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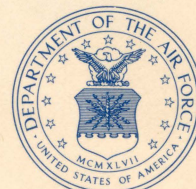
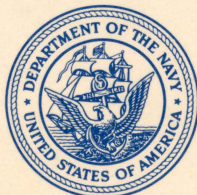
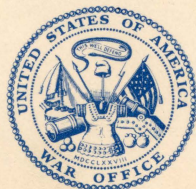
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Interviewer's Aid

for

VD

Contact Investigation



DEPARTMENTS OF THE ARMY, THE NAVY, AND THE AIR FORCE

Revised, June 1967

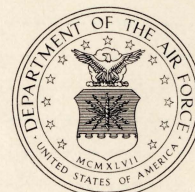
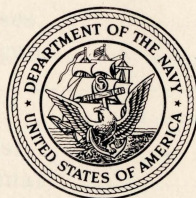
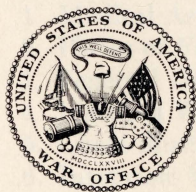
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CONTENTS

	Page
INTRODUCTION.....	1
A. Purpose.....	1
B. Background.....	1
I. EPIDEMIOLOGY.....	
A. Techniques, Definitions, and Procedures.....	2
B. Interviewing.....	3
1. The Interviewer.....	3
2. The Patient.....	3
3. Interview Situation and Setting.....	4
4. Interview Periods.....	4
5. Interview pattern.....	4
6. Cluster Interview.....	7
C. Contact Investigation.....	8
1. Role of Military Interviewer in the Investigation Process.....	8
2. Investigation of Contacts.....	9
3. Liaison with Civilian Health Agencies.....	9
II. ADMINISTRATION.....	
A. Epidemiologic Forms.....	10
1. Venereal Disease Epidemiologic Report, PHS-2936.....	10
a. Initiation.....	11
b. Routing of PHS-2936.....	12
c. Disposition.....	12
2. Morbidity Reporting.....	12
3. Epidemiologic Control Record.....	13
B. Evaluation of Epidemiologic Activities.....	13
1. Evaluation of Contact Interviewers.....	13
2. Evaluation of Contact Interviews.....	13
C. Health Record Syphilis SF-602.....	14
D. Principles for a Comprehensive VD Control Program.....	14
III. APPENDIX.....	
1. Medical Aspects of Venereal Diseases.....	15
2. Plates of Female and Male Sex Organs.....	16-17
3. Venereal Disease Summary Charts.....	18-19
4. Plates of VD Lesions.....	20
5. Chart illustrating How VD Spreads.....	21
6. Interview Worksheet (Sample Format).....	22
7. Standard Routing of PHS-2936.....	22

Supersedes TBMED 243/NAVMED P-5036/AFP 160-5-8 of June 1954.

CONTENTS

Page	
1	INTRODUCTION
2	A. Purpose
3	B. Background
4	I. EPIDEMIOLOGY
5	A. Terminology, Definitions and Theories
6	B. Interviewing
7	1. The Interviewer
8	2. The Interview
9	3. Interview Situation and Setting
10	4. Interview Methods
11	5. Interview Content
12	6. Content Interview
13	C. Contact Investigation
14	1. Role of Military Interviewer in the Investigation Process
15	2. Investigation of Contacts
16	3. Liaison with Civilian Health Agencies
17	II. ADMINISTRATION
18	A. Epidemiologic Form
19	1. General Disease Epidemiologic Report (ED-200)
20	a. Interview
21	b. Reporting of ED-200
22	c. Distribution
23	2. Monthly Reporting
24	3. Epidemiologic Control Record
25	B. Evaluation of Epidemiologic Activities
26	1. Evaluation of Contact Interviews
27	2. Evaluation of Content Interviews
28	C. Health Record System (H-200)
29	D. Principles for a Comprehensive YD Control Program
30	III. APPENDIX
31	1. Medical Aspects of Venereal Diseases
32	2. Phases of Female and Male Sex Organs
33	3. Venereal Disease Symptom Chart
34	4. Phases of YD Infection
35	5. Chart Illustrating How YD Spreads
36	6. Interview Worksheet (Sample Format)
37	7. Standard Listing of YIS-200

INTERVIEWER'S AID FOR VD CONTACT INVESTIGATION

INTRODUCTION

A. Purpose

The Interviewer's Aid for VD Contact Investigation is designed to furnish the VD contact interviewer with basic information necessary to conduct an effective interview and to properly carry out the necessary administrative procedures connected with the interviewing process. It may be utilized as a guide for new interviewers, as a training aid, and as a ready reference and source for review. Certain portions of the manual may serve the interviewer as an instrument to help motivate and educate the VD patient. It will also show how the military contact interviewer contributes to, and functions within, local, state and national VD control programs. The manual has been divided into three sections. Epidemiology (Section I) outlines an interviewing procedure that may be employed with most types of patients. It also describes the interviewing situation, and the equally responsible role of both the interviewer and patient in the interviewing process. The second part of this section deals with information the military interviewer should know in order to carry out his duties more effectively.

Under Administration (Section II) will be found a discussion of various forms utilized by the interviewer with the necessary information as to their preparation and use. Also included here are certain recommendations that will prove helpful in establishing and maintaining an efficient control program.

The Appendix (Section III) contains a quick summary chart of the major venereal diseases; illustrations depicting typical VD lesions; drawings of the male and female sex organs; and a diagram showing the chain of infection in a syphilis outbreak. This diagram shows the relationship between civilian and military cases which may be of value in re-educating the VD patient. A directory of State Health Departments will provide the interviewer with information necessary for the routing of forms or other correspondence.

B. Background

The incidence of venereal disease is still high.

This occurs even though medical progress has produced reliable diagnostic aids and widely available inexpensive therapeutic agents. One must conclude that medical knowledge and the "wonder drugs" alone will never eradicate these diseases, and the vital role of epidemiology becomes more apparent. The problem then, is one of finding infected individuals who contribute to, and are a part of the reservoir of infection, to insure the greatest benefit from present medical techniques of treatment.

Before the advent of penicillin, medical personnel were committed to "caseholding" techniques; that is, due to the lengthy treatment schedules with Arsenic and Bismuth, they could do little more than keep known infected individuals on their course of treatment. The discovery of penicillin and its use as a therapeutic agent against syphilis brought about a revolution in control efforts. Field workers were freed from their holding techniques to apply newer "case finding" techniques.

Current case finding efforts center around the Contact Interview and Contact Investigation. Not only have medical and epidemiologic measures changed, but attitudes towards venereal infections have changed. Not very long ago, for instance, the military took a disciplinary approach which resulted in punitive action against those who acquired a venereal infection. This attitude caused the men to conceal their infection or to resort to attempted self-treatment.

At times the educational efforts used the fear approach by illustrating gross malignancies and lesions of late cases, while passing lightly over the early symptoms which when known tend to encourage a man to present himself for early diagnosis and treatment.

It has been found that the best approach in VD education is one that is straight-forward, factual, and non-moralistic, which at the same time does not condone promiscuity by implication.

I. *Epidemiology*

Epidemiology is the field of science which is concerned with the factors and conditions that determine the occurrence and distribution of disease. Epidemiologic principles become meaningful

and practical when their application brings about early diagnosis and treatment of infectious disease and prevents its further spread within the population. This portion of the manual is devoted to epidemiologic procedures as they apply to the control of syphilis.

Syphilis in its infectious stages is an epidemic disease. No case occurs in isolation; each case is related to others. Basic to epidemiology is the realization that a person with syphilis exists because a personal interchange of an infecting organism took place through some form of intimate sexual contact with another person.

Syphilis epidemiology is simple in theory, complex in application. This chapter attempts to explain the recognized techniques and procedures which have been used and have proven to be effective.

A. Techniques, Definitions, and Procedures

Essentially, the epidemiology of syphilis is divided into two basic elements: contact interviewing and contact investigation. A third and equally important technique, clustering, supplements and is closely entwined with both interviewing and investigation. These three basic parts of the epidemiologic pattern are defined as follows:

CONTACT INTERVIEW: A planned, controlled conversation between interviewer and an infected patient designed to elicit information which will make it possible to find and bring to examination all those people with whom the patient was sexually intimate during the critical time period. The critical time period is the time

during which the infected patient could have acquired and transmitted the infection.

CONTACT INVESTIGATION: The locating and bringing to therapy persons known to have been exposed to an infected patient. These persons are identified and located on the basis of information obtained in the contact interview.

CLUSTERING: The technique used to extend the epidemiologic procedures to include persons other than critical period sex contacts named by the patient. The people involved in the epidemiologic process may be divided into four groups:

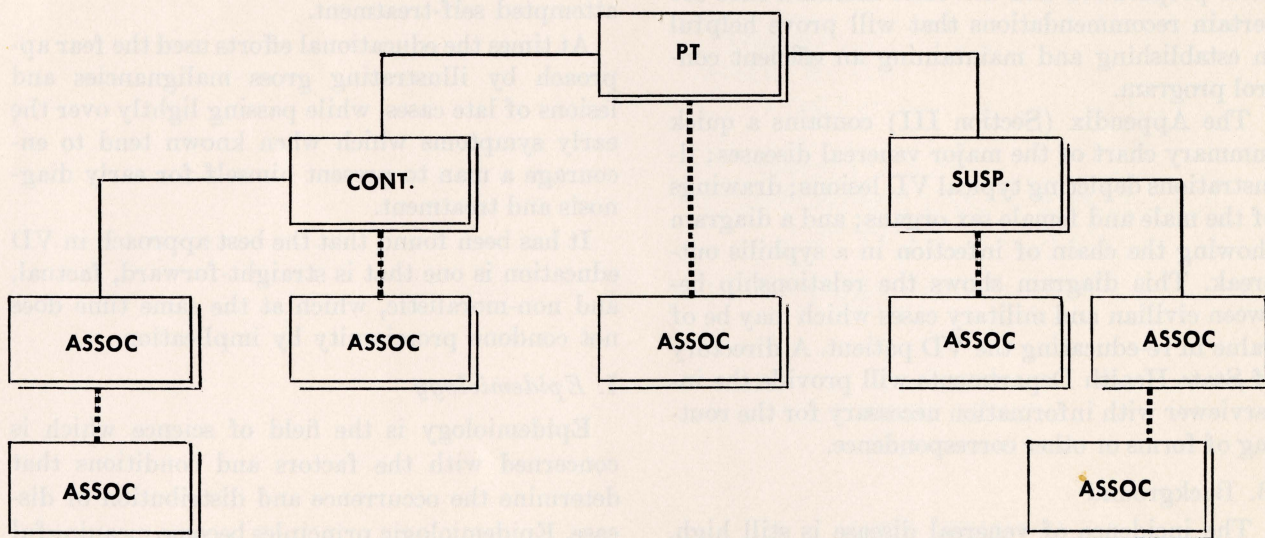
1. **PATIENT:** The person infected with primary, secondary, or early latent syphilis on whom the epidemiologic process is initiated and around whom the entire process revolves.

2. **CONTACTS:** Those persons named by the patient as his sex partners during the critical time period.

3. **CLUSTER SUSPECTS:** Those persons named by the patient, other than contacts in the critical time period, for whom an examination for syphilis is deemed necessary.

4. **CLUSTER ASSOCIATES:** Those persons who are not named by the infected patient, but who are involved in the epidemiologic process due to their close social relationship to the patient, his contacts or cluster suspects.

This categorical breakdown of contacts, cluster suspects, and cluster associates with their relationship to the patient and to each other is illustrated by the following diagram:



B. Interviewing

In dealing with the patient with venereal disease, the most productive method of interviewing is one designed to produce the greatest amount of useful information in the shortest period of time. A good interview will necessarily follow an organized plan. This plan is what makes the interview a controlled conversation. Success with this method is directly dependent upon the interviewer's ability to motivate a patient through a positive projection of attitudes, ideas, and responses. This projection is accomplished through *positively phrased* questions, comments, aids and implications which convey to the patient concern for him and his problem.

During the interview, three areas of information should be explored in considerable detail. The first of these areas is concerned with general information about the patient's own identity and environment. After completing inquiry in this general area, the interviewer proceeds to a more specific area which is concerned with eliciting a medical history of previous venereal infections. The third and final area explored, using this method, is one concerned with a sexual history which includes a discussion of both normal and deviate sexual activity and the people who may be involved.

Patient education should be included in an interview when the patient seeks information regarding his disease. Such information should motivate the patient to name additional contacts.

For epidemiologic purposes, the interviewer will be concerned with two periods of time, a *critical period* and an *interviewing period*. The critical period is always determined individually for each patient and is based on that particular patient's duration of symptoms and the maximum incubation period for his particular stage of syphilis infection.

CRITICAL PERIODS:

Primary syphilis—3 months plus duration of symptoms

Secondary syphilis—6 months plus duration of symptoms

Early latent syphilis—1 to 4 years.

The *interviewing period* is arbitrarily established by the interviewer, making it long enough to overlap the critical period involved. The basic ground rules of interviewing having now been

established, the individual components of the interview situation will be discussed in detail.

1. The Interviewer

The VD interviewer is the most important single individual in the total VD program, since the epidemiological success or failure is in his hands. While training is very important, without the proper motivation and attitude on the part of the interviewer, results will be less than successful. For instance, what is the meaning and import of an interview? A 10-minute talk with the patient to fill out a contact report? How important is the interview? The goal of an interview should be to obtain the names of all the contacts a patient has had within the critical period of his infection. Rather than viewing a patient as simply having an isolated infection, the patient should be seen as part of a chain of infection involving numerous other infected individuals. If the interviewer is poorly motivated or fails to see the importance of his role, then it is highly unlikely that the patient can be impressed as to his responsibility to reveal all sexual contacts. The interviewer is most effective when he undertakes each interview situation with an open mind concerning the patient's sexual activities. *The interviewer's personal moral standards and convictions concerning sexual behavior must never be expressed, implied, or conveyed in any manner to the patient.* This attitude will create an atmosphere more conducive to a full discussion of sexual behavior between the patient and the interviewer.

The medical department representative assigned the responsibility for contact interviewing must bear in mind that **ANY AND ALL INFORMATION OBTAINED IN THE INTERVIEW IS PRIVILEGED COMMUNICATION AND MUST REMAIN SO.** He should impress the patient with this fact. This status of privileged communication exists in all cases except those which involve homosexual contacts.

2. The Patient

Many infected patients, especially those with their first venereal infection may have built up fears as to what will happen to them. Their fear may arise from ignorance as to medical aspects such as treatment, and late manifestations of the disease; or possible punitive measures which may be taken such as restriction, loss of rate, notifica-

tion of family, etc. The patient may fear the interview itself; what may happen as a result of information given to the interviewer; what will happen to his contacts, how will they be approached, and examined; will their parents, wife, husband find out? Confidentiality and re-education of the patient should be included if the interviewer feels the individual patient warrants particular emphasis on one of these points. The interviewer should be acquainted with the section on Contact Investigation in order to explain to the patient just how the contact information will be utilized by the local Public Health Department. The patient who has been infected before, and has been successfully motivated and educated as to the importance of being interviewed, may be much easier to interview the second time. Occasionally, a patient is reinfected a short time after the initial infection is treated. The interviewer should stress that the source of reinfection might be a contact not mentioned in the original interviews. This might provide the motivational impetus needed to secure more complete naming of contacts by the patient.

3. Interview Situation and Setting

It should be obvious to the interviewer that since the subject matter to be discussed with the patient is of a highly personal and privileged nature, the physical surroundings and site chosen for the interview should be conducive to creating this kind of atmosphere. A small room with a desk and two chairs is sufficient. Most important is that the room chosen be free from interruptions either by phone or persons walking in and out during the interview. Above all, the interview should be conducted in privacy—*only* the interviewer and patient should be present. The interviewer should have available for ready use sufficient contact report forms, visual aids, and any epidemiologic or road maps of the surrounding areas frequently named in previous interviews. Telephone directories may also be useful. The military interviewer, particularly on the small installation or ship, may be at some disadvantage in that the interviewer lives and works in too close proximity to the patient. If the interviewer feels that the patient is holding back information, it would be worthwhile to have a reinterview performed in another location, by a different interviewer. If necessary, request assist-

ance from the local Public Health Department Interviewer.

4. Interview Periods

Before attempting to perform the interview, the interviewer should review the medical record, onset of symptoms, and diagnosis of the patient, with the medical officer. If the diagnosis is syphilis, the interviewer should be aware of the stage of infection, as this will have a direct bearing on the duration of infection and therefore will affect the interviewing period. Since the purpose of the contact interview is to elicit all sexual partners of the patient within the critical period of infection, in order to identify the source and all possible spread of infection, the interviewer must be aware of the critical time period. If the patient is poor in his recall of past dates, the interviewer may arbitrarily expand the interview period so as not to miss any critical period contacts. The interviewer should attempt to fix the interviewing period firmly in the patient's mind, possibly with the aid of some date important to the patient, such as birth date, Christmas, a holiday, paydays, etc., which corresponds closely with the start of the interviewing period. The interviewer may also employ some means of checking the patient on his ability to recall time periods. An example might be his estimate as to how long ago his ship returned from its last cruise, or how long ago was the last change of command ceremony. His answers to these questions may give some idea as to how reliable are his estimates of exposure dates.

5. Interview Pattern

The Interviewing Pattern included here is by no means the only approach to the contact interview. It is, however, one that has been used successfully by many interviewers, both military and civilian, on all types of patients. The following points are suggested for the interviewer to keep firmly in mind to help increase his chances for success.

(1) State questions in a positive manner. A negatively posed question is sure to get a negative response.

(2) Don't be reluctant to talk about sex, or various types of sexual behavior. Keep an open mind.

(3) Don't show surprise or disgust at a patient's response.

(4) Don't agree with the patient, or confirm a negative response.

For instance, at the start of the interview the patient may blurt out, "I've only had contact with one person, I know where I got it." The interview is over before it is started if the interviewer believes the patient, and says "All right, let's talk about this person." The following paragraphs of this section are the sequence of questions in the pattern and a recommended method of posing each question, followed by some explanation. A sample interview format is presented in the Appendix. The format and questions should be memorized. Copies of the pattern may be duplicated and utilized for recording each interview. The information elicited from the patient's responses should be written down since the interviewer may want to refer to it later in the interview, even "quoting" the patient.

QUESTIONS

1. "What is your full name?" It may not be necessary to ask this question if you have the patient's chart in front of you, or if you are on a small installation or ship when you know each individual, except to avoid having the wrong patient or wrong chart or to assure correct spelling of name.
2. "What is your duty station? Military address?" This question again may not be necessary in some instances; however, many patients will be interviewed at dispensaries or hospitals to which patients are referred from many other commands.
3. "Where can you be reached during the day? Evening? Phone? Extension?" "What is your local civilian address, if it should become necessary for me to reach you?" It may be necessary to contact the patient to set up a reinterview, or to clarify some information obtained in prior interview. This is also an opportunity to obtain an address the patient has in town when not on duty.
4. "How long have you been at your present duty station (or on this ship)?" If the patient has been at the present duty station less than the time of the interviewing period then the past duty stations or, prior to E.O.D. in service, civilian address may be necessary.
5. "How long have you been in port?" (If interviewer is not familiar with movements of patient's ship within interviewing period).
6. "What cities have you visited?"

7. "When is the last time you were on leave?" "Where did you visit?" "You went back to your home town, didn't you?"

The importance of information gained from questions 3 through 6 is that it gives the interviewer knowledge of the patient's movements during the interviewing period and therefore the places he may expect to find contacts. The length of time the patient has been in the area may also give the interviewer some insight as to how well the patient knows the area. If the patient has been to his home town on leave, there is the strong possibility of a girlfriend or other contacts whom he might know quite well. These contacts might be the last ones the patient wants to mention.

8. "When you're off duty with whom do you live?" It is important that this question be posed in a positive manner, so that the patient will admit to a steady partner if one exists. Is he living with his wife? Steady girlfriend? Roommate?
9. "How many times have you been infected with Gonorrhoea or Syphilis before?" By ascertaining the patient's history of previous VD infections, the interviewer may gain some insight into the patient's promiscuity. The interviewer may suggest other common synonyms when asking this question, such as "drip", "strain" or "clap" for gonorrhoea, and "bad blood", "lues" or "old joe" for syphilis.

At this point in the interview, there is a transition from locating information and medical history to information concerning the patient's personal sexual behavior. Up to this point there is usually no reluctance to answer every question in rapid succession. The value of this is that it encourages the patient to talk freely about himself. The transition might be accomplished by using the following method:

10. "*(Patient's name)*, you know you have syphilis. You and I both know there is only one way you can catch syphilis, and that is by having sexual intercourse with a person who is infected with it."
11. "*(Patient's name)*, how old would you say you were when you first had sexual intercourse with another person? Would you say about 10?" In this question the interviewer should suggest responses, starting at an early age. The suggestions are aimed at obtaining an immediate response rather than giving the patient time to deliberate and give a false reply.

12. "Since you were ——— (use age patient admitted to in question 11) until now, how many different people have you had sexual intercourse with? Would you say about 500? More than 500? Less than 500?" The interviewer should arrive at a definite number and in suggesting further numbers, in rapid succession, arrange the numbers out of sequence (that is: 250, 110, 320). It is better to suggest larger numbers in the beginning indicating you expect people to have sexual contact with many different people. If the patient's response is less than 500 then the interviewer should not drop to say 10 or 12 but try suggesting about 250, more than 250, less than 250. The final number arrived at should give some indication on the promiscuity of the patient.

13. "(Name), of these ——— different people would you say that half, more than half, or less than half are men or boys?" (If interviewing a female use girls or women). If the patient replies in the negative, the interviewer may continue the questioning on this point by saying: "(Name), many of the people I talk to, with your problem, have been infected by members of their own sex. When is the last time you were approached by another man or boy who wanted to have sexual contact?" If the patient mentions an occasion, the interviewer (in a positive manner) should suggest "This was the last time you had contact then in this way?" This question is an important part in the interview and the interviewer should not hesitate to explore these possibilities since many infected patients are acquiring their infections from homosexual contacts. Very few patients are upset by the above questioning. It is quite likely that the patients who are most vehement in their denial, are the ones to be suspected as having had some deviant exposures. Next, the interviewer should attempt to arrive at a definite number of contacts during the interviewing period.

14. "(Name), since ——— (date of beginning of interviewing period) how many different people have you had sexual intercourse with?" Suggest a number. This number should be dictated by the number of lifetime contacts the patient previously gave. Also, the patient's response should be in keeping with the number of previous lifetime contacts. If it does not, it may indicate that the patient is now holding back, because he can see where the line of questioning is leading. For instance, it would be illogical if the patient admits to 500 dif-

ferent contacts in a lifetime period of five years, but admits to only 2 contacts during the previous 8 months.

15. At this point there is a transition from discussing numbers of contacts to discussing specific contacts. The interviewer will find the transition easier if only first names or nicknames of contacts are used. Therefore, the interviewer might state; "To better help you with your problem, let's talk about these people by their first names or nicknames, and see how they figure in your infection. As you think of these people just mention their first or nickname and I'll jot them down." It is important that the interviewer not stop to obtain identifying and locating information about each individual contact at this point. This is too time consuming, and instead of 10 or 20 contacts in an interview, only 3 or 4 may be mentioned. When the patient stops giving names, even if the number previously given for interviewing period has been reached, the interviewer should suspect that the patient probably had additional contacts. The patient will most likely name first those contacts toward whom he does not feel any personal attachment (one-time pickups or prostitutes). This is the time for the interviewer to explore for marital contact, or a steady girlfriend. He may also reopen the question of homosexual contacts.

16. Example: "Now (name), that we've listed the women or girls, let's list the fellows or men that may be involved in your infection."

17. The interviewer at this point should obtain information as to dates of first exposure. Example: "When was the very first time you had sexual intercourse with ———?" He should do this for each contact listed, then proceed to obtain frequency of exposure.

18. Example: "How often do you have sexual intercourse with ———?" Asking this for each contact. Finally, the interviewer obtained the *date of last exposure*. Example: "When was the very last time you had sexual intercourse with ———?" From this series of questions the interviewer gains insight into how much information the patient should have about each particular contact when he begins to talk about specific locating and identifying information. For instance, if the patient first had sexual contact with a particular person four years ago and has contact with that person about twice a month and the last ex-

posure was a week ago, then the interviewer would expect that the patient knows this contact quite well and should be able to furnish adequate locating and identifying information. After the interviewer has asked the question about date of first exposure for each contact, he might decide to ask the patient about additional contacts.

19. "(*Patient's name*), since we've been talking, have you remembered any one else?" If the patient has recalled additional names, the interviewer should ask the same questions about these contacts, regarding exposure periods. When this is finished, the interviewer should make a decision as to which persons will be initiated as contacts, and proceed by obtaining additional information.

20. Example: "(*Patient's name*), I think (names of contacts) should have examinations. Let's talk a little more about each one of these people."

The interviewer then proceeds to obtain the information necessary for completion of the Epidemiologic Contact Report Forms (PHS-2936). He may again interrupt between gathering information on individual contacts to ask for additional contacts remembered since the beginning of the interview. If the patient balks at giving further information on one or more contacts, then it may be that the patient needs additional education as to the confidential handling of information and/or the methods employed by the Public Health Department Investigator. Some patients will hesitate, however, because they wish to notify the contacts themselves. The interviewer should attempt to persuade the patient that it would be better for the health department workers to handle this since they are expert in dealing with these situations. The interviewer may point out:

1. He is trying to handle this in a completely confidential manner and up-to-now, no one except the doctor and interviewer know the patient has VD. Therefore he, the patient, should not be spreading the word that he is infected.

2. The interviewer should stress that the patient never knows what other people will do with the information, or how many other people they might tell.

3. Contacts may blame the patient for giving them the disease; or if not infected, may blame him for exposing them to it.

Whatever decision is made as to who will notify contacts, the contact report form should always be

initiated. If it is finally decided that the patient will notify the contact, then this fact should be so stated in the "other identifying and locating information" section of the PHS-2936 Form. Specific instructions should indicate to the health department investigator that the contact will report to the clinic on a particular date, or will visit a private physician, giving the name and address of same. The interviewer should inform the patient that the contact will be given until a certain date to report to the clinic. If the contact does not report by then, the health department will followup on the contact.

6. Cluster Interview

When the interviewer feels he has exhausted all possible contacts for the present interview, and when the patient being interviewed is infected with SYPHILIS, the interviewer may proceed to obtain CLUSTER SUSPECTS. The cluster technique as applied to syphilis infections has proved to be a valuable tool in the identification of additional cases of syphilis. If the patient has been well-motivated as to the seriousness and importance of his syphilis infection, he may be encouraged to mention the names of other individuals who should be examined. Through clustering, the interviewer gives the patient an opportunity to name people who may actually be contacts but that he otherwise would not mention. Various ways of asking for cluster suspects would be:

1. "Who do you know has a sore or breaking out?" Suggest to the patient they may be sores similar to the ones he has or to those shown in the visual aids.

2. "Who is having sexual intercourse with the same people you are?"

3. "Who else may need a blood test because they may have picked up the same disease that you have?"

In the military, other people who can be included in the cluster are some of the patient's buddies, those he goes on liberty with, and the ones who were with him when encounters and exposures took place. Some of these same buddies may have had sexual contact with the same people as the patient. Some of the men in the cluster may have been transferred or discharged and the cluster suspect forms should be routed to the new military or civilian address. Even though the interviewer should concentrate on obtaining cluster sus-

pects after all possible contact information has been obtained, the interviewer should be alert for potential clusters during the entire interview. The patient may casually bring up the names of other people when talking about contacts. These individuals are potential clusters and the names should be noted and discussed later in the interview.

NOTE: The cluster is not a sexual contact within the critical period of infection and therefore it is sufficient to obtain one serology and, if possible or practicable, a physical examination for lesions. If negative, the report form is dispositioned as not infected, and no followup is necessary.

If the patient can remember no additional contacts, and all cluster suspect information has been obtained (if a syphilis interview), before terminating the interview, the interviewer should give the patient a chance to ask any questions he may have been holding back up to this time. The interviewer should also advise the patient that he will want to talk to him again. A definite appointment should be set with the patient for the reinterview before he leaves the original interview.

It is highly improbable that a patient, being interviewed because of a syphilis infection, could ever remember all of the epidemiologic information that must necessarily be obtained on his sexual contacts within the framework of a one-hour interview. Therefore, it is recommended that *every* SYPHILIS patient be reinterviewed for additional contacts and contact information *at least on one more occasion* within a short period of time after the original interview. Studies by the U.S. Public Health Service have shown that the percent of infected contacts obtained in re-interviews is almost equal to the percent of infections among contacts obtained in original interviews. Many times the original interview is less than successful, because the patient is nervous or upset about his infection. He may hesitate to give locating information on certain contacts or refuse to give any information at all. He may claim he would like to help but can't remember anything about his contacts or where they live. For these and many other reasons the re-interview is of value. For example, the patient who, during the original interview, is upset or concerned about his being cured may be more relaxed and therefore more ap-

proachable in the re-interview. In almost every interview there are several contacts whom the patient will mention and of whom he will claim to know very little. The interviewer should give the patient instructions that during the time until the re-interview he, the patient, should gather the necessary information about the contacts. If it is a bar contact or pickup, it may be possible to have him visit the area again, get the name of bar or hotel, or the contact's first name or phone number. In the interview, one should always suspect the patient who mentions a one-time unknown pickup as the only contact. It is very easy for the patient who has had homosexual exposures or who is covering up for a girlfriend to throw out to the interviewer unknown chance pickups or the story about being too drunk to remember anything. With these patients there is obviously no sure way to success; however, in the re-interview the interviewer may suggest to the patient that they are not talking about the proper people. If the interviewer can get the patient to admit that he isn't telling the truth or giving all the required information, he can then concentrate on the cause of the patient's uncooperativeness. The interviewer may at least get the patient to give him the names of contacts and through re-interviews supply the names and addresses of the physicians or clinics to which the contacts will go. Enter this information on the contact report.

The interviewer should point out to the patient who refuses to talk that the whole purpose of the interview is to guarantee the protection of his health and those of his contacts. Lastly, the interviewer should point out that the contact may not go for an examination if told to do so only by the patient. The interviewer may say here for example: "How do you know that next week or next month when you want to have sexual intercourse with that person (or those people) again, that they are not waiting to give you back the same infection you gave them?" If the patient remains uncooperative, it may be of value to have him re-interviewed by another interviewer in a different setting if feasible.

C. Contact Investigation

1. Role of Military Interviewer in the Investigation Process

It is realized that few field investigations are carried out by the military VD worker except

on certain military installations and in occupied areas. By and large, military VD epidemiology is centered around the Contact Interview. There are times when military personnel are named as contacts to VD in civilian interviews, and military workers do the investigation. For the most part, however, military interviewers do very little investigating. It is important for the interviewer to realize that the success of the contact investigation phase depends upon the quality and quantity of useful information supplied by the interviewer. The interviewer, when initiating contact reports, should carefully review the information he has compiled. If the interview produces only vague locating information, then there is little to be gained from initiating such a report. What is needed is specific identifying or locating information. A contact report should not be withheld because the interviewer feels there may not be enough information. As a rule what is needed is at least a good description, a first name, and some point of reference such as a hangout. With less information than this it might be better to hold the form and obtain additional information through re-interviews. The interviewer should explore other ways of gaining useful locating information aside from what the patient knows about the contact. For instance, the patient may have had contact with a person he knows nothing about other than a first name. He may, however, be able to tell you that he knows two or three other persons who know this contact very well. One of them could easily supply the necessary information. These other persons may be friends on the same ship or installation, or perhaps friends in his hometown. In this case the interviewer could initiate the contact report even though it has scanty information. He should note in the "other identifying and locating information" section of the PHS-2936 Form that this contact is known by or can be located through (give name and address of this person).

2. *Investigation of Contacts*

As stated above, the military VD control worker does very little contact investigation. This is so, since most contacts are civilians and therefore are the responsibility of the local public health department. The military interviewer should be aware of the methods and techniques

employed, because a patient might be concerned about how the investigation is conducted.

The best method of acquiring this information is to meet the VD Contact Investigator of the local public health department, who can outline the exact mode of operation in his area.

Generally, upon receipt of contact reports, the Health Department checks its files and its epidemiologic records to ascertain whether the patient is known to the clinic. If the person had been recently treated, the investigation may stop there.

If the person needs to be examined, he is contacted and notified in the most confidential manner possible. When the patient is found, he or she is told, "We have reason to believe that you may have been exposed to a communicable disease. For your own protection, we would like you to have an examination." Arrangements are then made for the patient to visit the clinic or a private physician. In order to ensure confidentiality, and to protect the original informant, the investigator never tells the contact:

- (1) The name of the informant.
- (2) The date of exposure.
- (3) The site of origin of the contact report.

If the investigator reveals to the contact the dates of exposure, or the place of origin of the report, this might be tantamount to disclosing the name of the informant.

The interviewer should stress these points so that the patient will not be reticent about giving information.

To demonstrate the relationship between military and civilian infections to the patient, a chart is included in the Appendix.

3. *Liaison with Civilian Health Agencies*

Cooperation between military and civilian health agencies is supported by the Eight Point Agreement of 1948. This agreement gives guidelines for control of VD between the military and civilian agencies.

"It is recognized that the following services should be developed by state and local health and law enforcement agencies in cooperation with the Public Health Service of the Federal Security Agency, (Now (DHEW)), the Coast Guard of the Treasury Department, the Departments of the

Army, Navy and Air Force of the National Defense Establishment, and interested voluntary organizations:

(1) The Armed Services and the Coast Guard will provide early diagnosis and adequate treatment for military personnel infected with venereal disease.

(2) Health departments will provide adequate case finding, diagnostic treatment and case holding procedures for the venereal diseases in the civilian population.

(3) The civilian contacts of military personnel infected with venereal disease will be determined, and reported by officers of the Armed Services and the Coast Guard through medical channels to State and/or local health authorities only.

(4) The military contacts of infected civilians should be reported to appropriate officers of the Armed Services and the Coast Guard by local or State health authorities.

(5) Recalcitrant infected persons should be isolated during the period of communicability. In civilian populations it is a duty of local health authorities to obtain any needed assistance of the law enforcement authorities in enforcing such isolation.

(6) The law enforcement authorities are responsible for the repression of commercialized and clandestine prostitution. In order to limit the spread of venereal infections from these sources, the local health departments and State health departments, the U.S. Public Health Service, the Armed Services and the Coast Guard will cooperate directly or through Armed Forces Disciplinary Control Boards with law enforcement authorities in repressing prostitution and allied vice conditions, by providing them with the necessary available information relative to places and means of procurement and/or exposure, as may assist them in carrying out their responsibilities.

(7) An aggressive continuous program of education should be carried on among military personnel and the civilian population regarding the dangers of promiscuous sexual conduct and venereal diseases, methods of preventing venereal infections and the action which should be taken by a person who suspects that he is infected.

(8) State and Territorial health officers, the Public Health Service of the Federal Security Agency, the Coast Guard of the Treasury Department, the Department of the Army, the Navy, and the Air Force of the National Defense Establishment, all invite the assistance of representatives of the American Social Hygiene Association, affiliated social hygiene societies and of other official and voluntary welfare organizations or groups, in developing and stimulating public support for the above measures."

It is recommended that the military personnel in VD control become actively aware of their civilian counterparts, especially within their immediate area. A telephone relationship should be established and maintained. The military interviewer should also become familiar with local reporting and routing procedures. The military interviewer may ask assistance from the local health department in the epidemiology of certain cases. It may be beneficial and practical in certain areas to have Public Health Interviewers perform the re-interviews on all syphilis patients. Knowledge of homosexual or other contacts that might not otherwise be mentioned may be obtained in this fashion.

II. Administration

The following section deals with instructions concerning VD report forms and records that are currently recommended for use.

A. Epidemiologic Forms

1. PHS-2936 *Venereal Disease Epidemiologic Report Form*, sometimes called an "E.R.," a "C.R.," a "contact report," or a "rainbow," is the most commonly used form in VD contact interviewing and investigation. This form is commonly misused, by omissions, errors in routing, and improper disposition. It should be initiated on every sexual contact obtained in the interview process. It may also be used for suspects, such as cluster suspects to a syphilis infection. Other persons on whom a PHS-2936 Form is executed, are persons with a reactive or weakly reactive serology who need further examinations and persons who have an untreated or inadequately treated venereal infection and therefore need followup.

When the form is used, it must be used and completed properly so that there is no doubt in the mind of the investigator as to the disease involved, or what type of followup is necessary.

LAST NAME (1-20)		FIRST (AND MICKNAMES)		ADDRESS (INCLUDE APT. NO., CITY & STATE)			
DATE INITIATED (29-32)		AGE (33-34)	RACE (35)	SEX (36)	MARITAL STATUS (37)		
HEIGHT		SIZE, BUILD	HAIR (COLOR, STYLE)	COMPLEXION (SKIN)	PLACE, HOURS OF EMPLOYMENT (AND PHONE)		
CONTACT REPORTED BY PATIENT WITH: (38-39)		DATES OF EXPOSURE		OTHER IDENTIFYING AND LOCATING INFORMATION (AS SPEECH, TEETH, PHYSICAL DEFECTS, TIME AND PLACE OF ENCOUNTER AND EXPOSURE, HANG-OUTS, FRIENDS AND ACQUAINTANCES, MAP, ETC.) BE SPECIFIC.			
<input type="checkbox"/> (1) SYPHILIS STAGE <input type="checkbox"/> (2) GONORRHEA <input type="checkbox"/> (3) OTHER VD SPECIFY		FIRST				LAST	
TYPE OF PATIENT (40)		PATIENT IDENT. (41-46)					
<input type="checkbox"/> (1) MILITARY <input type="checkbox"/> (2) PRIVATE PHYSICIAN <input type="checkbox"/> (3) CLINIC							
CONTACT'S RELATION TO PATIENT (47)							
<input type="checkbox"/> (1) MARITAL <input type="checkbox"/> (2) FRIEND <input type="checkbox"/> (3) PICKUP NO FEE <input type="checkbox"/> (4) OTHER (SPECIFY)							
SOURCE: (48)							
<input type="checkbox"/> (1) MILITARY <input type="checkbox"/> (2) PRIVATE PHYSICIAN <input type="checkbox"/> (3) CLINIC							
DISEASE SUSPECTED: (49)							
<input type="checkbox"/> (1) SYPHILIS <input type="checkbox"/> (2) GONORRHEA <input type="checkbox"/> (3) OTHER VD							
REFERRAL BASED ON: (50)							
<input type="checkbox"/> (1) SELECTEE <input type="checkbox"/> (2) CLUSTER ASSOCIATE <input type="checkbox"/> (3) SEPARATEE <input type="checkbox"/> (4) OTHER							
INITIATING AGENCY (51-52)		INTERVIEWER (53-55)		CLOSURE: (78)			
CLINIC CODE				<input type="checkbox"/> (1) ADMINISTRATIVE <input type="checkbox"/> (2) RECORD SEARCH <input type="checkbox"/> (3) VOLUNTARY SEARCH <input type="checkbox"/> (4) CONTACT WITH PHYSICIAN <input type="checkbox"/> (5) FIELD INVESTIGATION OF PATIENT			
<input type="checkbox"/> (1) NOT INFECTED <input type="checkbox"/> (2) INFECTED, BROUGHT TO TREATMENT (PREVIOUSLY UNTREATED THIS INFECTION) <input type="checkbox"/> (3) INFECTED, RETURN TO TREATMENT THIS INFECTION <input type="checkbox"/> (4) PREVIOUSLY TREATED THIS INFECTION <input type="checkbox"/> (5) INFECTED, NOT TREATED		DISPOSITION (56)		<input type="checkbox"/> (6) UNABLE TO LOCATE <input type="checkbox"/> (7) LOCATED, REFUSED EXAMINATION <input type="checkbox"/> (8) INSUFFICIENT INFORMATION TO BEGIN INVESTIGATION <input type="checkbox"/> (9) MOVED FROM JURISDICTION			
		IF INFECTED, GIVE DISEASE, STAGE: (57-58)		NEW ADDRESS: _____			
		TREATED BY: (59-61)		DATE FIRST TREATED: (62-65)			
		<input type="checkbox"/> (X) EPIDEMIOLOGIC TREATMENT <input type="checkbox"/> (Y) OTHER (SPECIFY)					
DATE FIRST EXAMINED (66-68)		INVESTIGATING AGENCY (69-71)		INVESTIGATOR (72-74)			
				DATE OF DISPOSITION (75-77)			

PHS 9 2936 (NCD) (FORMERLY PHS 2936)
REV 5-67

FORM APPROVED
BUDGET BUREAU NO. 68-R0191

VENEREAL DISEASE EPIDEMIOLOGIC REPORT

1

a. Initiation

Depending upon whether the PHS-2936 Form is being initiated for a contact or for a suspect, only the appropriate section CONTACT or SUSPECT should be completed and never both sections. If the person on whom the form is being initiated is a contact within the critical period, then the section marked CONTACT on the left margin of the form and outlined in heavier print shall be COMPLETED. This section refers to information about the patient you have interviewed. If the patient interviewed (not the contact) has primary syphilis, then check syphilis stage and indicate either primary, secondary, or early latent. Also enter the dates of first and last exposure. On the second line within the contact block, the patient's place of treatment—military, private physician, or clinic should be checked. The Patient Identification block (41-46) should show some numerical listing which will be connected with the patient's interview record. The contact's relation to patient should be checked as appropriate. The information in the suspect block marked SUSPECT (vertically beneath contact) is only filled out on people other than contacts. A check should be placed as to the source of the referral,

either Military, Private Physician or Clinic. Check the disease suspected and check one square under referral based on: Normally blocks #1 (Premarital) through #6 (Survey), are used for initiation of persons with reactive serologies who need further examinations. Block #7 (Cluster Suspect) is used for a person obtained from a syphilis interview who needs an examination for a specific reason. Block #8 (Cluster Associate) is another type of person who may be named by a contact or found in the vicinity of a contact (to a syphilis patient). Block #9 (Other) may be used for other persons who have a reactive serology and need treatment or followup and not described above. These might be a blood donor or a routine hospital admission with a positive serologic test for syphilis. In all cases initiated for reactive serology followup or because a patient needs further treatment, the "Other Identifying and Locating Information" section should give all pertinent data, such as date, place and results of serologies for reactive serology followup. For persons needing followup re-treatment—this section should contain original diagnosis, amount of treatment, results of tests and also what additional action needs to be taken. The Race (35) block at the top of the form is a poten-

tial source of confusion. Often, forms are initiated with only the letter "C" to designate race. While in the military "C" may mean caucasian, in many areas of the country "C" may mean "colored." This is of particular importance when the other locating information is scanty and the investigator must look for the contact in a bar. For instance, two girls may fit the same description as to height, weight, etc., and both may have the same first name. It would be extremely difficult under some circumstances to determine which person is the correct contact. The section for *Initiating Agency* (51-52) must contain a complete mailing address of the department and command initiating the form. If this is left blank (and many times it is) or is incomplete, then other agencies can hardly be expected to reroute the dispositioned forms back to the initiating agency. The address, place of employment, and home phone are self-explanatory. However, when a patient's address is not known, care should be taken to ensure that at least the city is listed, or a hangout or frequented bar is noted. The "*Other Identifying and Locating Information*" section is used for detailed and specific information pertaining to the contact or person through whom the contact may be located. If more space is required, use the back of the form making sure that the information is on the form that will be sent to the investigating agency. As was previously noted, this section should also include results of tests with regard to followup of persons with reactive serologies or other suspects.

b. *Routing of PHS-2936 Venereal Disease Epidemiologic Report Form*

After the Contact Interview has been performed it is essential that the contact forms be promptly initiated and routed to the proper agency for investigation. The routing of the Form PHS-2936 may vary in different areas and individual commands may wish to check on routing procedures within their areas of jurisdiction with state or territorial health departments. The most frequently used routing is as follows:

- (1) White and pink copies to the Health Department of the area where contact resides.
- (2) Yellow copy to State Health Department.
- (3) Green copy retained as file copy by the initiating agency.

(4) When the investigating agency has dispositioned the report, the white copy is returned to the State Health Department which in turn routes it to the initiating agency. See Appendix for routing diagram.

c. *Disposition*

It is important that when the person listed on the form has been located, examined, and diagnosed, that the disposition be recorded promptly, and that the form be returned to the initiating agency. The disposition section (lower half of the form) is filled in by the investigating agency.

This portion of the form shall be completed in the following manner:

#0—*Not Infected*. The diagnostic tests are negative and no preventive antibiotics are given. In the case of syphilis, the contact should have negative serologies at least 3 months after date of last exposure—when no preventive (epidemiologic) treatment is given.

#1—*Infected*. Brought to Treatment (previously untreated for this infection). Check if patient has not had treatment for this infection prior to the initiation of this investigation.

NOTE: Dispositions #1 through #5 require filling in of the "center block" giving disease; treated by; and date first treated.

#X—*Epidemiologic Treatment*. Diagnostic tests and clinical symptoms are negative, however, the patient was given treatment anyway. NOTE: Dispositions #6 through #9 represent persons who were not examined for some reason. If the person has moved disposition #9 may be used only, if a new address or other specific locating information has been obtained for the new investigating agency. When this disposition has been used, the white and pink copies should then be forwarded to the proper State Health Department.

#Y—*Other*. May be used when other disposition blocks do not apply. The reason for this disposition should then be specified. Example of this disposition might be: "contact deceased".

2. *Morbidity Reporting*

Every case of venereal disease should be reported. In the military, each infection is reported on the Monthly Morbidity Form 602. In addition, as soon as the diagnosis is established, a morbidity report (each state has a particular form) should be filed with the state or local health

department where your installation or ship is operating. Every State has a reporting law and each command should obtain from the respective State Health Departments reporting procedures and a supply of the form to be used. If you are treating VD patients, a report on some type of state or local health department morbidity form should be submitted. Ships normally would report morbidity to the local or state health department where they are home-ported within the continental limits of the United States. However, when the ship is in the yards or visiting other United States ports, reports should be submitted to the health department in the locale. Refer to the directory of state and local health departments (Appendix) for addresses in requesting information on procedures. While operating outside of the United States, Army follow AR40-554, Air Force follow AFR161-7, Navy follow Commander in Chief, U.S. Atlantic Fleet or Commander in Chief, U.S. Pacific Fleet Instructions that pertain to reporting venereal diseases. Prompt and complete reporting of all cases is essential to evaluate the incidence and prevalence of VD, thereby determining the needs of VD control programs in a given area for additional personnel. Complete reporting of military cases within an area will give the Public Health Department a more accurate estimate of the reservoir of infection.

It has also been found that persons will report to public health clinics or to private physicians stating that they have been exposed to a case of VD. They may mention the name of a contact who was supposed to have been treated by the military. If the health department had received a Morbidity Report from the ship or installation, the department would know exactly to what disease the patient had been exposed. This being the case, the health department could more quickly effect the disposition of the patient. This action could be a serologic test for syphilis or epidemiological treatment. The importance of notifying health departments is strongly emphasized.

3. *Epidemiologic Control Record*

It is recommended that a system be developed whereby the interviewer maintains, as a ready reference, essential epidemiologic information given by each patient in one card file, or log book. Such a card system should be arranged in numerical sequence. Each card would contain information such as the patient's name, rate, divi-

sion, diagnosis, date of diagnosis, date of interview and reinterview along with columns listing each contact or cluster suspect with respective PHS-2936 number. Also included should be the date of initiation, exposure date, place of investigation, and columns where the disposition and date of disposition can be recorded when the forms are finally returned. The patient should be given a number as soon as he is diagnosed. This number is recorded on the card and is also placed on each PHS-2936 Form in the "Patient Ident" block; thereby making it easy to properly file the dispositioned form when it is returned several weeks or months later. A log book with columns marked-off across the page to record the same information is also useful. Either the card or the log book can also be used to record other data, such as when the patient is to return for repeat and/or followup tests. The date when the morbidity report was submitted to the state or local city/county health department should also be noted on the card.

B. *Evaluation of Epidemiologic Activities*

The object of the contact interview is to obtain information on all sexual contacts to the infected patient; thereby identifying the source and all possible spread of infections. There should be some method devised that will enable one to look upon the epidemiologic activities being performed and evaluate their success or failure.

1. *Evaluation of Contact Interviewers*

One method that will give some indication of the performance of an interviewer is a review of the epidemiologic control record or log book kept on all interviews. An interviewer who consistently obtains one contact on syphilis interviews when the average contact rate should be somewhere between 3 and 4 contacts, or the interviewer who turns up an undue number of uncooperative patients who name no contacts at all, should be closely scrutinized.

Perhaps this person needs advice or additional training. Possibly the man should be relieved of his duties. The interviewer might also be found to be deficient, especially if another interviewer can consistently obtain additional contacts after the original interviewer has talked to a patient two or more times.

2. *Evaluation of Contact Interviews*

The recommended card system or log book, with patient numbers, supplies a method for

review of the quality of interviewing mainly by types of disposition of the contacts named by the patient. For example, if a review of the dispositions of contacts given by a patient shows that none of the named contacts were infected, then certainly this patient needs to be reinterviewed, for there should be additional infected contacts. In syphilis, many exposed contacts may be incubating the disease when located and may still be serologically negative. These will be dispositioned as "epidemiologic treatment". However among the contacts at least one, the source of the patient interviewed, should be seropositive and therefore should be diagnosed as having syphilis and dispositioned accordingly. If a review of the log or record shows that the three contacts given were all dispositioned as "unable to locate", it may mean the patient is giving false information, or that the interviewer did not obtain all the necessary locating information.

C. Health Record Syphilis FS-602

Whenever a diagnosis of any venereal disease is made, this fact along with all data, such as results of physical examination(s), laboratory tests, treatment and followup, should be entered in the person's health record. When a diagnosis of syphilis is made, it should be recorded in SF-602 Form. This is important not only to guarantee proper followup of the patient, but the job of the medical officer at the next duty station will be easier when the record is completed. All too often, a patient is found to have a reactive serology on reenlistment, hospital admission, or separation, and the patient states he remembers having been treated for an infection, but his health record shows nothing. To avoid such an occurrence a SF-602 Form should be completed on every case of syphilis and entered in the patient's health record.

D. Principles for a Comprehensive VD Control Program

1. Obtaining lists of *all* reactive serologies from laboratories, with pertinent information, on a weekly or daily basis.
2. Following-up positive serologies by contacting the requesting medical officer, making him aware of the positive findings, checking with him on progress of the case, and seeing to it that the patient returns at an appointed time.
3. Asking for the diagnosis if there is any question. This will expedite timely interviews for contacts.
4. Asking the medical officer to sign the morbidity report and submit same.
5. Making sure the SF-602 Form record is in the patient's health record.
6. Initiating and submitting the contact reports to appropriate investigating agencies.
7. Visiting physicians within the area of responsibility to familiarize them with the VD control program, and on the assistance the VD control officer offers. The busy medical officer will hardly take the time to come to the VD control officer's desk.

NOTE: Because of the rapid turnover in reserve medical officers, the importance of such visitation cannot be overemphasized.

8. Distributing VD literature, showing VD films, giving lectures, etc.
9. Reinterviewing—or seeing that someone else does—*every* syphilis patient.
10. Evaluating one's own programs so that they may constantly be up-to-date. Application of these procedures will help to identify the missed cases—particularly as applies to latent syphilis.

III. Appendix

Medical Aspects of the Venereal Diseases

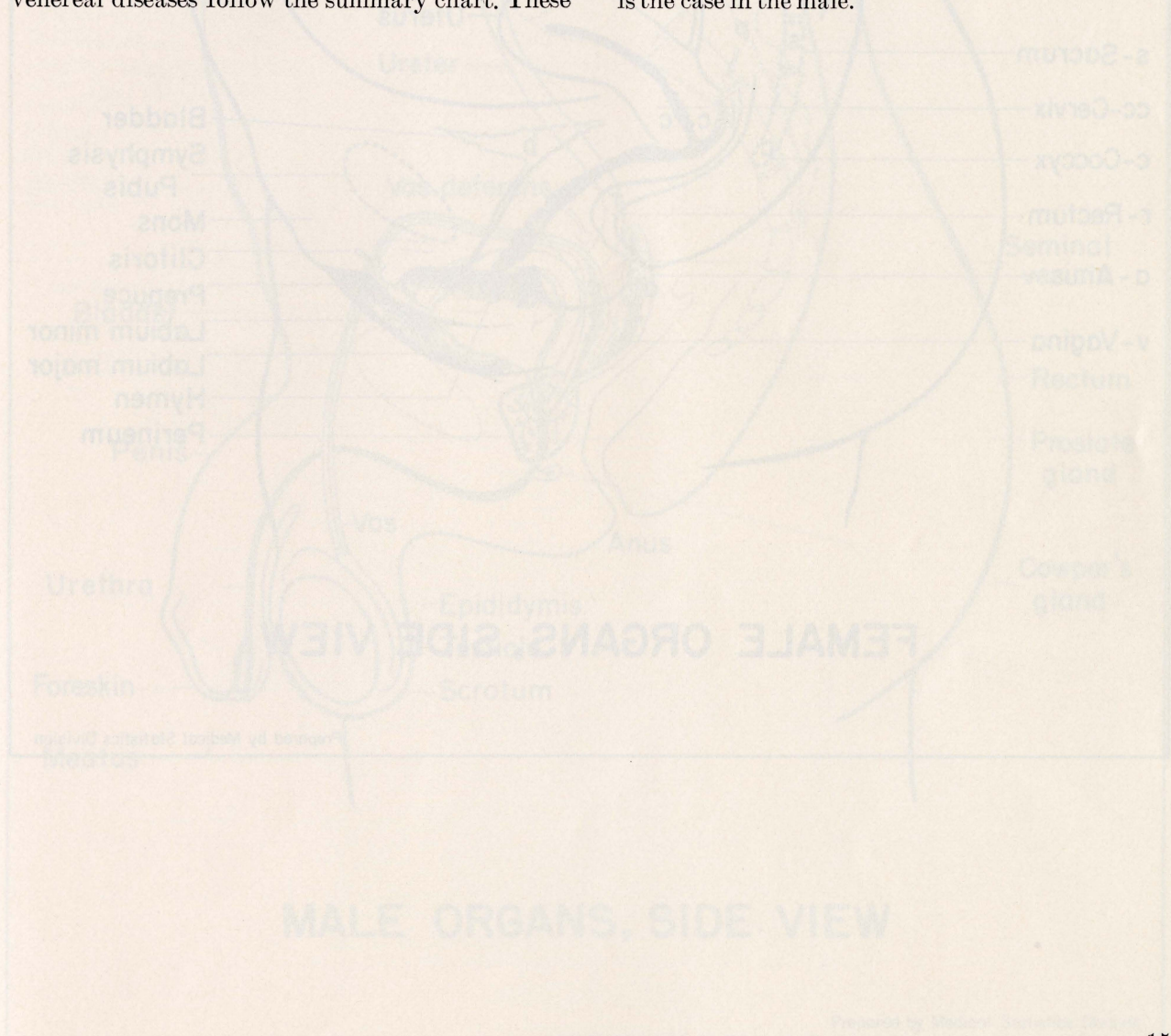
It is beyond the scope of this manual to discuss in complete detail the venereal diseases. Included here is basic information, with which the interviewer should be completely familiar, so that he might be able to answer routine questions that the patient may raise during the interview.

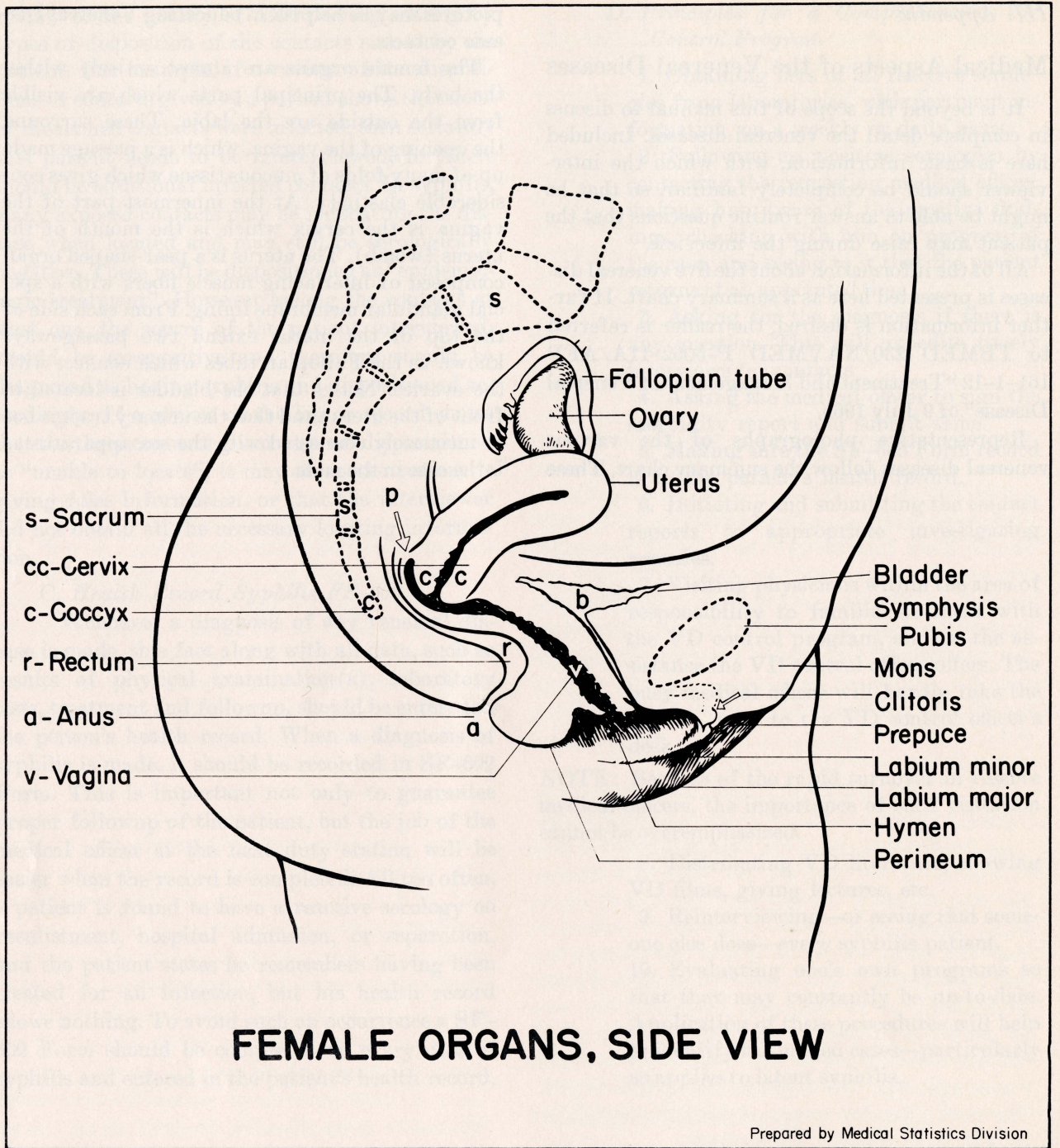
All of the information about the five venereal diseases is presented here as a summary chart. If further information is desired, the reader is referred to TBMED 230/NAVMED P-5052-11A/AFP 161-1-12 "Treatment and Management of Venereal Disease" of 9 July 1965.

Representative photographs of the various venereal diseases follow the summary chart. These

pictures may be helpful in educating Venereal Disease contacts.

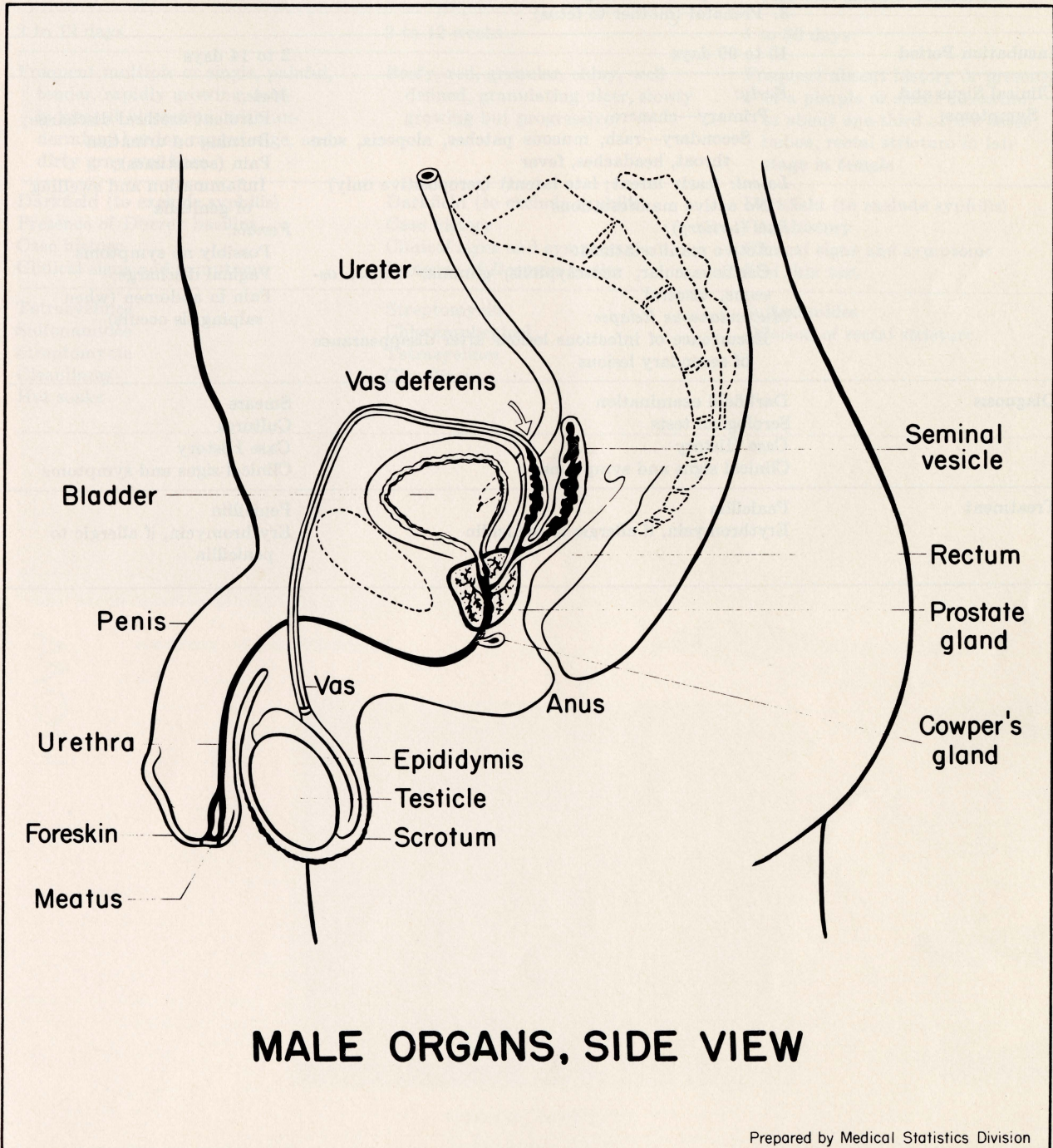
The female organs are almost entirely within the body. The principal parts which are visible from the outside are the labia. These surround the opening of the vagina, which is a passage made up of many folds of mucous tissue which gives considerable elasticity. At the innermost part of the vagina is the cervix which is the mouth of the uterus (womb). The uterus is a pear-shaped organ composed of interlacing muscle fibers with a special glandular membrane lining. From each side of the top of the uterus extend two passageways known as the Fallopian tubes which connect with the ovaries. Notice that the bladder is located in front of the uterus and that the urinary tract is not as intimately connected with the sex apparatus as is the case in the male.





The sex organs of the male are partly on the outside and partly on the inside of the body. The parts which are visible from the outside are the penis and the scrotum. Inside the scrotum are the testicles and the epididymis. The testicle is the complicated mechanism in which the life-giving sex cells are produced. When these cells mature they pass into the coils of the epididymis where

they further develop. They then pass through the spermatic cord up into the seminal vesicles inside the abdominal cavity. Here they are stored until discharged through the urethra, along with secretions from the seminal vesicles themselves and from the prostate gland. If any of the organs become diseased, the whole complicated system may be disturbed.



VENEREAL DISEASE SUMMARY CHART

Title	Syphilis	Gonorrhea
Common Names or Synonyms	"Syph," "pox," "lues," "old Joe," "bad blood," "hard chancre," "chancre"	"Clap," "dose," "the drip," "running," "gleet," "GC"
Causative Organism	<i>Treponema pallidum</i> (popular term, "spirochete")	<i>Neisseria gonorrhoea</i> (gonococcus)
Method of Spread	<ol style="list-style-type: none"> 1. Usually sexual intercourse 2. Kissing and fondling 3. Prenatal (mother to fetus) 	Sexual intercourse and infection at birth
Incubation Period	10 to 90 days	2 to 14 days
Clinical Signs and Symptoms	<p><i>Early:</i> Primary—chancre Secondary—rash, mucous patches, alopecia, sore throat, headaches, fever</p> <p><i>Latent:</i> (early latent; late latent) (seropositive only) No active manifestations</p> <p><i>Late (tertiary):</i> Active manifestations: Cardiovascular, neurosyphilis, gumma, ocular, osseous, visceral</p> <p><i>Mucocutaneous Relapse:</i> Recurrence of infectious lesions after disappearance of secondary lesions</p>	<p><i>Male:</i> Purulent urethral discharge; Burning on urination Pain (sometimes); Inflammation and swelling of genitalia</p> <p><i>Female:</i> Possibly no symptoms Vaginal discharge; Pain in abdomen (when salpingitis occurs)</p>
Diagnosis	Darkfield examination Serological tests Case History Clinical signs and symptoms	Smears Cultures Case History Clinical signs and symptoms
Treatment	Penicillin Erythromycin, if allergic to penicillin	Penicillin Erythromycin, if allergic to penicillin

VENEREAL DISEASE SUMMARY CHART
CONTINUED

Chancroid	Granuloma inguinale	Lymphogranuloma venereum
"Soft chancre," "bubo," "hair cut"	"Ulcerative granuloma of pudenda"	"Lymphopathia venereum"; "Lymphogranuloma inguinale"
Ducrey bacillus	<i>Donovania granulomatis</i>	A specific filterable virus
Sexual intercourse	Sexual intercourse; direct contact by skin and mucous membrane	Sexual intercourse; direct contact by skin and mucous membrane
2 to 12 days	2 to 12 weeks	5 to 30 days
Frequent multiple or single, painful, tender, rapidly growing, non-indurated ulceration, with undermined border, ragged edge, and dirty gray wet base	Beefy, red, granular, shiny, well defined, granulating ulcer, slowly growing but progressive	Frequent absent history or presence of a pimple or small ulceration in about one-third of the cases; bubos; rectal stricture in late stage in female
Darkfield (to exclude syphilis) Presence of Ducrey bacillus Case history Clinical signs and symptoms	Darkfield (to exclude syphilis) Case history Clinical signs and symptoms Presence of <i>Donovan</i> bodies	Darkfield (to exclude syphilis) Case history Clinical signs and symptoms Frei skin test
Tetracyclines Sulfonamides Streptomycin Cleanliness Hot soaks	Streptomycin Chloramphenicol Tetracyclines Cleanliness	Sulfonamides Dilation of rectal stricture



Primary syphilis with multiple chancres



Chancroid



Secondary syphilis with condylomata

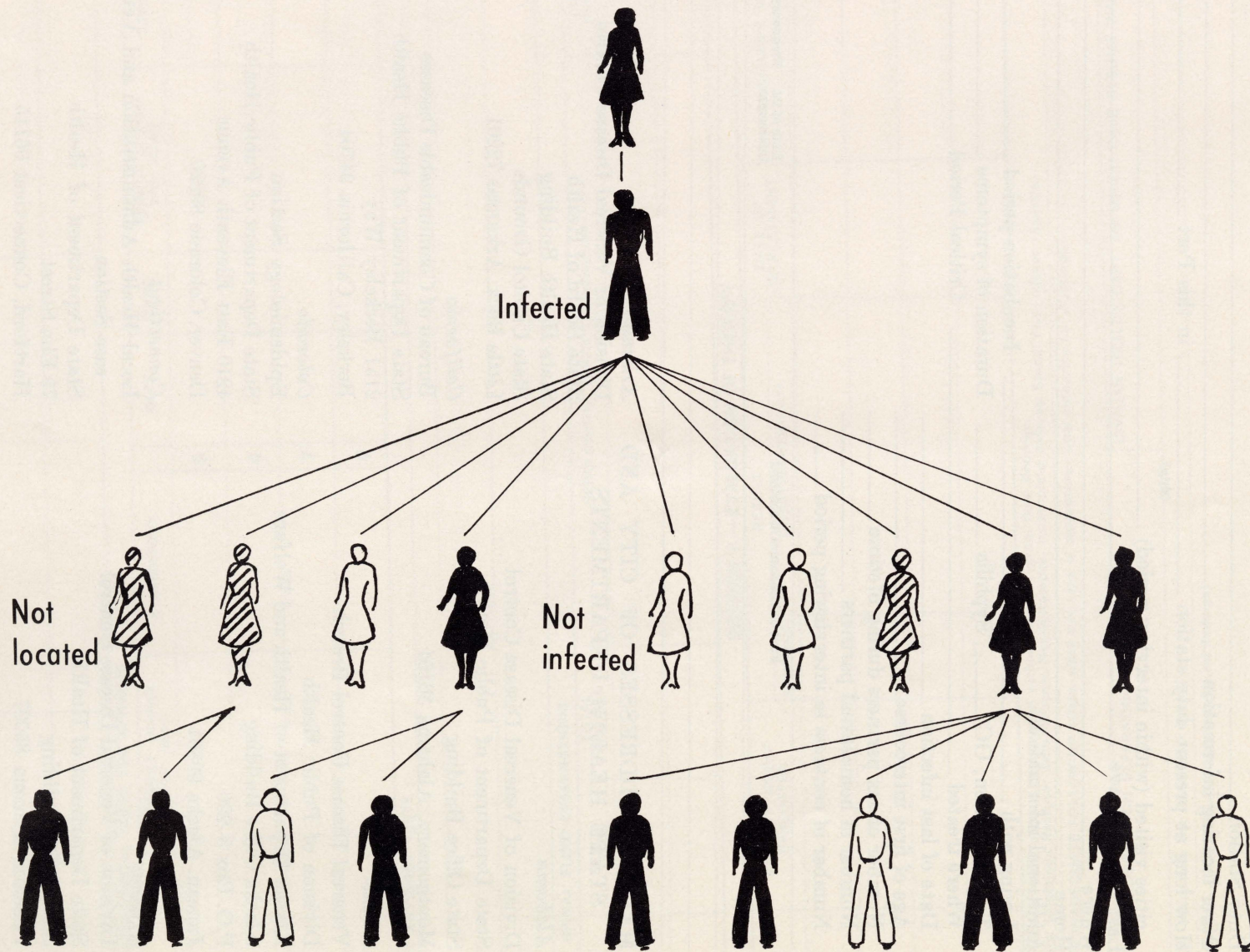


Lymphogranuloma venereum



Granuloma inguinale

HOW VD SPREADS



INTERVIEW WORKSHEET

Modified Direct approach
Male or Female

Patient's full name _____ Diagnosis _____

Duty Station _____

Other locating information _____

How long at present duty station _____, in this Port _____, port or
(ship)

cities visited (within interview period) _____

Last time on leave _____

Where _____

Home _____

Additional information:

Living with _____ Incubation period _____

Total infection; GC _____, Syphilis _____ Duration of symptoms _____

Where treated _____ Critical Period _____

Date of last infection _____

Age of first intercourse _____

Number of sex partners during lifetime _____

Number of homosexual partners _____

Number of contacts in interviewing period _____

First or nicknames of contacts

Date of 1st
Intercourse

Frequency

Date of last
Intercourse

MAILING ADDRESSES OF CITY AND STATE HEALTH DEPARTMENTS

Alabama

Division of Venereal Disease Control
State Department of Public Health
State Office Building
Montgomery, Alabama 36104

Alaska

Venereal Disease Control Branch
Division of Public Health
Alaska Department of Health and Welfare
Alaska Office Building
P.O. Box 3-200
Juneau, Alaska 99801

Arizona

Division of Venereal Disease Control
State Department of Health
State Office Building
Phoenix, Arizona 85007

Arkansas

Division of Venereal Disease Control
State Board of Health
State Health Building
State Capitol Grounds
Little Rock, Arkansas 72201

California

Bureau of Communicable Diseases
State Department of Public Health
2151 Berkeley Way
Berkeley, California 94704

Colorado

Epidemiology Section
State Department of Public Health
4210 East Eleventh Avenue
Denver, Colorado 80220

Connecticut

Local Health Administration and Venereal Dis-
ease Section
State Department of Health
79 Elm Street
Hartford, Connecticut 06115

Delaware

Venereal Disease Control Section
State Board of Health
State Health Building
Dover, Delaware 19901

District of Columbia

Division of Chronic Disease Control
District of Columbia Department of Public
Health
300 Indiana Avenue, NW.
Washington, D.C. 20001

Florida

Division of Epidemiology
State Board of Health
1217 Pearl Street
Jacksonville, Florida 32201

Georgia

Venereal Disease Control Section
Georgia Department of Public Health
State Health Building
Atlanta, Georgia 30334

Guam

Division of Public Health
Department of Public Health and Welfare
Territory of Guam
P.O. Box 2816
Agana, Guam 96910

Hawaii

Epidemiology Branch
Hawaii Department of Health
Kinau Hale
P.O. Box 3378
Honolulu, Hawaii 96801

Idaho

Division of Preventive Medicine
Idaho Department of Health
State House
Boise, Idaho 83707

Illinois

Bureau of Epidemiology
Illinois Department of Public Health
State Office Building
400 South Spring Street
Springfield, Illinois 62706

Indiana

Division of Communicable Disease Control
State Board of Health
1330 West Michigan Street
Indianapolis, Indiana 46207

Iowa

Division of Venereal Diseases
State Department of Health
State Office Building
Des Moines, Iowa 50319

Kansas

Venereal Disease Control Section
State Department of Health
State Office Building
Topeka Avenue at Tenth
Topeka, Kansas 66612

Kentucky

Venereal Disease Control
State Department of Health
275 East Main Street
Frankfort, Kentucky 40601

Louisiana

Venereal Disease Control Section
State Board of Health
Civic Center
325 Loyola Avenue
New Orleans, Louisiana 70160

Maine

Division of Communicable Disease Control
Maine Department of Health and Welfare
Bureau of Health
State House
Augusta, Maine 04330

Maryland

Bureau of Preventive Medicine
State Department of Health
State Office Building
301 West Preston Street
Baltimore, Maryland 21201

Massachusetts

Division of Communicable Diseases
Massachusetts Department of Public Health
546 State House
Boston, Massachusetts 02133

Michigan

Venereal Disease Control Section
Michigan Department of Health
3500 North Logan Street
Lansing, Michigan 48914

Minnesota

Section of Chronic Diseases
State Department of Health
University Campus
Minneapolis, Minnesota 55440

Mississippi

Division Preventable Disease Control
State Board of Health
Felix J. Underwood State Board of Health
Building
P.O. Box 1700
Jackson, Mississippi 39205

Missouri

Venereal Disease Control Section
Missouri Department of Public Health and
Welfare
State Office Building
221 West High Street
Jefferson City, Missouri 65101

Montana

Division of Disease Control
State Board of Health
Cogswell Building
Helena, Montana 59601

Nebraska

Communicable Disease Control Section
State Department of Health
State House Station
Lincoln, Nebraska 68509

Nevada

Bureau of Preventive Medical Services
Division of Health
State Department of Health and Welfare
Carson City, Nevada 89701

New Hampshire

Division of Communicable Disease Control
State Department of Health and Welfare
State House
Concord, New Hampshire 03301

New Jersey

Venereal Disease Control Section
State Department of Health
129 East Hanover Street
Trenton, New Jersey 08625

New Mexico

Venereal Disease Control Section
New Mexico Department of Public Health
408 Galisteo Street
Santa Fe, New Mexico 87501

New York

Venereal Disease Control Section
State Department of Health
84 Holland Avenue
Albany, New York 12208

North Carolina

Venereal Disease Control Section
State Board of Health
225 North McDowell Street
Raleigh, North Carolina 27602

North Dakota

Communicable Diseases, Tuberculosis and Venereal
Disease Control Section
State Department of Health
Capitol Building
Bismarck, North Dakota 58501

Ohio

Division of Communicable Diseases
Ohio Department of Health
306 Ohio Departments Building
Columbus, Ohio 43215

Oklahoma

Venereal Disease Control Section
State Department of Health
3400 North Eastern
Oklahoma City, Oklahoma 73105

Oregon

Section of Epidemiology and Venereal Disease
State Board of Health
1400 South West Fifth Avenue
Portland, Oregon 97201

Pennsylvania

Venereal Disease Control Section
Pennsylvania Department of Health
State Capitol
Health and Welfare Building
Harrisburg, Pennsylvania 17120

Puerto Rico

Venereal Disease Control Section
Puerto Rico Department of Health
Ponce de Leon Avenue
San Juan, Puerto Rico 00908

Rhode Island

Communicable Disease Control Section
Rhode Island Department of Health
State Office Building
Providence, Rhode Island 02903

South Carolina

Venereal Disease Control Section
State Board of Health
J. Marion Sims Building
Columbia, South Carolina 29201

South Dakota

Division of Tuberculosis and Communicable Disease Control
State Department of Health
State Capitol
Pierre, South Dakota 57501

Tennessee

Division of Preventable Diseases, Venereal Disease Control
Tennessee Department of Public Health
Cordell Hull Building
Sixth Avenue, North
Nashville, Tennessee 37219

Texas

Communicable Disease Control Section
State Department of Health
1100 West 49th Street
Austin, Texas 78756

Utah

Division of Communicable Disease Control
State Department of Health
44 Medical Drive
Salt Lake City, Utah 84113

Vermont

Division of Communicable Disease Control
Vermont Department of Health
115 Colchester Avenue
Burlington, Vermont 05402

Virginia

Bureau of Chronic Disease Control
State Department of Health
Bank and Governor Streets
Richmond, Virginia 23219

Virgin Islands

Bureau of Specialized Services, Chronic and Communicable Diseases
Virgin Islands Department of Health
Charlotte Amalie
St. Thomas, Virgin Islands 00802

Washington

Communicable Disease Control Section
State Department of Health
Public Health Building
Olympia, Washington 98501

West Virginia

Bureau of Venereal Disease Control
State Department of Health
State Office Building No. 1
1800 Washington Street, East
Charleston, West Virginia 25305

Wisconsin

Division of Venereal Disease Control
State Board of Health
P.O. Box 309
Madison, Wisconsin 53701

Wyoming

Section of Preventive Medicine
State Department of Public Health
State Office Building
Cheyenne, Wyoming 82001

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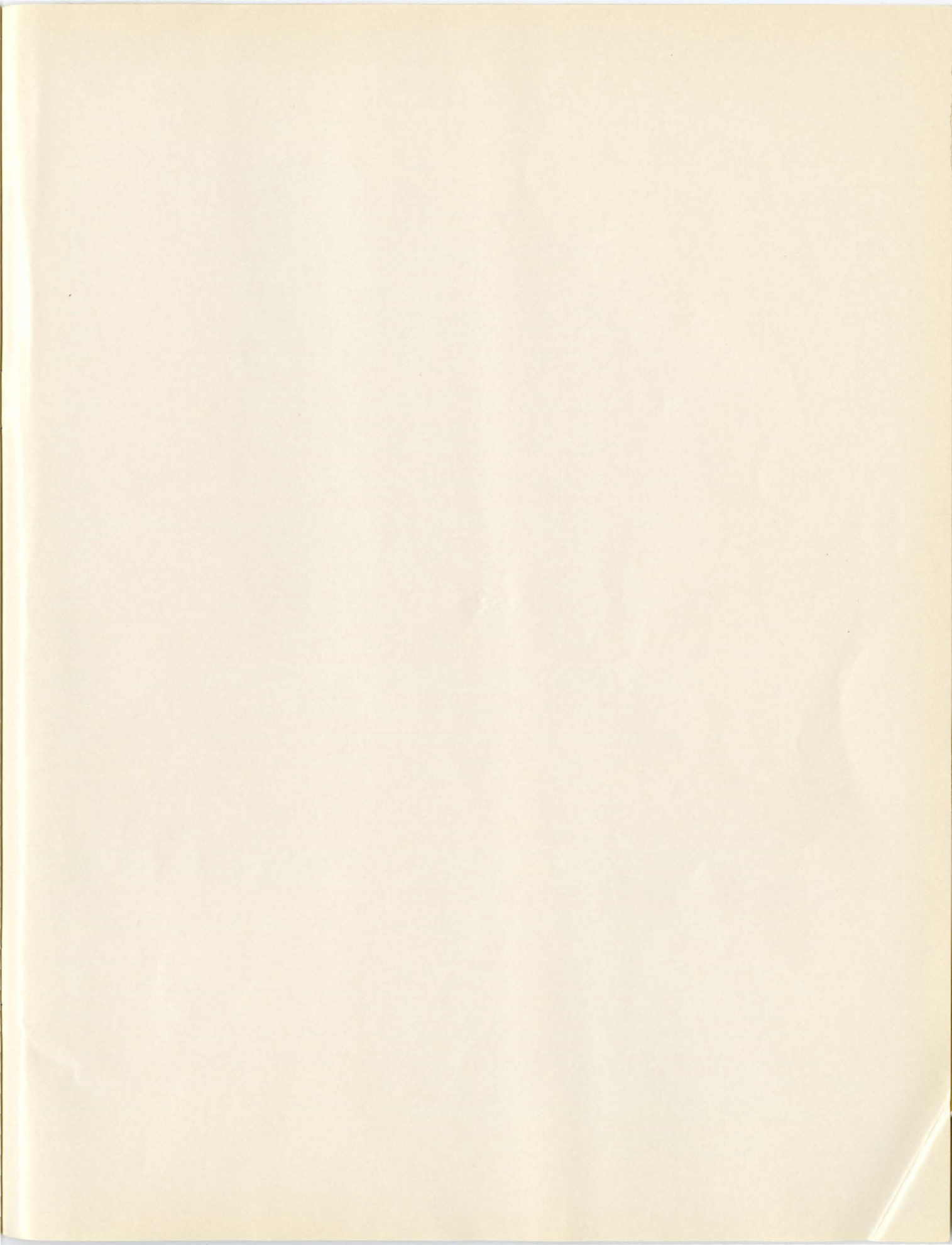
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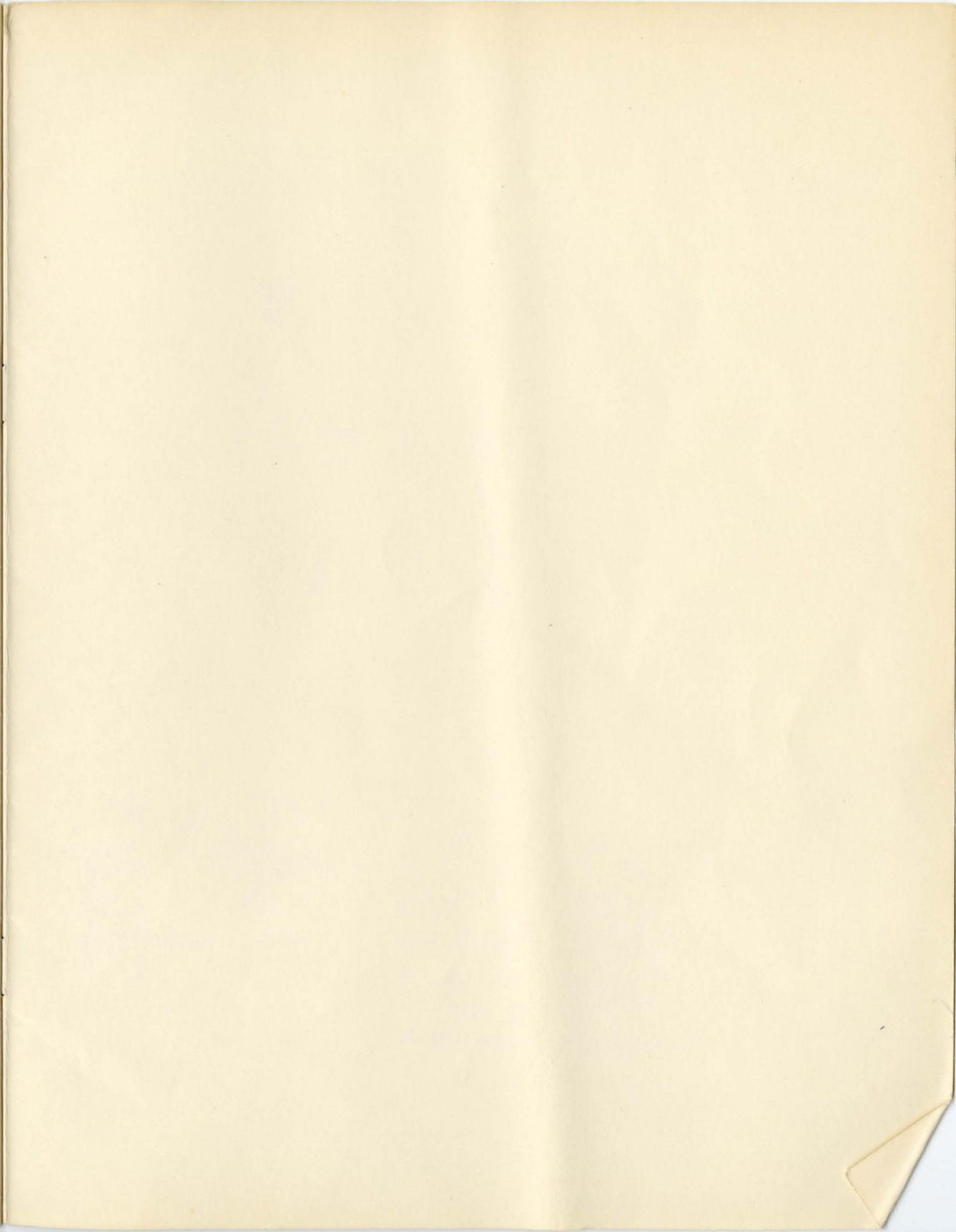
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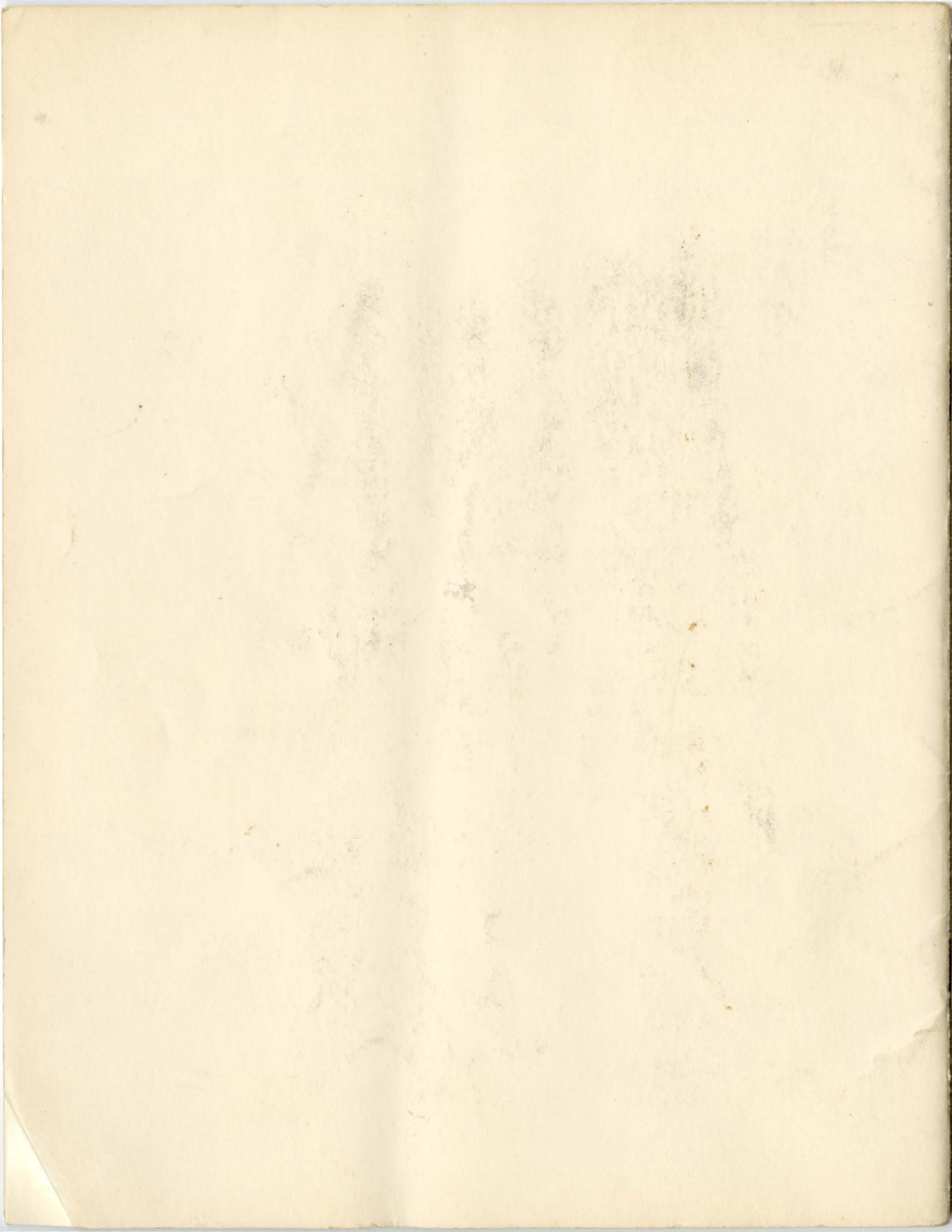
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B.







HEALTH RECORD

SYPHILIS RECORD

SECTION I.—HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS

DATE	DISEASE (Give stage)	PRIOR TO MIL. SERVICE		TREATMENT (Give type, amount and dates)	TREATING AGENCY	PLACE
		YES	NO			
1						
2						
3						
4						

SECTION II.—HISTORY OF PRESENT INFECTION

CAME TO MEDICAL ATTENTION BY: VOLUNTARY CONTACT REPORT PHYSICAL INSPECTION FOOD HANDLER

INCIDENT TO HOSPITALIZATION PREMARITAL PRENATAL OTHER (Specify) _____

DATES: ONSET SYMPTOMS _____ REQUESTED TREATMENT _____ DIAGNOSIS ESTABLISHED _____

DIAGNOSIS (Include stage and diagnosis No.) _____

DIAGNOSTIC CRITERIA (Enter results of tests)

DARKFIELD _____ S.T.S. _____

SPINAL FLUID (If indicated) _____

OTHER (List) _____

LIST VD CONTACT FORM SERIAL NOS. _____

CLINICAL DATA (Include chief complaint, physical findings—eye, cardiovascular and nervous system, even in early syphilis)

RECOMMENDED TREATMENT AND FOLLOW-UP _____

SIGNATURE OF PHYSICIAN _____ DATE _____

SIGNATURE OF PATIENT AND DATE _____

I HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION (Including certain prescribed tests) FOR THE CARE OF THIS DISEASE.

SECTION III.—TREATMENT

TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN
1			
2			
3			
4			

PATIENT'S IDENTIFICATION (Mechanically Imprint, Type or Print):

- ▶ Patient's Name—last, first, middle initial; Sex; Age or Year of Birth; Relationship to Sponsor; Component/Status; Department/Service.
- ▶ Sponsor's Name—last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

SECTION IV.—CUMULATIVE LABORATORY SUMMARY

RESULTS OF DARKFIELD EXAMINATION

	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER
1					
2					

RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS

	DATE	TYPE	RESULT (Include titer value)	LABORATORY		DATE	TYPE	RESULT (Include titer value)	LABORATORY
1					5				
2					6				
3					7				
4					8				

FLUORESCENT ANTIBODY TESTS

	DATE	RESULTS
1		
2		

RESULTS OF SPINAL FLUID EXAMINATIONS

	DATE	CELLS	TOTAL PROTEIN	SEROLOGICAL TESTS (Including titer)	LABORATORY WHERE DONE
1					
2					

SECTION V.—EVALUATION OF THERAPY

	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE
			Satisfactory*	UNSATISFACTORY**		
1						
2						
3						
4						

*Satisfactory result cannot be reported without normal spinal fluid findings.

**Specify: Infectious Relapse; Sero-Relapse; Neuro-Relapse; Incomplete data on Spinal Fluid; Other (Specify)

REASON FOR INADEQUATE FOLLOW-UP (Date, place and type of separation—Give authority for discharge)

PATIENT'S HOME ADDRESS ON SEPARATION

CIVILIAN HEALTH DEPT. TO WHICH CASE RESUMÉ WAS SENT

REINFECTION (Give date new record was opened)

REMARKS (Include significant posttreatment clinical findings)

SECTION VI.—MEDICAL OFFICER CLOSING THIS RECORD

NAME (Typed or printed)	SIGNATURE	STATION	DATE
-------------------------	-----------	---------	------

SECTION VII.—MEDICAL OFFICER SENDING ABSTRACT TO VETERANS ADMINISTRATION ON DISCHARGE

NAME (Typed or printed)	SIGNATURE	STATION	DATE
-------------------------	-----------	---------	------