RCPE Casenotes: Past & Present Podcast - Genitourinary Transcript

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[introductory music]

Welcome to the Royal College of Physicians of Edinburgh's Casenotes podcast. Over the next few months we're going to delve into the different physician branches or specialties.

Just to start off with, what is a physician? Most people know what a GP is, and what a surgeon is, but not everyone knows exactly what a physician does. Well the formal description is specialists in internal medicine, so diseases and complaints that happen inside your body. And even if that sounds unfamiliar, you have almost certainly heard of a lot of the areas that this covers, like cardiology, diabetes, allergies, palliative care, infectious disease and neurology. These are all branches of medicine, or specialties, that physicians are responsible for.

In each coming episode of Casenotes we will pick one of these specialties and delve into its history, looking at its development over hundreds of years, and some of the interesting stories and cases from the past. We'll also talk to a current physician working in that area, to find out what it is like to be working as a specialist physician in the twenty-first century.

[musical interlude]

In this episode of our Casenotes podcast we are going to talk about genitourinary medicine. We will start by looking at the history of genitourinary medicine. We're then going to talk to Professor Claudia Estcourt and Dr Andrew Winter, two current specialists working in the field. There's no historical case study at the end of this episode. Instead we're going to spend a bit more time than usual with Claudia and Andy, really getting into their experiences as modern day specialists.

But starting at the beginning. A lot of people have written a lot on the history of venereal infections. A lot less has been written on the history

of urinary complaints. But in reality it was often very difficult for doctors in the past to tell the difference between the two.

Bladder stones were a common problem in the seventeenth and eighteenth centuries and while technically the treatment for this was surgical, many patients were afraid of surgical procedures in a time before anaesthetics and good hygiene standards.

Fear of surgical cutting to remove stones, a procedure also known as lithotomy, was not uncommon amongst patients. Daniel Defoe, writing in 1725, described the experience of undergoing this procedure as being “torn and mangled by the merciless Surgeons, cut open alive, and bound Hand and Foot…the very Apparatus is enough to chill the Blood". Patients would often go to a physician, hoping that medicine would cure them instead of having to undergo surgery.

But while bladder stones were usually relatively easy to diagnose, in most cases neatly identifying and ordering diseases into either urinary or venereal was not simple. Leucorrhoea, a non-venereal disease, and gonorrhoea had exactly the same symptom – in both conditions being a whitish discharge.

Determining which of these conditions a patient was suffering from could be based on whether they were, according to one eighteenth-century doctor, "young women of suspic[ious] charact[er]” as much as on their medical symptoms. This was not an uncommon approach to the diagnosis of venereal complaints, particularly regarding female patients. Thomas Young, Professor of Midwifery at Edinburgh University, emphasised the importance of considering the “Character of the woman” when forming a diagnosis.

Leucorrhoea was not the only condition which could prove difficult to distinguish from a venereal infection. Various skin diseases could look a lot like syphilis. Smallpox also could manifest in a very similar way. Syphilis was often known as the “great pox”, and this was to distinguish it from smallpox, the similarity in their names showing how easily they could be confused. And the list doesn’t stop there: rheumatism, tuberculosis, ulcers, gout, all of these were at one time or another confused with venereal diseases.

Even identifying what was meant by the broad category of venereal disease is complex. Where the term venereal was applied in the eighteenth century, it was often used to describe a range of genitourinary and skin complaints, not all of which were the result of sexual activity.

This is exemplified in the case of sibbens, a skin complaint common in Scotland in the eighteenth century. A Dumfries surgeon, James Hill, argued that this disease was not necessarily transmitted by sexual contact, but rather often passed between members of a family who shared a bed or cutlery, but because he believed the original first case of the condition had been transmitted sexually, it should be identified as a venereal condition. So according to this definition, the category of venereal disease could include diseases which were not transmitted primarily through sexual contact.

Wrapped up, of course, in any discussion about genitourinary disease is the underlying morality and shame. Euphemistic language was often used, particularly when the patient was a wealthy paying client. For example, in a letter to Edinburgh physician, William Cullen, dated February 1782, Dr Alexander Hunter noted that although he believed that the complaint of his patient, the son of Sir Hedworth Williamson of Durham, included a venereal taint, “this is a subject of great delicacy, [Williamson] being engaged to marry a young Lady”. This did not diminish the doctor’s suspicions, but rather resulted in the decision to forgo pronouncing this diagnosis, because “such a connection would be highly imprudent at present”. You have to feel for the poor unsuspecting wife.

Moral censorship is more obvious when we’re looking at poor patients. When John Mason Good, a fellow of the Medical Society of London, carried out a survey of English workhouses, he wrote on the subject of venereal infection that the poor “are liable to…a thousand temptations, which every superior rank of life is free from; and they feel not, from want of education, the same happy exertion of delicacy, honor, and moral sentiment, which every where else is to be met with”. Even more stridently, the regulations of Edinburgh’s St. Cuthbert’s Charity Workhouse stated that a failure to follow their regulations would result in an adult being "deprived of their next meat”, with repeat offenders “locked in a room, without getting any food or water for a whole day”. In

such institutions, therefore, charity was often interwoven with elements of moral reform and condemnation.

Cases of deception were unsurprisingly more common when hospitals refused to admit patients suffering from venereal complaints, which was the usual model of English infirmaries. The Edinburgh infirmary, unusually, did admit venereal patients. But they separated, as they put it, those “female patients…being sufferers, not by any fault of their own" from those "whose conduct and manners are less correct”. These venereal wards were known as “foul wards” or “salivating wards”. ‘Salivating’ referred to the use of mercury to treat syphilis, a common by-product of the use of mercury being that patients produced a large amount of saliva.

[musical interlude]

Daisy: So thank you, so joining us today we have Professor Claudia Estcourt and Dr Andrew Winter, and we are looking at genitourinary conditions and they are specialists in the field. So I was just wondering if we could start off by each of you just introducing yourself, telling us a little bit about you. Claudia, could you start?

Claudia: Hello, everyone. I am a clinical academic, which means that I do a lot of research in addition to my clinical work, so clinically I practise at Sandyford Sexual Health Services, which is the largest sexual health service in Scotland and that’s based in Glasgow, and my research base is Glasgow Caledonian University and also University College London.

Andrew: And hello to everyone from myself, I’m Dr Andy Winter. I’ve been a consultant in genitary medicine, sexual health and HIV in Glasgow since 1999, and the last few years I’ve also branched out into doing digital health leadership, which is that place many people in my specialty seem to end up doing, and I work at the Sandyford clinic along with Claudia and also run an HIV service at the Brownlee Centre in Gartnavel as well.

Daisy: Thank you very much. So we start with the biggest question, which is – what is genitourinary medicine? What does a specialist in that field do?

Andrew: I think Daisy, it's important there, it's quite a unique British specialty and there's a long history which you might get into later on about how the specialty arose from sort of World War I, and in Europe it's known as dermato-venereology so our colleagues in Europe spend a lot of time being skin doctors, quite a lot doing cosmetic surgery and so on, and a little bit of STIs on the side, whereas in the UK and indeed in Australia, this is a sort of proper specialty, which is a true medical specialty. You can become a consultant physician in this specialty, although it's largely outpatient based, and that's because of the breadth of what we do, particularly under public health control. So I think that's one of the differences as well, is that the people looking at international careers, this specialty is not recognised in quite the same way as, for example, cardiology or endocrinology might be around all countries, and it's quite hard to find what it's called in other countries, but they all have people who specialise in this area but they might be immunologists or infectious disease physicians or gynaecologists, and so that's one of the challenges we have about recognition.

Daisy: Thank you very much. So I suppose, you've touched on what it is, I'm also interested in what it isn't. So, you know, what are the sort of stereotypes or the misconceptions, the things that people get wrong about genitourinary medicine?

Claudia: Andrew, do you want to start on that one?

Andrew: Yeah, I think some, it's, the specialty's come a long way, you might ask us later on about what sort of advanced it, but, I mean back in the 1970s, I can just [unintelligible] into my first student attachment in the early eighties, you were in sort of basement clinic, classically in a hospital and you had a sort of crusty old person with a wire loop steriliser and a bunsen burner inserted very painfully into the urethra of some unsuspecting male who'd crept in wishing not to be seen. I think that's the misconception, I think that's largely finished now, I think people recognise that we have a very important role. Our clinics see well over a million people every year in the UK, our own sexual health computer system in Scotland has something like one and a half million people registered on it, so we've seen, you know, through our services something like a third of the population of Scotland. So we're actually really very busy, we have a very high footfall and contacts, and we have a very wide breadth of patients of both genders and ages as well, so it's

not just all about young people, it's not just all about men who have sex with men.

Claudia: Yeah, I think I'd add to that, it's a really fun, vibrant and diverse specialty, and that's reflected in the staff as well as in the people who use our services, and I think we are very pro-change, partly because we don't have any problems talking about STIs, HIV, talking about sex. So that attracts into the specialty people who are very open-minded and hopefully people who are non-judgemental. So that particular mix of both staff and people in the academic circles means that you can have great debates, it means that I hope we're extremely open-minded, there's a diversity of lens through which we see medicine and we have to, because that's really important for making people feel they can come and see us and we are happy, we don't judge, we listen and we manage as far as we can and hopefully expand people's horizons and our own.

Daisy: Thank you. So, what I'm going to ask you next is probably the worst thing to ask you, given everything you've just said about how varied your work is, how many different things that everyone is involved in. So I was going to ask you, what is a 'day in the life'? It sounds like that's not an easy question to answer, but I'm just sort of curious. Claudia, you know, what is, you know, an average day if there is even remotely such a thing in your work?

Claudia: OK, I'll try and answer that the easy way, which is giving you an idea of the sorts of things that I do, and then bringing in a few other ideas, and then you have to ask Andy cause he's got some fascinating bits of his job, which again illustrate the diversity within the sorts of roles that we have at consultant level and particular interests. So I don't have a typical day, I kind of have a typical week or a typical month, and it always starts for me with one of my favourite days, which is Mondays in clinic.

So Mondays in clinic in Glasgow I am doctor of the day, and that's the role that I love, because as the consultant right in the middle of the clinical floor, I'm responsible for the safe and effective running of the service. So I will be answering people's questions, popping in examining patients when staff (not just doctors but across the multidisciplinary team) have questions, taking every opportunity to teach them – many people have skills they need to acquire, and they have quite an in-depth

talk with an individual patient because we are a very multidisciplinary specialty, and it can be very difficult to know exactly why a person is attending, because sometimes people don't realise that they can come straight to our service, they don't have to be referred by a GP, and that's really different from almost all other medical specialties, where you need a GP referral. So it could be, for instance, that a relatively junior nurse is seeing somebody who it would appear had a straightforward problem, immediately she or he picks up that that individual has a much more complex problem and I'll be asked to come in and help. I might be answering telephone calls from obstetrics, gynaecology, from local GPs to talk about patients for which, for whom they would like advice. I might be looking at complex lab results on some of our patients and helping decision making, supporting staff, looking at training, maybe speaking to public health if there are particular issues. So that would be a very typical clinical day for me. But within the role, looking at the service – can we deliver care more efficiently, how might be want to change things, how do we involve our services users and those who we most want to use the service but currently don't.

Again, another big part of my job is research and my research focuses on prevention of transmission in the broadest sense. So one of the strands looks at HIV pre-exposure prophylaxis, which is when you take anti-HIV medication to prevent you acquiring HIV. Another is looking at digital health, and that's certainly something that Andy will talk about, that's one of his interests as well. And then finally for me, teaching and education of the next generation of consultants, helping the junior doctors get the skills and experience they need to be accredited to become a consultant themself. There will be lots of activities that I have forgotten, and lots that Andy does that I don't, so I think I should hand over to him now.

Andy: So it's very varied, I mean, I started this morning taking the dark ground test for somebody with primary syphilis. Now this is one of the surprising things that syphilis is really common, so it's not a condition that you just see medieval illustrations or only affecting Victorian kind of people, and it was very satisfying teaching a senior nurse exactly how to get the best sample, and getting that successfully. This person arrived at nine in the morning with quite a painful lesion, by kind of quarter to ten he's fixed and diagnosed and fully treated with injectable penicillin. All that technology's actually fifty to a hundred years old, so we're using

dark ground microscopy with a very skilled microscopist so there's that pleasure of using something and actually seeing the organism you're treating literally wiggling in front of you, and being able to treat that person, and they leave the clinic fixed and sorted, having not known what on earth was going on.

But then in between that I'm trying to sort out getting in someone who's moved to Glasgow with HIV infection with other problems, kind of a proper clinical pathway and finding a space and place and reassuring him that treatment was free, we can sort things out, while also batting discussions with the labs about why their turn round time has lapsed a bit. And because we're facing pressures in our service, with COVID having taken resource, but we still have people with acute STIs coming in, like the person I saw with syphilis, we need the diagnostic tests to turn around as quickly as possible. So that attention to service quality and detail.

And then in the afternoon, you know, working on protocol revisions around the various conditions that we've got, which are being launched next week, and making sure that the services is got all the right quality standards, and importantly they're in place, and always looking for the loose ends and the flaws and the holes in the system through which people can fall. So it's a huge amount of our work to just make sure the whole system's running and ticking, that's where the digital stuff comes in cause we rely a huge amount on the safety nets, and making sure that they all are in place. Because it's so busy and we do so much testing, most of the tests we do are completely clear, but we have to have really efficient systems to pick up positive results, make sure people with conditions are managed and treated correctly.

Daisy: Thank you very much. So, this is again a possibly, a slightly tricky question, and I think you've both touched on examples already, you know, Andy you've mention syphilis, but are there any particular cases or particular diseases that you found – I say interesting, but perhaps challenging or unusual – that could kind of give people a bit of a feel of the sorts of work that you do? Obviously without breaching data protection by giving any patient names or anything like that.

Andy: For people that are approaching my age they were those really challenging cases, we just won't forget the 1990s. I still actually see the

patients I looked after then and the Kaposi's [?], I mean that's the challenge, I think that sort of stays with you. For all those people that lived through that era, it's still very present, actually in the work you do, even though you're thankful of the advances that we've had. I would probably talk about another one. We did quite a lot of outreach education in our clinic, we made a programme called *Sex, Warts and All* in 2001, I think it was, and I think I did the world's first televised proctoscopy, so, and it was amazing to have somebody – I think it illustrates this specialty – we had a patient who (I won't name him) but he was willing to be filmed on national TV with me, demonstrating the kind of things that happen when you go to a clinic to try and destigmatise what happens when you go to a clinic, and we had a camera crew and lights and all the usual stuff, and this was amazing, because this helped really show people what happened in our clinics and what went on.

And all that was fine until I was staying with some cousins down in London only a couple of years later and late night TV's on and there I am on the telly, popping this proctoscope into somebody's rear end. But I think the fact that someone would agree to do that, and we had that relationship and trust, and it was something that this person valued sufficiently to try and show others what was needed and to break down the stigma, which back then was still – you know, we're talking about twenty years ago now – still was a difficult, we still had specialist services [unintelligible] and there were still a lot of concerns, and I think that stuck with me very much, that there was a willingness from the grassroots to be able to help others use the service that they've found helpful, and sufficient to having essentially, you know, themselves being filmed in quite awkward positions on the telly.

Daisy: Thank you, that's very fascinating and very brave, I think, for that person to put themselves in that position. So Claudia, you know, are there any particular standout, sort of, moments in terms of patients or diseases that you can think of from your career?

Claudia: I think I'm going to agree with Andy and I think doctors of our generation in the field were – our practice, our beliefs – were so influenced by those early days of HIV and patients taught us, and we worked with people, and the medicine was very, very complex, and it was emotionally hugely draining. But there was a feeling which has

continued with some people from the community of people living with HIV of “we are doing this together", this community plus the medics in the widest sense, and I think that’s hugely important and genuinely is something at our core. And I feel that that – and like Andy I have now flashing in front of my eyes memories of people, many of whom did very well, many of whom lived just too soon, too early before the drugs came in and didn’t survive – so I think in the specialty of our generation that’s huge, and that has really shown us what a privileged job we have. I think medicine is the most privileged job in the world. People tell us incredibly private information, they trust us with very private information and not just in what now for some would be historic times, but today.

Daisy: No, and I think those challenges also make it, sort of, particularly fascinating as a specialty as well. So Andy, you’ve touched on a little bit about how these sort of future changes might impact, you know, the next generation of specialists in the field. Is there anything else that either of you would recommend if people are considering this specialty? You know, is there a particular approach they should take at school or university subjects they should study, you know, things they should read for more information?

Andy: Yes, there’s a few things, aren’t there, you have to be inquisitive about human life. I mean, you’ll never get bored sitting in the clinic listening to stories, but if you’re not inquisitive about kind of why people do the things they do, and understand the breadth, and getting that kind of life experience, is important. You’re going to need a grounding in some of the basic science, microbiology, so you’ll need more than a passing understanding of whole genome sequencing and typing and these kind of things are likely to be quite an issue coming forward. And then you will need that general medicine view, so if we continue to look after people with HIVs, I have people with HIV in their seventies and even eighties now, so you have to be pretty across, the kind of, how primary care works, how health systems work, and you often help people navigate quite a complex health and care system. Many of the people we look after haven’t navigated that very well, or lack some of the skills to do so successfully, so you’ve got to be a really good advocate for them and help them find ways, and definitely a problem solver. So we’re really looking for inquisitive problem solvers who know quite a lot about microbiology, really good at listening to people and make cogent, sensible plans and are able to do that in outpatient

settings very quickly, but also happy to look after people for twenty-five years who have a long-term condition. So that's the kind of challenge. If that's attractive to you then there's a big community waiting for you.

Daisy: So I'm going to ask you a final question now, it's the question which we cannot avoid when making a podcast in, as it is, January 2022, which is COVID. So I'm interested to know for your specialty, how has it impacted your work, but also how has it impacted your specialty more generally, do you think?

Andy: We've looked at this across Europe, actually, there's been a lot of concern about the lack of access to services. So we, in our own area, we've kind of kept things running, we kept the lights on, we had to radically reduce the footfall. We had to close walk-in clinics because it wasn't really safe to have, I mean there was, not that long ago we had, I think I counted 110 people in the waiting room at ten to nine, waiting to be seen, so we've had to stop those kind of clinics. We've aggressively pushed, sort of, digital first, but as Claudia will mention, I'm sure, that the inequalities then comes to fore. So we've reduced the number of people we're testing for conditions like HIV, so we're very worried that we're missing conditions that otherwise would not have been picked up, and that's been the case right across Europe. Some countries have recovered better than others in terms of keeping that service going.

We've had challenges over laboratory capacity, because people have been diverted into COVID, and there's another challenge which is the sort of, if you like, the intellectual capacity, the ability to think and plan of a new service. If you, if I go to my lab colleagues and say "Hey, I've got this great idea for a new service, let's all test for Trichomonas [?] and molecular testing", no one's got any energy left, you know, you have to be really good at engaging and in trying to enthuse people, because everyone is really shattered after making so many transitions and changes, so getting new stuff done is getting harder, and we'll need a bit of recovery time to do it. At the same time, COVID is clearly bringing us a new era of vaccination or vaccinology, and we have a massive shed-load of molecular testing kit that will not be needed for ever, to test for COVID, so hopefully we might be able to divert some of that to testing for some of the STIs and get some good turnaround time. And the population have also learnt how to do self-swabbing, self-registration,

self-resulting, which we were uncertain would happen, so some of those things I think will be very positive.

Daisy: Thank you very much, and it is, yeah, the impact as you say is so vast in so many different ways. Is there anything else, Claudia, that you can think of in terms of COVID, and also I suppose the future, do you think, what do you think the changes of COVID will be impacting in two years' time or three years' time, do you think?

Claudia: I think they undoubtedly will across the NHS and, like Andy, I'm really worried. I do feel that eyes have been almost exclusively focused on COVID-related health issues, and I am delighted that there are certainly signs that we need to refocus, because COVID is not the only virus in town. I think as well it's been very easy for people to assume that people just shouldn't be having sex, there's just too much important stuff going on. Now we know from behavioural surveys that for most people sexual activity did drop, and I think actually that itself is going to have implications. I really worry about young people, I worry about them because of COVID, because of the impacts that their stasis of life for two years has had, to say nothing of the more significant impacts to do with their education. And for young people sex is tremendously important, it's part of life, those are the years when people get to have their sexual debut (that's a lovely term we have in our specialty), as they start their sexual careers (that's another one for you), and that's a tremendously important part of growing up. I worry that that's been very fragmented for some people, and I worry that isolation has been hard.

Sexual health is so linked to good mental health, so I think that for us as a specialty is incredibly important to recognise, and also to perhaps project a little bit about what happens going forward as well, because many STIs are present without any symptoms, so we have to try very hard to entice people to come in to our service or at least to access check-ups. We've spent a huge number of years, and when we thought we were getting reasonable at that, and then suddenly we had to tell people to stop getting check-ups because of COVID, so there's going to be really work to be done there as well. And I think too, as we move forward there will be fewer resources around, so we need to getting smarter, we need to be doing more for less and I think that we'll need to embrace the new technologies that we talked about, but with a very

close eye on whether that risks widening health inequalities, such that the people who most need care are the ones least likely to access it.

But with challenges also come opportunities. The specialty, as we've said, is quite good at change, so there have been [unintelligible] innovations brought in and again we've done a lot of these nationally, not just Scotland nationally but UK wide, to look at ways that we can streamline pathways of care, do telephone assessments wherever it's feasible. Now for some people that reduces the cost of attending a service, cause they don't have to pay for transport, so I think there are reasons to be cheerful, but I think there are also grave challenges for us as we fight for our viability and the need for our services with all of the other important medical specialties and issues for other people outside of STIs and HIV.

Daisy: Thank you, thank you, so I have now run out of questions to ask you, so before we finish up though I just wanted to ask – is there anything that we haven't talked about that you'd like to bring up that feels important to you or that you'd like to, that you would ideally like me to ask you?

Andy: No, I think the challenge is to help people understand that the clinical service is running. I think one of the biggest things is, you still see people is, didn't know we were open for business, and so if anyone is listening who perhaps has something they have ignored or a vaccine they might have missed or, and so on, I think that it is really important to just try and find out and make sure you get some help, because I think it is one of the challenges you've got at the moment is people just, perhaps, not being sure that the services are running, and I think that's really important that people understand that we are very much wanting to see people with conditions as well. And obviously anyone that wishes to ask anything else more deeply about a career, or what they want to do, there are many resources to look for. I would just highlight the professional association's called BASHH (https://www.bashh.org/) and there's a wealth of information there, and there's a very good sort of student branch that if you like, they're quite active on Twitter as well, so many STI doctors are fairly active social media users as well, and you'll probably see and follow a few people to get a feel for what's happening in the specialty as well.

Daisy: Thank you so much, and well thank you both for joining me, Claudia and Andy, it's been fantastic.

[musical interlude]

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