No. 41	4	17	21	2	25	27	4	22	26	3	14	17	4	30	34
,, ,, No. 44	5	35	40	3	28	31	6	18	24	1	34	35	3	24	27
,, ,, No. 45	2	3	5	1	3	4	2	3	5	.....	7	7	1	3	4
Simon Fraser	24	72	96	9	73	82	6	72	78	7	43	50	14	40	54
School District No. 40	18	64	82	7	67	74	5	63	68	6	36	42	12	35	47
,, ,, No. 43	6	8	14	2	6	8	1	9	10	1	7	8	2	5	7
North Fraser	9	27	36	2	24	26	1	32	33	3	24	27	1	13	14
School District No. 42	1	5	6	.....	3	3	.....	3	3	.....	4	4	.....	3	3
,, ,, No. 75	6	7	13	2	9	11	.....	10	10	1	8	9	1	5	6
,, ,, No. 76	2	15	17	.....	12	12	1	19	20	2	12	14	.....	5	5
School districts not covered by health units	22	94	116	6	59	65	4	46	50	4	85	89	9	101	110
School District No. 46	5	23	28	.....	8	8	2	8	10	.....	15	15	1	10	11
,, ,, No. 48	10	24	34	5	13	18	.....	24	24	.....	17	17	3	24	27
,, ,, No. 49	2	20	22	.....	14	14	2	9	11	1	15	16	2	10	12
,, ,, No. 61[7]	.....	.....	.....	1	1	2	.....	.....	.....	.....	.....	.....	.....	.....	.....
,, ,, No. 73	3	16	19	.....	14	14	.....	3	3	.....	30	30	1	29	30
,, ,, No. 74	2	11	13	.....	9	9	.....	2	2	.....	4	4	1	8	9
,, ,, No. 80[8]	.....	.....	.....	.....	.....	.....	.....	.....	.....	3	4	7	1	20	21
Unorganized	6	38	44	7	80	87	5	52	57	1	45	46	2	18	20
Ex-Province	.....	1	1	.....	.....	.....	1	1	2	.....	1	1	.....	.....	.....
Unknown	.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Totals	480	3,337	3,817	307	3,099	3,406	229	2,968	3,197	188	2,668	2,856	248	2,494	2,742

[3] Organized as a school district on March 1st, 1955.
[4] Includes Victoria and Esquimalt only.
[5] Excludes Victoria, Esquimalt, and Oak Bay.
[6] Organized as a school district on January 1st, 1953.
[7] Includes Oak Bay only.
[8] Organized as a school district on July 1st, 1953.

This table shows the areas in the Province (by health units and school districts) where venereal disease presents the greatest problem. As in past years, most new notifications (53 per cent) were from the Greater Vancouver area.

The other areas from which a relatively large number of reports come are Prince George, Prince Rupert, and Kamloops. With the exception of the Kamloops area, there is a slight decline in the total number of cases reported from each of these districts compared with 1954. The increase (over 100 per cent) in the number of cases reported from the Upper Vancouver Island is probably due to the influx of single males working on the major construction projects under way there. In most other areas reported cases are roughly the same in number.

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