

The Great Pox and the Secret Disease

**Humanity in the Face of Syphilis, from Naples to the Twenty-First
Century**

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Abstract

Syphilis is one of the diseases whose history reaches far beyond medicine. From the explosive epidemic recorded during the Italian Wars at the end of the fifteenth century, it accompanied armies, migration, urbanisation and the creation of global trade routes. At the same time, it became an instrument of moral judgement: it was blamed on foreign nations, sex workers, the poor, sexual minorities and racialised communities. Over the following centuries, responses ranged from expulsion and isolation to specialist hospitals, police surveillance, military campaigns, screening programmes and modern epidemiology. This chapter presents the social and political history of syphilis from the Neapolitan epidemic to the contemporary rise in reported infections. Questions concerning the bacterium's origin, detailed diagnosis and treatment are included only where they are necessary to understand historical change.

Keywords: syphilis, history of epidemics, sexually transmitted infections, public health, stigma, bioethics

Editorial note

This text has been designed both as a self-contained popular-science article and as a chapter in a wider work on infectious diseases. It does not attempt to settle the debate about the geographical and evolutionary origin of *Treponema pallidum*, which belongs in a separate chapter. The history of treatment is mentioned only when it altered society's perception of the disease or the organisation of care. Epidemiological data reflect sources available up to July 2026.

A plague enters history

It is impossible to identify the day on which the first European contracted syphilis. It is possible, however, to identify with reasonable precision the moment when the disease ceased to be the private misfortune of individual people and became a historical event. That moment came at the end of the fifteenth century, in the age of the Italian Wars, transoceanic voyages, expanding commerce and political upheaval.

Europe was opening itself to the wider world. People, goods, armies and ideas began to move on a previously unprecedented scale. Microorganisms travelled with them. The first well-documented European outbreak of the disease later known as syphilis occurred during the campaign of King Charles VIII of France against the Kingdom of Naples in 1494-1495.¹

Within a short time, the illness was being described in Italy, France, the German lands, Switzerland, Spain, Poland and Rus'. Within a few decades it also appeared in Asian records. It was one of the first epidemics of the age of print: news about it circulated not only in letters and chronicles but also in broadsheets, woodcuts, poems and medical treatises.

Unlike plague, syphilis did not usually devastate entire cities within a few weeks. Its historical terror was different. The disease could develop slowly, vanish from the surface of

¹ M. Tampa et al., "Brief History of Syphilis," *Journal of Medicine and Life* 7, no. 1 (2014): 4-10; Lisa Ekselius, "The Syphilis Pandemic Prior to Penicillin: Origin, Health Issues, Cultural Representation and Ethical Challenges," *Acta Dermato-Venereologica* 104 (2024): adv34879.

the body and return years later as damage to bones, the cardiovascular system or the nervous system. It combined the explosive force of an epidemic with the prolonged suffering of a personal tragedy.

An infected person could continue to live, work, travel and form relationships without knowing that the disease remained present. This ability to hide made syphilis an exceptionally persistent companion of human history.

[ILLUSTRATION PLACEHOLDER 1]

Suggested image: a map of Charles VIII's Italian campaign in 1494-1495 and the principal routes along which the disease spread after the army's retreat.

Editorial note: an original map based on a historical atlas would be preferable; Naples, Rome, Florence, Fornovo and the mercenaries' return routes should be marked.

Naples, 1495: the army as a travelling city

In the autumn of 1494, Charles VIII entered Italy at the head of a multinational army. Alongside French troops were Swiss, German and Spanish soldiers and mercenaries from several Italian states. They were accompanied by servants, traders, drivers, craftspeople, beggars and people selling sexual services. The total moving population was considerably larger than the fighting force alone.

Such an army resembled an enormous travelling city. People lived in crowded billets and improvised camps, used local inns and brothels and dispersed among civilians after a town had been occupied. War brought commercial sex, rape, coercion and the breakdown of ordinary social restraints. Together, these conditions favoured the transmission of an infection spread through close physical contact.²

In February 1495, the French army occupied Naples. Soon, soldiers and residents were suffering from a severe disease marked by ulcers, extensive skin lesions, pain in the limbs and progressive wasting. In the summer, Charles VIII's army began to withdraw. Mercenaries returned to their own countries or enlisted in other forces. The disease moved with them.

The war for Naples need not have been the biological birthplace of syphilis. It was, however, a powerful amplifier of transmission. It gathered people from many regions, joined mass mobility to violence and then dispersed the participants throughout Europe. The same mechanism would recur during the Napoleonic Wars, the two world wars and periods of large-scale migration.

Popular accounts frequently claim that the first epidemic killed five million people. This figure cannot be accepted as a reliable demographic total. Late-fifteenth-century Europe had no unified system for recording cases and deaths, and physicians did not always distinguish syphilis from other diseases causing rashes and ulcers. We can speak of a wide geographical reach, large numbers of severe cases and a profound social shock, but not of a precise death toll.³

² Gabriella E. C. Gall et al., "Quarantine as a Public Health Measure against an Emerging Infectious Disease: Syphilis in Zurich at the Dawn of the Modern Era (1496-1585)," *Hygiene and Infection Control* 11 (2016): Doc13; Tampa et al., "Brief History of Syphilis."

³ The figure of five million is often repeated in popular literature but is not derived from comparable demographic records. On the limitations of the evidence, see Jon Arrizabalaga, John Henderson and Roger French, *The Great Pox: The French Disease in Renaissance Europe* (New Haven and London: Yale University Press, 1997).

The first blow: a disease more violent than it later became

Accounts from the turn of the sixteenth century describe an exceptionally severe illness. Skin lesions were said to be numerous and extensive, ulcers foul-smelling, bone pains excruciating, and some patients died within months. Italian and German writers compared the new affliction with leprosy, smallpox and elephantiasis while stressing that it was identical to none of them.

One of the earliest printed images associated with the epidemic is the so-called *Syphilitic Man* of 1496, a woodcut traditionally attributed to Albrecht Dürer. It shows a mercenary covered in lesions. Zodiacal signs appear above his head because some scholars explained the outbreak through an ominous conjunction of planets. The image brought together three of the period's fears: war, bodily corruption and cosmic disorder.⁴

[ILLUSTRATION PLACEHOLDER 2]

Suggested image: *Syphilitic Man*, woodcut attributed to Albrecht Dürer, 1496.

Suggested caption: One of the earliest printed representations of the new epidemic. The mercenary associates disease with war, while the zodiac evokes an astrological explanation of pestilence.

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Over the following decades, the clinical picture changed. Syphilis did not disappear, but it increasingly became a chronic illness developing in stages. One hypothesis is that natural selection favoured less rapidly destructive variants: strains that did not kill their hosts quickly had more time to reach new people. Changes in population immunity and more precise recognition of symptoms may also have contributed.⁵

There is no single proven mechanism for this transformation. Historically, however, it was of great importance. In its most violent form, the disease provoked panic comparable with that inspired by other plagues. As it became more chronic, it entered everyday life: marriage, childbirth, inheritance, the ability to work and the reputation of entire families.

Syphilis was not a one-season epidemic. It remained within society across generations.

The disease always came from somewhere else

Before the term “syphilis” became widespread, Europeans used names that identified an alleged culprit. Italians and Germans spoke of the “French disease”. In France it became the Neapolitan or Italian disease. The Dutch blamed the Spanish, Russians blamed the Poles, and people in the Ottoman Empire called it the Christian or Frankish disease. In Poland it was known by names including *franca*, the French disease, the German disease, *przymiot* and the secret disease.⁶

These names reveal less about genuine routes of transmission than about politics, fear and prejudice. The illness was attributed to neighbours, enemies, foreign soldiers, sailors, pilgrims, Jews and people regarded as morally suspect. The psychological mechanism was

⁴ “Syphilitic Man, ascribed to Albrecht Dürer (1496),” German History in Documents and Images, accessed 13 July 2026; Ekselius, “The Syphilis Pandemic Prior to Penicillin.” The attribution to Dürer remains disputed.

⁵ Robert J. Knell, “Syphilis in Renaissance Europe: Rapid Evolution of an Introduced Sexually Transmitted Disease?” *Proceedings of the Royal Society B* 271, suppl. 4 (2004): S174-S176, <https://doi.org/10.1098/rsbl.2003.0131>.

⁶ Tampa et al., “Brief History of Syphilis”; Claude Quétel, *History of Syphilis*, trans. Judith Braddock and Brian Pike (Baltimore: Johns Hopkins University Press, 1990).

simple: if an epidemic disturbed the order of a community, it was assumed to have arrived from outside.

During the first outbreaks, blame was even placed on communities that were themselves victims of persecution and forced migration. Some Italian accounts accused Jews expelled from Spain in 1492. Such accusations did not arise from epidemiological knowledge but from established patterns of xenophobia. As during earlier plague epidemics, disease became a pretext for identifying a group that could be held responsible.

The “national” names of syphilis formed a map of European conflict. Every community portrayed itself as the victim and the illness as a neighbour’s gift. In reality, the disease had no nationality. It followed human movement: war, trade, shipping, pilgrimage and migration.

This habit of thought did not vanish with the rise of microbiology. In later centuries, infectious diseases continued to be associated with immigrants, minorities and “foreign customs”. Syphilis was one of the earliest and clearest examples of a pathogen being fused with the image of a political enemy.⁷

From the “French disease” to syphilis

The name that eventually entered medicine was born not in a hospital or laboratory but in literature. In 1530, the Italian physician and poet Girolamo Fracastoro published the Latin poem *Syphilis sive morbus gallicus* - “Syphilis, or the French Disease”. Its central character was a shepherd, Syphilus, who offended the sun god and was punished with a wasting illness.⁸

The story belonged to a long tradition of explaining epidemics as punishment for sin, pride or disobedience. At the same time, Fracastoro was among those scholars who attempted to understand disease as something transmitted between people. In his later *De contagione et contagiosis morbis*, he considered invisible “seeds of contagion” capable of passing directly between people, through objects or at a distance.

He did not know bacteria, and his ideas were not germ theory in the modern sense. They were nonetheless an attempt to move beyond explanations based entirely on divine wrath, astrology and imbalance among the bodily humours.

The word “syphilis” did not triumph immediately. Terms such as *lues venerea*, the great pox, *franca*, *przymiot* and the secret disease continued to be used for centuries. Gradually, the literary name of a shepherd became a medical term and entered European languages.

The history of the name shows how deeply medicine, religion, poetry and mythology remained intertwined. Before the disease could be seen through a microscope, people tried to give it meaning through a story.

⁷ Howard Markel and Alexandra Minna Stern, “The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society,” *Milbank Quarterly* 80, no. 4 (2002): 757-788, <https://doi.org/10.1111/1468-0009.00030>.

⁸ Girolamo Fracastoro, *Syphilis sive morbus gallicus* (Verona, 1530); “Etymologia: Syphilis,” *Emerging Infectious Diseases* 17, no. 6 (2011): 1158.

[ILLUSTRATION PLACEHOLDER 3]

Suggested image: a title page or early edition of Girolamo Fracastoro's *Syphilis sive morbus gallicus* (1530).

Suggested caption: The modern name of the disease derives from the mythical shepherd Syphilus and gradually displaced numerous national and moralising terms.

Rights: the early printed work is in the public domain; a high-resolution reproduction should be obtained from a library with clear reuse conditions.

Sin made visible on the body

Syphilis rapidly came to be regarded not only as a disease but as evidence of moral guilt. Once its association with sexual contact had been recognised, infection was interpreted as punishment for promiscuity, adultery or the purchase of sex. In the eyes of others, the sick person became both patient and defendant.

Other infectious diseases also produced fear and stigma, but the stigma of syphilis was unusually intimate. Illness could reveal a secret about sexual life. It could threaten a marriage, a place at court, a clergyman's reputation, an official's career or the future of a woman economically dependent on her family.

Visible skin lesions, hair loss, scarring and facial deformity meant that the body could disclose what the patient wished to conceal. Late disease could destroy tissue in the nose and palate. In societies where the face was central to recognition, honour and social standing, disfigurement could become a social catastrophe.

Wigs, powder and elaborate clothing may sometimes have helped to hide hair loss, scars or skin lesions. It would nevertheless be misleading to explain the European fashion for wigs solely through syphilis. Court fashion had many sources: imitation of rulers, status display, protection from cold, hygienic practices and the concealment of many kinds of imperfection. Syphilis may have been one factor, but it was not the only one.

Lists of famous people supposedly afflicted by syphilis require equal caution. In many cases, diagnoses were made centuries after death on the basis of incomplete descriptions, court gossip or sexual reputation. Syphilis could mimic numerous neurological, dermatological and systemic diseases. Without laboratory tests, certainty was usually impossible.

We learn more from people who described their own suffering. The German humanist Ulrich von Hutten left an account of pain, foul ulcers, isolation and exhausting therapies. Modern researchers caution, however, that parts of his description need not correspond exactly to the modern clinical picture of venereal syphilis. This is an important reminder: personal testimony is invaluable, but it too must be interpreted.⁹

Not merely a disease of courts

In Poland and elsewhere, syphilis was sometimes called the "court disease" or "courtly affliction". The phrase is potentially misleading. The illness was not confined to palaces,

⁹ Urs Leo Gantenbein, "The Poet Ulrich von Hutten (1488-1523) and the French Disease," 2025. Gantenbein cautions that historical descriptions of the "French disease" do not always correspond to the modern clinical picture of venereal syphilis.

aristocrats or elites. It affected soldiers, craftspeople, merchants, servants, rural migrants, sex workers, clergy and the family members of infected partners.

Elites left behind more letters, diaries, bills and medical records, so their illnesses are more visible in historical sources. Poorer patients usually appear only in hospital registers, municipal records and expulsion orders. This creates an illusion that syphilis was primarily a disease of monarchs, artists and philosophers.

The infection crossed class boundaries, but its social consequences depended on wealth, sex and status. A wealthy patient could obtain a private physician, discretion and good nutrition. A poor person might be expelled from a town, confined to an institution or delivered into the hands of an itinerant “specialist”.

Syphilis was therefore not democratic in the full sense of the word. It infected people across social ranks but did not impose the same fate on all of them.

Cities respond: expulsion, isolation and the first institutions

European municipal authorities quickly recognised that the new disease was not exclusively a private matter. They did not know bacteria or the exact mechanisms of transmission, but they observed that the illness passed between people and followed newcomers.

One of the best documented responses occurred in Zurich. As early as 1496, the city council issued orders concerning people suffering from the “evil pox”. Initial measures included expulsion and restrictions directed at outsiders and people regarded as sexually immoral. The city then created a special institution, the *Blatternhaus*, for the isolation and care of patients. Municipal physicians supervised admission, confinement and discharge, while the community paid for poor patients.¹⁰

This was an important stage in the development of public health. Authorities no longer relied solely on prayer and moral instruction. They created an institution, employed medical practitioners, set rules for admission and financed maintenance.

These measures did not rest on modern epidemiology. People with visible symptoms were isolated, while infected people without skin lesions remained in society. Care was joined to repression, and poverty to suspicion of immorality.

Even so, special institutions marked a transition from spontaneous fear to organised administrative action. Syphilis contributed to the growth of specialist hospitals, medical administration and municipal sanitary policy.

From the beginning, however, it exposed a conflict that would recur for centuries: where does the protection of a community end and violence against a patient begin?

The Polish *Przymiot*: Wojciech Oczko organises knowledge

The disease appeared relatively early in sources from the Polish lands. Trade, military movement, the journeys of courtiers and students, and the position of the Polish-Lithuanian Commonwealth on routes linking western Europe with Lithuania, Rus’ and the Black Sea region all favoured its spread.

¹⁰ Gall et al., “Quarantine as a Public Health Measure.”

The central figure in the early Polish history of syphilis was Wojciech Oczko, a physician educated in Kraków and Italy and associated with the courts of Stephen Báthory and Sigismund III Vasa. In 1581, he published *Przymiot* in Kraków, the first substantial Polish-language book devoted to the disease.¹¹

The importance of the work extended beyond syphilis. Oczko wrote in Polish at a time when Latin was the dominant language of medical learning. He therefore had to create and organise terminology, naming symptoms, parts of the body and medical procedures in a language accessible to domestic readers. *Przymiot* became a landmark in Polish medical writing.

Oczko attempted to order scattered observations and distinguish forms or stages of disease. He remained a man of his time: his understanding of causation and his recommendations could not transcend contemporary knowledge. What mattered was his treatment of syphilis as an illness requiring accurate description and systematic practice rather than moral condemnation alone.

The Polish word *przymiot* had a long life. It suggested an affliction or condition that befell a person and stayed for years. The phrase “secret disease” pointed to the social necessity of concealment. The language preserved an entire history of fear: of pain, disgrace and the exposure of private life.

[ILLUSTRATION PLACEHOLDER 4]

Suggested image: the title page of Wojciech Oczko's *Przymiot*, or the jubilee edition *Przymiot i Cieplice*.

Suggested caption: Wojciech Oczko produced the first substantial Polish-language monograph on syphilis and helped create Polish medical terminology.

Suggested source: the National Library of Poland's Polona service; the exact bibliographic record and reuse terms of the selected scan should be checked.

Ports, routes and the first early-modern globalisation

After its explosive appearance in Europe, syphilis was soon recorded in other regions of the world. It did not spread in a vacuum. It followed the same routes as merchandise, silver, spices, soldiers, enslaved people and missionaries. The early sixteenth century saw the creation of a global maritime network linking Europe to the coasts of Africa, India, Southeast Asia, China and Japan.

Chinese sources mention an illness resembling acquired syphilis in the early sixteenth century. Texts used names such as “Cantonese sores” and “plum-blossom sores”. The first well-documented Japanese outbreak dates from 1512-1513, only about two decades after the European epidemic. Research on remains from the Edo period indicates that the disease became established in Japanese urban populations.¹²

It would be misleading to imagine that the infection was carried only by Europeans sailing directly from Lisbon to Canton or Nagasaki. The Indian Ocean and Asian seas formed

¹¹ Wojciech Oczko, *Przymiot* (Kraków, 1581); jubilee edition *Przymiot i Cieplice* (Warsaw: Towarzystwo Lekarskie Warszawskie, 1881), digitised by the National Library of Poland, Polona.

¹² Eun Jin Woo et al., “Syphilitic Infection in a Pre-modern Population from South Korea (19th Century AD),” *Anthropological Science* 127, no. 1 (2019): 55-63, especially 60; the authors cite Chinese records from the early sixteenth century and the Japanese outbreak of 1512-1513.

a complex network of Arab, Persian, Indian, Malay, Chinese, Korean, African and European intermediaries. The pathogen could move in stages, port by port, in many directions.

The Asian history of syphilis shows that early-modern globalisation was a multidirectional process. Diseases did not follow straight lines drawn on European maps. They used existing regional networks of trade, labour and migration.

In China, syphilis eventually became a major social problem. After 1949, the government of the People's Republic organised a mass campaign against sexually transmitted infections. It included screening, free treatment, the closure of brothels and the social reintegration of some women who had previously sold sex. By the 1960s, reported infection had been virtually eliminated. After economic reform, greater mobility and the re-emergence of commercial sex, the disease returned.¹³

China's experience shows that an epidemic is never determined by biology alone. It can retreat under a coordinated social policy and reappear as economic and social relations change.

Comparable processes occurred in European colonies. Colonial physicians often blamed the spread of syphilis on the supposed "promiscuity of natives", while overlooking forced labour, migration, sexual violence, the disruption of existing communities and the rise of port cities. Syphilis became an instrument for justifying surveillance of colonised bodies.¹⁴

The eighteenth century: an epidemic hidden in the metropolis

By the eighteenth century, syphilis no longer produced the panic that had accompanied the first European epidemic. It had nevertheless become extremely widespread in large cities. Population growth, rural migration, expanding armies and navies, the mobility of apprentices, domestic servants and labourers, and the growth of poor districts all created extensive networks of contact.

Historians have attempted to reconstruct infection levels from physicians' accounts, hospital registers, pharmacy records and censuses. A study of London in the 1770s suggests that by the age of thirty-five more than 20 per cent of residents may have undergone treatment for the illness described as *the pox*, interpreted by the authors as syphilis. This was a cumulative estimate assembled from several incomplete sources, not a modern epidemiological registry.¹⁵

Another study, comparing the city of Chester with its rural hinterland, found a considerably higher treatment rate in the urban population. The difference did not arise from an abstract "immorality of the city". Cities concentrated young, single, mobile and

¹³ Zhi-Qiang Chen et al., "Syphilis in China: Results of a National Surveillance Programme," *The Lancet* 369, no. 9556 (2007): 132-138; Therese Hesketh, Xudong Zhang and Qiang Dong, "Syphilis in China: The Great Comeback," *Emerging Health Threats Journal* 1 (2008): e6.

¹⁴ Guillaume Linte, "Syphilis, blanchiment and French Colonial Medicine in Sub-Saharan Africa," *Medical History* 67 (2023); see also Patrick N. Graham, "Sex Work, Containment and the New Discourse of Public Health in French Colonial North Africa," *Medical History* 65 (2021).

¹⁵ Simon Szreter and Kevin Siena, "The Pox in Boswell's London: An Estimate of the Extent of Syphilis Infection in the Metropolis in the 1770s," *The Economic History Review* 74, no. 2 (2021): 372-399, <https://doi.org/10.1111/ehr.13000>.

economically dependent people. They made anonymous contacts easier, while also providing hospitals and practitioners through whom more cases entered the documentary record.¹⁶

Syphilis was both visible and concealed. It was visible because it filled hospital wards, advertisements for secret remedies and satirical prints. It was concealed because patients withheld their names, used side entrances, purchased medicines by correspondence and feared disclosure to their families.

Poor patients might enter the so-called foul wards reserved for venereal disease. These wards offered a possibility of care but carried disgrace, discipline and inferior treatment. A paying patient could preserve discretion. A pauper had to surrender the body to institutional control.

The nineteenth century: the state enters the bedroom

Industrialisation and urbanisation gave the problem a new dimension. Great cities, garrisons and naval ports concentrated thousands of young people. Governments began to view venereal disease not merely as an individual's misfortune but as a threat to armies, economic productivity, population growth and the "strength of the nation".

Women who sold sex were most often blamed. Men were portrayed as soldiers, workers and future fathers whose health had to be protected. Women, by contrast, were treated as reservoirs of infection requiring police surveillance. This was a double standard: the client remained a citizen; the prostitute became an object of control.

The best-known example was the British Contagious Diseases legislation beginning in 1864 and extended in subsequent years. It operated in selected garrison and port towns. Police could detain women suspected of prostitution and send them for compulsory examination. A woman diagnosed with disease could be confined in a lock hospital. The men who purchased her services and could transmit infection to others were not subjected to a comparable regime.¹⁷

Some women and campaigners described examinations with a speculum as sexual violence carried out under legal authority. Lock hospitals sought to cure not only the body but also "moral fallenness". Patients were subjected to discipline, labour, prayer and attempts to persuade them to abandon their former way of life.

A women's movement led by Josephine Butler opposed the legislation. Campaigners argued that the state punished poor women for conduct tolerated in men. They also warned that controlling one group created false reassurance and ignored infection within marriage and in non-commercial sexual relationships. After a prolonged struggle, the laws were suspended and finally repealed in 1886.¹⁸

¹⁶ Simon Szreter, "Treatment Rates for the Pox in Early Modern England: A Comparative Estimate of the Prevalence of Syphilis in the City of Chester and Its Rural Vicinity in the 1770s," *Continuity and Change* 32, no. 2 (2017): 183-223, <https://doi.org/10.1017/S0268416017000212>.

¹⁷ "The Prostitute Whose Pox Inspired Feminists," Wellcome Collection, 20 July 2017, accessed 13 July 2026.

¹⁸ Ibid. The Ladies National Association campaign began in 1869; the legislation was suspended in 1883 and repealed in 1886.

The controversy established a public-health dilemma that remains recognisable: can a disease be effectively controlled through compulsion, police power and the labelling of a “risk group” if human rights and the behaviour of the wider population are ignored?

[ILLUSTRATION PLACEHOLDER 5]

Suggested image: a photograph or print of a British lock hospital, a portrait of Josephine Butler, or a satirical image opposing the Contagious Diseases Acts.

Suggested caption: Nineteenth-century venereal-disease control often meant police supervision of poor women, while male clients remained outside the coercive system.

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Women and children: the invisible victims of a “male disease”

Nineteenth-century public language portrayed syphilis chiefly as a problem of soldiers, sailors and prostitutes. In reality, many infected women did not sell sex. They acquired the disease from husbands who had other partners before or during marriage.

Women were expected to be faithful, but often had no recognised right to ask about a fiancé’s sexual history or request a medical examination. An economically dependent wife had little power to refuse sex. Infection could therefore result not only from sexual contact but from unequal power.

A man could infect his wife and later accuse her of infidelity. Women’s symptoms were sometimes less visible or located internally, delaying diagnosis. If a child became ill, moral responsibility might be placed entirely on the mother.

The most tragic consequences concerned pregnancy. Infection could lead to miscarriage, stillbirth, neonatal death and severe disease in children. For a long time, the mechanism of transmission from mother to fetus was poorly understood. A sick infant might be treated as evidence of familial “degeneration”, although the child bore no responsibility.

Fear of congenital syphilis permeated nineteenth-century debates about marriage, heredity and the future of the nation. It contributed to premarital testing and prenatal care, but also to eugenics, involuntary sterilisation and discrimination against people classified as “biologically unfit”.

Syphilis demonstrated that the language of protecting future generations could support care, but could also legitimise violence.

The military: sexual health becomes a strategic concern

From the Neapolitan epidemic onwards, armies remained important environments for the spread of syphilis. In the nineteenth and twentieth centuries, this connection became administrative. States began counting not only the wounded and dead but also days of service lost to sexually transmitted infections.

For military commanders, syphilis was not a matter of a soldier’s private morality. A patient required hospital care, could be unavailable for duty for long periods and might infect others. Venereal disease affected combat readiness, mobilisation costs and the functioning of military transport.

During the First World War, millions of young men were removed from their communities and concentrated in barracks, ports, training camps and towns behind the front. War weakened ordinary social controls, increased casual contacts and encouraged commercial sex. Loneliness, fear of death and short periods of leave also shaped sexual behaviour.

Governments responded with moral lectures, the closure of brothels, examinations of soldiers, contact-reporting systems and propaganda. Posters portrayed an infected woman as a trap set for a patriot. They spoke less often about male responsibility, sexual consent or the danger of carrying infection home to a wife.

Wartime experience accelerated the growth of laboratories, clinics and health education. It also entrenched a language in which the infected woman was an “internal enemy”, almost as dangerous as an opposing soldier.¹⁹

In the Polish lands, both world wars produced mass migration, poverty, family disruption and increasing infection. In the Second Polish Republic, venereal diseases were described as a social disaster; clinics were opened and prostitution was subjected to surveillance. After 1945, displacement, demobilisation, sexual violence and shortages of medical staff and drugs intensified the problem.²⁰

Science removes part of the mystery

At the beginning of the twentieth century, the history of syphilis entered a new phase. In 1905, Fritz Schaudinn and Erich Hoffmann identified the pale spirochaete in material taken from a patient. A year later, the Wassermann reaction provided a means of indirectly detecting infection. Syphilis was no longer only a collection of visible symptoms. It could be identified even when the patient had no skin lesions.²¹

These discoveries had enormous social consequences. Soldiers, pregnant women, blood donors and asymptomatic people could be tested. At the same time, laboratory diagnosis created new possibilities of control. A result could determine employment, marriage, hospitalisation or whether a person was treated as a danger to others.

More targeted medicines followed, and penicillin entered practice in the 1940s. The detailed history of treatment belongs in another chapter. What matters here is the change in mentality: after four centuries, syphilis was ceasing to be a mysterious punishment and becoming an infection whose cause could be detected and attacked.

The triumph of the laboratory did not automatically become a triumph of ethics.

¹⁹ Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, expanded ed. (New York: Oxford University Press, 2020); Samuel E. Wilson, “Vicious Habits: Sexually Transmitted Infections among Black Soldiers in World War I,” *Journal of the National Medical Association* 111 (2019).

²⁰ Krzysztof Kopociński et al., “Kiła endemiczna w powiecie brasławskim woj. wileńskiego i zwalczanie chorób wenerycznych w Polsce w latach 1918-1939,” *Forum Bibliotek Medycznych* 8, no. 2 (2015); “Zwalczanie chorób wenerycznych występujących w pierwszych latach powojennych wśród żołnierzy WP,” *Medycyna Nowożytna* 29, supplement (2023).

²¹ Tampa et al., “Brief History of Syphilis.” The history of diagnosis will be developed in a separate chapter.

Tuskegee and Guatemala: when people became research material

The best-known abuse associated with syphilis is the study conducted by the United States Public Health Service in Macon County, Alabama. It began in 1932 and included 600 Black men: 399 with syphilis and 201 controls. Their informed consent was not obtained. Participants were told that they were receiving help for “bad blood”, a local expression covering several conditions.²²

Researchers wished to observe the natural course of untreated disease. When penicillin became the standard and widely available treatment, it was still not offered to the participants. The study ended only in 1972 after press exposure. A federal panel found it ethically unjustified.

This was not the work of one physician acting in secret. The programme lasted for forty years, involved government institutions and produced scientific publications. It showed how racism, paternalism and confidence in expert superiority could destroy the basic principle of medicine: the patient is a human being, not observational material.

A fuller name is preferable: the U.S. Public Health Service Study at Tuskegee and in Macon County. It identifies the responsible institution and avoids placing stigma on the local community or Tuskegee University, whose role was complex and subordinate to federal health authorities.²³

Even more direct abuses occurred in Guatemala between 1946 and 1948. People with little or no practical ability to refuse - including prisoners, soldiers and psychiatric patients - were intentionally exposed to syphilis, gonorrhoea and chancroid in experiments on prevention and treatment. Informed consent was not obtained, and records indicate that some participants did not receive complete treatment.²⁴

Tuskegee and Guatemala became part of the history of modern bioethics. They contributed to stronger requirements for informed consent, independent ethical review and special protection for people vulnerable to exploitation.

[ILLUSTRATION PLACEHOLDER 6]

Suggested image: a photograph of participants in the U.S. Public Health Service study at Tuskegee or a reproduced document from the National Library of Medicine collection.

Suggested caption: Conducted from 1932 to 1972, the study became a symbol of institutional racism and the denial of effective treatment to people who had not consented to participate.

Rights: prefer material held by U.S. federal institutions; the rights statement and identification of participants should be checked for every item.

War, post-war reconstruction and the illusion of victory

During the Second World War, governments mounted wide-ranging educational campaigns. Films, posters and pamphlets told soldiers that infection weakened the war effort. Disease

²² Centers for Disease Control and Prevention, “The Untreated Syphilis Study at Tuskegee Timeline,” updated 4 September 2024, accessed 13 July 2026.

²³ National Library of Medicine, “Digitized Document Collection from USPHS Untreated Syphilis Study at Tuskegee Now Publicly Available through NLM,” 19 October 2023; CDC, “About the Untreated Syphilis Study at Tuskegee.”

²⁴ Michael A. Rodriguez et al., “First, Do No Harm: The US Sexually Transmitted Disease Experiments in Guatemala,” *American Journal of Public Health* 103, no. 12 (2013): 2122-2126; Thomas R. Frieden and Francis S. Collins, “Intentional Infection of Vulnerable Populations in 1946-1948,” *JAMA* 304, no. 18 (2010): 2063-2064.

was represented almost as sabotage. Military and civilian clinics expanded, screening programmes were organised and the partners of diagnosed patients were traced.

The end of the war did not bring immediate improvement. Europe was a continent of destroyed cities, returning prisoners, forced labourers, displaced people and demobilised soldiers. Family disruption, housing shortages, poverty and survival sex favoured infection.

In Poland, as in other states of east-central Europe, networks of clinics were created, selected cases were made notifiable and coercive measures could be used against people classified as sources of infection. Health policy joined medical care with attempts to impose social norms. Comparisons between Poland and East Germany show that state-socialist systems relied both on mass campaigns and on administrative control of patients.²⁵

Penicillin radically changed expectations. Late syphilis, neurosyphilis and congenital infection declined in many countries. For the first time, the disease appeared to be an enemy that could be driven to the margins of history.

Success had an unintended consequence. Syphilis disappeared from public attention. For later generations it became an old disease, encountered in textbooks, artists' biographies and stories of toxic remedies.

In the second half of the twentieth century, infection rates rose and fell. They depended on sexual behaviour, access to testing, the quality of health services, migration and the stigma attached to sexual minorities. In several countries an increasing proportion of diagnoses occurred among men who had sex with men. Criminalisation and discrimination discouraged people from seeking help.

In the 1980s, the HIV epidemic altered behaviour. Condom use and reductions in higher-risk sexual contact also reduced syphilis in some communities. Later, with effective HIV treatment, changing social norms, easier contact through the internet and reduced fear of AIDS, syphilis began to rise again.²⁶

This does not mean that a single technology or group caused the increase. Epidemics are shaped by sexual networks, access to care, testing frequency, social exclusion, substance use, mobility and the quality of sexual-health education. Rising diagnosis may also partly reflect better detection.

[ILLUSTRATION PLACEHOLDER 7]

Suggested image: a military poster or still from an anti-venereal-disease film produced between 1940 and 1945.

Suggested caption: Wartime propaganda presented prevention as a patriotic duty but often personified disease as a dangerous woman.

Rights: collections of the National Library of Medicine, U.S. National Archives, Wellcome Collection or Library of Congress offer possible material; choose an item with a clear rights statement.

The twenty-first century: the return of an old adversary

By the beginning of the twenty-first century, it was clear that syphilis did not belong only to medical history. The World Health Organization estimates that about eight million people

²⁵ Marcin Orzechowski, Cornelia Schochow and Florian Steger, "Policy Approaches toward Combatting Venereal Diseases in Poland and East Germany after 1945," 2021.

²⁶ Matthew M. Solomon et al., "The Evolution of the Syphilis Epidemic among Men Who Have Sex with Men," *Sexually Transmitted Diseases* 42, no. 7 (2015): 372-377.

aged 15-49 acquired the infection in 2022. Many infections are asymptomatic, unnoticed or never diagnosed.²⁷

The European trend is clearly upward. According to a report published by the European Centre for Disease Prevention and Control in May 2026, 29 EU/EEA countries reported 45,577 confirmed cases in 2024. In countries with comprehensive surveillance, this corresponded to 10.8 notifications per 100,000 population. Between 2015 and 2024, notification rates more than doubled.²⁸

In 2024, notifications were more than six times higher among men than women, with the highest rate among men aged 25-34. Most cases with a known transmission category were reported among men who have sex with men. At the same time, ECDC has observed a sustained rise since 2021 among heterosexual women and men in every adult age group. Transmission is therefore extending beyond populations traditionally labelled “key populations”.

Congenital syphilis remains an especially painful measure of inequality. Modern medicine can prevent it through antenatal screening and timely treatment. Nevertheless, WHO estimated about 700,000 congenital cases in 2022, associated with approximately 390,000 adverse pregnancy and birth outcomes.²⁹

Every such case shows that the existence of an effective drug is not enough. Antenatal tests must be accessible, penicillin supplies continuous, clinics reachable and health workers trusted. Where services fail or people fear judgement, the disease exploits the gap.

ECDC data for 2024 recorded 140 confirmed congenital cases in 14 EU/EEA countries, the highest number since ECDC assumed coordination of surveillance. Fourteen other countries, including Poland, reported no cases. The figures should be interpreted cautiously because the completeness and quality of national surveillance vary.³⁰

[ILLUSTRATION PLACEHOLDER 8]

Suggested image: an original chart showing reported syphilis cases in the EU/EEA from 2015 to 2024, based on ECDC reports.

Suggested caption: Despite the availability of effective treatment, syphilis notification rates in Europe more than doubled within a decade.

Editorial note: create a new visualisation from the source data and identify the source and retrieval date beneath the chart.

A biological and social epidemic

The history of syphilis is not a simple account of medicine advancing from ignorance to victory. It is also the history of how societies responded to a disease associated with sexuality.

Foreigners were blamed first. Later, suspicion fell on prostitutes, the poor, people living outside marriage, gay men, colonial populations and racial minorities. The vocabulary

²⁷ World Health Organization, “Syphilis,” fact sheet, 29 May 2025, accessed 13 July 2026.

²⁸ European Centre for Disease Prevention and Control, *Syphilis. Annual Epidemiological Report for 2024* (Stockholm: ECDC, 2026), based on EpiPulse data retrieved 7 April 2026.

²⁹ World Health Organization, “Mother-to-child Transmission of Syphilis,” accessed 13 July 2026. The WHO estimate for 2022 includes approximately 150,000 early fetal deaths and stillbirths, 70,000 neonatal deaths, 55,000 premature or low-birth-weight births and 115,000 infants with a clinical diagnosis.

³⁰ European Centre for Disease Prevention and Control, *Congenital Syphilis. Annual Epidemiological Report for 2024* (Stockholm: ECDC, 2026).

changed, but the mechanism remained: infection was assigned to “others”, while the speaker’s own community claimed moral purity.

This attitude hindered control. A person fearing condemnation concealed symptoms. Partners did not discuss risk. Physicians avoided direct language. Governments concentrated on controlling selected groups rather than ensuring universal access to tests, treatment and honest education. Stigma became the bacterium’s ally.

At the same time, syphilis accelerated the development of many institutions of modernity: specialist hospitals, laboratories, sexual-health clinics, antenatal screening, epidemiological surveillance and research ethics. It forced physicians to observe patients over many years and to recognise links between apparently unrelated symptoms.

The disease spread with the help of three allies: time, movement and silence. Time allowed it to develop over years. Movement carried it between cities and continents. Silence protected it from detection.

None of these mechanisms belongs solely to the past. A modern traveller moves faster than a Renaissance soldier. The internet facilitates sexual contact but also access to information and testing. Medicine has effective treatment, but it has not eliminated fear of judgement.

The history of syphilis is therefore unfinished. It does not end with the discovery of the bacterium, the serological test or the antibiotic. Every generation must answer the same questions again: will the infected person be treated as someone needing help or as a culprit? Will the state educate and care, or primarily punish and control? Can sexuality be discussed openly before silence becomes an instrument of the epidemic?

An old enemy in a modern world

From besieged Naples to contemporary cities, syphilis has repeatedly changed its social face. It has been the “French disease”, a courtly affliction, a marital secret, a military threat, an argument for eugenics, the subject of unethical experiments and a disease prematurely declared defeated.

It is neither the most transmissible infection in history nor the one with the highest mortality. Its historical power lay elsewhere: it joined intimacy to epidemic, an individual secret to state policy, and a brief encounter to suffering that might appear many years later.

People repeatedly explained it through God’s anger, the corruption of foreign nations, female promiscuity or the supposed inferiority of particular communities. Only gradually did they learn to understand it as an infection governed by biological processes. That did not mean social prejudice disappeared with the growth of laboratory science.

The central lesson of the history of syphilis is paradoxical. An effective drug can remove bacteria from an individual body, but it cannot by itself remove the conditions that allow infection to circulate through society. That requires knowledge, accessible care, responsibility, equality and language free from contempt.

As long as infection is associated chiefly with guilt, some patients will choose silence. In the history of syphilis, silence has almost always given the advantage to the disease.

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