VENEREAL DISEASES.

By J. Ernest Lane, F.R.C.S.,

Surgeon to Out-Patients and Lecturer on Anatomy, St. Mary's Hospital; Surgeon to the London Lock Hospital.

1. The therapeutics of syphilis.

Apart from the choice of a mercurial preparation, and the method in which it may be introduced into the system, a somewhat vexed question is the exact time *when* the treatment should be administered: whether the chronic intermittent treatment as recommended by Fournier should be adopted—that is to say, the administration of mercury in successive courses of six months, more or less, with periods of intermission; or whether the treatment should be pursued only whilst manifestations of the disease are present—the symptomatic treatment, as it is termed.

Schwimmer (*Wien. med. Presse*, No. 44, 1897) recommends that mercury should be given before the onset of secondary symptoms. The severity of the primary symptoms is no guide to the subsequent course of the disease, and consequently all cases should be submitted to the same medicinal treatment. The discovery of the organisms of the chancroid and of gonorrhœa had led to no improvement in the therapeutics of those diseases, and the possibility of a bacterial cause for syphilis should not interfere with its present empirical treatment. With reference to the duration of treatment, and to the time when marriage could be permitted, he mentioned cases in which, after prolonged treatment and freedom from symptoms, patients were permitted to marry; no infection of the wives took place, and each had healthy children. Notwithstanding, these patients eight years after infection showed further manifestations of the disease in the form of orchitis and periostitis. Prolonged treatment could not be depended upon to procure immunity from relapses; and as such a lengthy treatment as three or five years was very depressing, he considered two years sufficiently long, though marriage should not be allowed till the end of the third or fourth year.

Zeissl (*Wien. med. Presse*, Nov., 1897) advocated the symptomatic method, and considered that the syphilitic microbe, when

treated by the chronic intermittent plan, was analogous to the parasite of malaria when treated by quinine, the action of which drug had been shown to differ at different periods in the life-history of the same parasite. By treating syphilis by the chronic intermittent method we might be giving the drug at one time when it was not required, and withholding it when it might be of use. Mercury should not be given until the secondary symptoms were fully developed, and should not be prolonged after their disappearance, or until some other manifestation of the disease occurred. The course of syphilis remained the same now as when all sores, both hard and soft, were treated with mercury, and this was an argument against the commencement of treatment during the primary stage; moreover, if the primary sore was treated by the administration of mercury, much larger doses of that drug would be required in order to subdue the secondary symptoms.

Neumann (*Wien. klin. Rundschau*, 47 and 48, 1897) held that no treatment could be relied upon to ward off the onset of constitutional symptoms in syphilis, though very exceptionally abortive treatment was successful. Mercury and iodine were antagonistic to the products of the syphilitic virus, though they were incompetent, as were all other drugs, to remove the poison. The abortive treatment, *i.e.* the administration of mercury and iodine during the primary stage, would, if those remedies acted on the cause of syphilis, completely destroy it before it could take possession of the whole human organism. But of 100 cases treated thus prematurely, there was not one in which the secondary phenomena did not subsequently show themselves. Saturation of the organism with mercury and iodine did not prevent relapses, and these had occurred up to fifty-five years from the date of infection. Late syphilitic manifestations occurred most frequently on the sites of the early lesions, which would be impossible if the cause of the disease had been destroyed. Whatever the treatment, in from 6 to 22 per cent. of cases of syphilis the disease reached the tertiary stage, indicating that mercury and iodine were not effectual in every case. Neumann concluded that the symptomatic treatment of syphilis was the sole rational one, and that it acted by establishing a temporary or permanent immunity to the ever-present cause of the disease, and that its results were as favourable as were those obtained by the chronic intermittent treatment.

[The above brief extracts appear fairly to represent the opinion of Viennese experts on the subject, and it will be seen that they are unanimously opposed to Fournier in his advocacy of the chronic intermittent treatment usually practised in France and in Great Britain. At the same time, though agreed as to the superiority

of the symptomatic treatment, they are not in accord as to the stage when this treatment should be commenced. Schwimmer would begin it during the primary stage—that is to say, when the diagnosis was yet in doubt; for induration of the initial lesion cannot be considered an unequivocal sign of syphilis, any more than its absence, especially in the female sex, was an indication that the sore was not a syphilitic one. Zeissl and Neumann, recognising this difficulty, would wait for unmistakable signs of constitutional infection before commencing the treatment. The advocates of the symptomatic treatment present the disease in a somewhat unfavourable light, for according to them the patient is liable to relapses till the close of his existence; they did certainly concede that the disease was not transmissible to the offspring for more than four or five years from the date of infection, and it would seem evident that if the virus retained its transmissibility for an indefinite period the whole community would ultimately become syphilised. There must be some limit to the activity of the virus, and it seems reasonable to think that this limit will sooner be reached by the chronic intermittent form of treatment than by the symptomatic.]

2. When should mercurial treatment be commenced in syphilis?

Neumann (*Med. Press and Circ.*, July 6, 1898), in a clinical lecture delivered in Vienna, expressed the opinion that the preventive treatment of syphilis by mercury might be briefly disposed of as valueless so far as the destruction of the virus was concerned; excision of the initial sore was equally fallacious. The character and course of syphilis were consistent with its parasitic origin, mercury and iodine being specifics which induced a temporary immunity by acting either on the germ or on its products. There was no proof that mercury or any other drug would annihilate the germs of syphilis; for then the first course of anti-syphilitic treatment would be sufficient to eradicate the disease. Mercury and iodine were equally powerless in preventing the sequelæ or other forms of tertiary syphilis, and at intervals of ten or even fifty years after anti-syphilitic treatment the germ or toxin, for a long time quiescent, might manifest itself suddenly and in some unexpected form, having been present in the organism for possibly half a century without showing any outward signs of its presence. The so-called cure of syphilis was hypothetical, and was no absolute criterion of the destruction of the syphilitic poison. The question of how long mercury should be administered was even more indefinite, the usual advice being to continue it only whilst manifestations of

the disease were present; but Neumann advocated the continuance of the treatment over a definite period after the recession of all visible signs, with a view of preventing relapses, and he found that this method greatly modified the tertiary stage. The administration of mercury before the appearance of constitutional symptoms with the object of suppressing or modifying them had the effect of protracting the eruptive stage, whilst it did not mitigate the disease as a whole and did not influence its general course and severity. Another objection to the preventive form of treatment was the loss of efficacy which was entailed by the early introduction of mercury; the drug so given might abrogate the prodromal eruption of syphilis, but its specific action thereafter was greatly enfeebled or lost. With our present knowledge we could not lay down dogmatically any rule for guidance either as to the magnitude of the dose, or the length of time for which it should be continued. In comparing the symptomatic with the chronic intermittent treatment, Neumann considered that to adhere to the latter method as an undeviating rule was irrational; from the tables of Fournier it would appear that treatment extending over two or three years arrested the appearance of tertiary symptoms, but *per contra* excessive drugging with mercury rendered the mucous membrane of the mouth, throat, and ear-passages more vulnerable and more disposed to disease, and caused the alimentary tract to be more amenable to morbid changes, while the internal organs might become influenced on the slightest provocation by the intense anæmia pervading the whole system. Neumann summarised his conclusions as follows:—(1) There was no drug yet known that would act as a preventive cure of constitutional syphilis, or would avert the manifestation of symptoms at variable periods, although there were a few exceptions to this general assertion; (2) mercury and iodine were specific anti-syphilitic remedies, that modified the syphilitic products but did not destroy the virus.

3. The treatment of gonorrhœa by protargol.

The value of nitrate of silver in the treatment of gonorrhœa in all its stages has long been recognised by the profession, but its irritating effects upon the urethral mucous membrane have been a material drawback to its employment except in very dilute solutions, or, by means of the urethroscope, as a topical application to limited portions of the urethra. In chemical laboratories researches have for some time past been undertaken with a view of producing some compound of nitrate of silver which, while possessing the bactericidal effects of that salt upon the gonococcus, should at the same time produce a minimum of inflammatory

reaction upon the delicate mucous membrane to which it had to be applied. Preparations known as argentamin and argonin have been alluded to in "The Year-Book of Treatment" for the last three years; and though they have been found to yield good results in the hands of a few observers, yet the success they have met with has been by no means universal. Argentamin was found to have a decidedly caustic effect upon the urethra; and argonin, although non-irritating, did not seem to affect the gonococcus to the same extent as other preparations of nitrate of silver.

Recently, however, a salt known as protargol has been introduced by **Professor Neisser**, of Breslau, and described by him in the *Centralb. f. Dermatol.* (Oct., 1897). Briefly stated, the properties of protargol are as follows: it is a light yellow powder, differing from argonin in that it is freely soluble in water up to 50 per cent., forming a clear light brown solution; it contains 8·3 per cent. of nitrate of silver, whereas in argonin the proportion is 4·1 per cent. and in argentamin only 2·0 per cent. Its non-precipitation by solutions of albumen and chloride of sodium rendered it especially valuable in the therapeutics of gonorrhœa, and its neutral reaction offered a safeguard which enabled it to be applied to mucous membranes without setting up any appreciable irritation. It caused no irritation or pain, in spite of the large proportion of nitrate of silver it contained, though its bactericidal properties were remarkable. Its non-irritating properties recommended it strongly to Neisser, and to others who were opposed to the expectant treatment, and who recommended that every attack of gonorrhœa should be treated by anti-bacterial injections as soon as possible after infection. It was found possible to retain solutions of protargol in the urethra for a period varying from five to thirty minutes, and its retention saved the patient from the frequent repetition of the process. The injections should first be used three times a day, the fluid being retained, first, for five minutes, but at the third time for as long as half an hour; the treatment could be continued for three or four weeks if necessary, but the disease generally yielded sooner than this. In conclusion Neisser stated that he had never obtained such good, certain, and quick results as with this substance.

Barlow (*Münchener med. Woch.*, 45 and 46, 1897) fully endorses the favourable opinion expressed by Neisser. It was necessary to ascertain if the posterior urethra was involved or not; and always to commence the treatment as soon as possible after infection. He summed up his conclusions as follows:—

(1) Protargol produced excellent results in the treatment of acute gonorrhœa, and was easily tolerated by patients in almost every instance.

(2) The prolonged injections lasting for up to thirty minutes acted especially favourably in the course of acute gonorrhœa of the fore-part of the urethra.

3. When using protargol in the early stages of the disease, the posterior part of the urethra was certainly less frequently affected than when using other medicaments.

4. In gonorrhœa of the anterior urethra the treatment by irrigation was superfluous, injection of small amounts of the solution by a syringe being sufficient to effect a cure.

5. If the posterior part of the urethra were affected, the irrigation method of treatment was indicated.

Goldenberg (*New York Med. Journal*, Jan., 1898) found that the irrigation treatment of gonorrhœa was inconvenient, and in acute cases unsuitable, and quite agreed with Neisser in his opinion that protargol surpassed all other agents in the treatment of such cases. Should the disease be localised in the anterior urethra, the patient should inject 3 drachms of a 1 per cent. solution with an ordinary urethral syringe; should retain the solution from ten to fifteen minutes; and should repeat the practice three times a day. In posterior urethritis a solution of $\frac{1}{2}$ to 1 per cent. should be introduced into the deeper urethra by a Guyon's instillator. The treatment was found to be absolutely painless, and unattended by any evidence of local irritation or general disturbance. It had also been introduced in the powdered form by means of the endoscopic tube, but it was found that the irritation caused by the passage of the tube somewhat detracted from the remedial efficacy of the drug.

Fürst (*Fortschritte d. Med.* 1898, No. 4) has found protargol of great service in the treatment of gonorrhœal ophthalmia neonatorum. It had the advantage over nitrate of silver in that it had no tendency to decompose or to irritate, while it was perfectly easy of application, and its action was quicker and more reliable.

Fürst (*Therapeut. Monatsheft.*, April, 1898) further advocated the use of protargol in the treatment of gonorrhœa in women. He had treated thirty-six adult patients, consisting of fourteen cases of gonorrhœa of the cervix and body of the uterus, eight cases of gonorrhœa of the cervix only, five cases of gonorrhœa urethro-cystitis, three cases each of vulvitis and of bartholinitis, two cases of gonorrhœal endometritis, and one case of colpitis. He looked upon gonorrhœa of the vagina as a rare disease, but found that in a large majority of

cases the gonococci settle first in the uterine cavity; consequently, special attention should be directed in every case of infection to the careful treatment of the cervical cavity and of the endometrium. The use of protargol rendered it possible to kill the cocci without producing an inflammatory reaction, or effecting a revival of the discharge, or transporting the cocci into the Fallopian tubes. The principal indication in the treatment of these cases was to prevent as early as possible a spreading upwards of the gonorrhœa into the cavity of the uterus. The objection to intra-uterine applications was that they frequently produced severe irritation; but protargol could be applied to the whole uterine cavity with impunity, and a thorough washing of the endometrium could be effected by its agency. The treatment adopted in cases of cervical gonorrhœa was as follows: after cleansing and disinfection of the vulva and of the vaginal tube, the vaginal part of the uterus was carefully and slowly drawn downwards, and if necessary the os was dilated. After the introduction of a carefully sterilised glass uterine catheter with a sufficiently large flowing off pipe, the parts were washed out with sterilised tepid water in the first instance, in order to wash away all secretions or collections of cocci which might lie on the endometrium. This preparatory cleansing of the surface of the mucous membrane was necessary, as although the solution of protargol did not form any precipitate with the secretion, the removal of the latter enabled the drug to act in a more direct manner on the mucous membrane. The above process was followed by a prolonged rinsing with $\frac{1}{2}$ per cent. solution of protargol. If this was well tolerated, it was followed by a 1 per cent. solution, at least two litres of fluid being injected on each occasion. The vagina was then carefully cleansed with sterilised cotton wool, and a short conical bougie of protargol 5 per cent. was introduced into the cervix. This bougie, which was fixed by a large cotton wool tampon, would melt in fifteen minutes; after which the vagina was cleansed by a 10 per cent. solution of protargol, and then a tampon of the drug at the same strength mixed with glycerine was inserted. There still remained the possibility of reinfection of the uterus from the tubes; but the endometrium now offered a less favourable soil for the gonococcus, and such reinfection was rare except in acute cases. The treatment was continued for five or seven days, and if necessary the strength of the solution might be increased to 2 per cent., and after the first week the strength might be gradually decreased, while subsequently astringent injections could be employed. Gonorrhœal vaginitis and vulvitis require a much simpler treatment, viz. by

injections of the 5 per cent. solution and the introduction of the protargol glycerine tampon and gonorrhœal urethritis might be treated by vesical injections of a weak solution and the introduction of the protargol 5 per cent. bougies.

Finger (*Die Heilkunde*, March, 1898) considered protargol a very effective anti-gonorrhœic which, if applied early, would cause the disease to take a rapid and favourable course; it prevented all acute symptoms, caused the secretion and the gonococci to disappear quickly, prevented the process from extending to the posterior urethra, and gave good results even in a perfectly developed acute general urethritis. It might for some unascertainable cause fail in a small proportion of cases. The course of gonorrhœa was considerably modified by protargol, but the duration of treatment was not shortened very considerably, because not only a prolonged application in every injection was required but also a protracted treatment, assisted towards the end by antiseptic astringents such as argentamin, or sulphocarbolate of zinc was absolutely necessary in order to free the tissue from the gonococci and to prevent the relapses which often occurred, even after an apparently clinical cure, if the treatment had been discontinued too soon.

Fournier (*Journ. des Mal. Cutan. et Syph.*, June, 1898) was in the habit of prescribing a solution of protargol of strength from 1 in 400 to 2 per cent. directly the presence of the gonococcus was ascertained. The injections were given three times a day, the first one being retained for five minutes, the second for ten, and the third for fifteen minutes; while at the end of the first week one injection daily would suffice. He employed a syringe containing 10 cubic centimetres; and whilst of opinion that prolonged contact of the solution with the urethral mucous membrane was advisable, he thought this could be as well carried out by a repetition of the process as by its retention for half an hour as practised by Neisser. Phenomena of irritation were so rare that the treatment need not be discontinued, as was the case with nitrate of silver; it was true that in some cases a very copious discharge was set up by protargol injections, but the microscope did not display any micro-organisms, and the condition rapidly yielded to astringent applications. Protargol, employed by Neisser's method, effected a cure more rapidly than any other form of treatment, especially in acute cases and in first attacks, though in chronic cases and in recurrent attacks, as well as in posterior urethritis its action was not quite so certain.

[A considerable amount of space has been devoted to the consideration of the merits of protargol, but this seems to be

justified by the large amount of literature on the subject, emanating from such distinguished authorities as those above quoted. So-called specifics for any disease must always be looked upon with distrust, and will seldom respond to the test of time and mature experience. Protargol, however, is not vaunted as a specific, but is recommended as being the best method of introducing nitrate of silver to the urethral mucous membrane, while avoiding the injurious reactionary effects of that salt. From the experience of the writer, extending over nearly a year, protargol far surpasses any remedy yet introduced as an adjunct to the therapeutics of gonorrhœa. Every acute case in the wards of the London Lock Hospital and in the out-patient department of a general hospital has during that time been treated by the writer with this substance, and, though no actual figures can be given, with the result of shortening the period of treatment and of leaving the patient permanently cured. In a large number of the cases the presence of the gonococcus was verified on commencing the treatment, and with the apparent cure of the case no attempts were made to prove its absence by the recommendation of alcohol and coitus, as has been done by some practitioners abroad, recommendations which may be considered superfluous in the majority of hospital patients. The fact that none of the patients have presented themselves complaining of relapse may be taken as an argument against a return of the disease. In cases of chronic and of posterior urethritis similar good results have been met with, though in such cases the solution has been applied topically by means of the endoscope or by deep injections with a Guyon's syringe, and in a strength of solution of 20 or 30 per cent.]

4. Treatment of gonorrhœa by largine.

Pezzoti (*Wien. klin. Woch.*, 1898, p. 260) described largine as an albuminate of silver, in the form of a whitish grey powder, of light weight, containing 1 per cent. of nitrate of silver, dissolving very readily in water, and forming a clear yellow solution; it dissolved more easily in glycerine, serum-albumen, or peptone, but was insoluble in alcohol, ether, or benzol. Its reaction was slightly alkaline, and in coloured bottles it remained indefinitely without alteration, while the strength of silver remained constant, which was not the case with other albuminates; it was, further, as of destructive to the gonococcus as any of the other albuminates silver. The author made use of prolonged injections of solutions of largine of a strength of from $\frac{1}{4}$ to $\frac{1}{2}$ per cent., gradually increasing the dose; it was applied three times a day for periods of from five to thirty minutes. In twenty-seven cases of acute anterior urethritis treated from the commencement of the disease, the result was very satisfactory; the discharge rapidly decreased, and the gonococci disappeared by the end of ten days, on an average. The mean duration of treatment was thirty days, during which time there was no sign of posterior urethritis. The second group comprised eight cases of the same nature, in which the same treatment had been carried out from the commencement, but where it was found necessary to suspend it owing to the supervention of acute posterior urethritis. In the third group were six cases of acute or subacute posterior urethritis not submitted to this treatment till long after the commencement of the disease, and here the results were far from satisfactory. Out of forty-one cases treated, thirty-five had acute anterior urethritis, and of these, twenty-seven were cured with largine, a proportion of 77 per cent.; in six cases it produced no effect, and ultimately the disease spread to the posterior urethra. If these results were compared with those of Finger, when using protargol, it was found that out of thirty-four cases of recent anterior urethritis treated by the latter drug twenty-two cases were cured, while in twelve cases the disease reached the posterior urethra in spite of the treatment. The remedy was not an abortive of gonorrhœa any more than was protargol, but it was an addition to the number—small at present—of efficient and non-irritating applications, and it certainly was on a par with protargol as an injection.

5. The treatment of gonorrhœa by itrol.

Peroni and Picardi (*Giorn. Ital. del Mal. Ven. e del. Pel.*, 1898, fasc. 1, p. 14) have used this substance, which is citrate of silver, in sixty-five cases of acute and chronic gonorrhœa, in the form of injections of solutions varying from 1 ad 1,000 to 1 ad 2,500. Itrol could be employed locally from the commencement of the disease, for it provoked no reaction in the urethral mucous membrane, but, on the contrary, usually a remarkable diminution in the inflammatory phenomena. By reason of its anti-gonorrhœal action, and of its power to penetrate into the tissues, due to the fact that it was not precipitated by albumen, it was indicated as much in acute as in chronic cases, and the best way of employing it was by irrigation.

6. The practical use of the endoscope.

Herman G. Klotz (*Journ. of Cut. and Gen.-Ur. Dis.*, July, 1898) treats of urethroscopy as a means of diagnosis, and describes the appearance of the various pathological conditions to which the urethra is liable. He proceeds to the consideration of its practical value in the different morbid conditions met with. By its aid we can determine the nature and location of the disease,

and can select proper therapeutic measures; we can expose the diseased portions to the eye, and bring them within easy reach of the hand, and so admit of the application of stronger and more effective remedies, which would injure any but the affected portions; further, we can control the effects of any treatment, and can early judge whether it is successful or not. Endoscopic treatment is principally indicated in those superficial inflammations in which circumscribed patches of the mucous membrane have undergone certain changes which cannot be affected any more by the usual injections of astringents or parasiticides, because those remedies are powerless in the solutions which may be syringed into the urethra without injury to the portions remaining healthy or only slightly involved. By the use of a wool tampon twisted round a wire we can apply strong solutions, or powders, or even caustics, to the diseased area. Should the lacunæ Morgagni be involved, a condition but little affected by injections, they can be exposed to their full extent, and impregnated with strong solutions, or can be touched with solid caustic, or with the electro-cautery. After dilatation of the urethra, the lacunæ are converted into longitudinal slits, into which solutions may easily be applied. Solutions of nitrate of silver may be used in the strength of from 1 to 20 per cent., or the solid stick may be applied; sulphate of copper in 2, 5, or 10 per cent. solutions, tincture of iodine, liquor ferri perchloridi and glycerine, corrosive sublimate, trichloracetic acid, liquor plumbi subacetatis, iodoform, aristol, dermatol, or airol.

RECENT PUBLICATIONS.

"An American Text-Book of Genito-Urinary Diseases, Syphilis and Diseases of the Skin." Edited by **L. Bolton Bangs, M.D.**, and **W. A. Hardaway, M.D.** Illustrated with 300 engravings and twenty full-page colour plates. (Philadelphia: W. B. Saunders. 1898.)

"Traitement de la Blennorrhagie chez l'homme et chez la femme," **E. Delefosse**. (Coccoz, Paris. 1897.)

"Traité Pratique des Maladies Vénériennes." **Henry Berdal, M.D.** (A. Maloine, Paris. 1897.)

Suarez de Mendoza, "La blennorragia." (Madrid. 1898. 59 pp.)

Fournier, A., "Traité de la Syphilis." Fasc. 1. (Paris. 1898. Rueff et Cie. 436 pp.).

Lambert, "Étude critique de la sérothérapie dans la Syphilis." (Paris. 1898. G. Steinheil. 56 pp.).

Van Niessen, "Beitrag zur Syphilis." "Hygiene," **Hann Munden**. (1898. P. Werthes. 23 pp.)

THE DISEASES OF WOMEN.

By G. Ernest Herman, M.B. Lond., F.R.C.P., F.R.C.S. Eng.,

Senior Obstetric Physician to the London Hospital, etc., etc.

1. Tubo-ovarian hæmorrhage.

Dr. J. Wesley Bovée (*Amer. Gynecological and Obstetrical Journ.*, May, 1898) has written a valuable paper calling attention to some facts which there is a tendency just now to overlook. He says: "A few years back pelvic hæmatocele was a condition that every practitioner appeared to meet occasionally, and many were its supposed causes. When the study of tubal pregnancy was so universally taken up, some of the most aggressive investigators told us to search in every case of pelvic hæmatocele and we would find a ruptured tubal pregnancy." Dr. Bovée upon this remarks: "While we make no attempt to cast reflection upon the common ætiological relation to pelvic hæmorrhages of ruptured tubal pregnancy, nor upon its very frequent occurrence, we desire to offer some very conclusive evidence against the positive statements that have gone out to the effect that we will *always* find this condition in such hæmorrhages. There are many instances in which women are deeply wronged by such diagnoses. Oftentimes these hæmorrhages have occurred in virgins at a very young age and in widows above reproach." He says: "The frequency of hæmatosalpinx cannot be doubted, and ovarian hæmorrhage is by no means rare." He relates a case of hæmatosalpinx in his own practice, in which careful examination of the specimen showed not the slightest evidence of pregnancy. He has collected from other authors reports of thirty cases of tubal or ovarian hæmorrhage in which either pregnancy was impossible or no trace of it could be found, although expected and looked for. Dr. Bovée concludes his paper by saying that "to ignore such evidence of the frequent occurrence of hæmorrhage from the ovary and Fallopian tube, due to an inherent disease of these organs, and to continue to diagnose ruptured ectopic pregnancy without microscopical or other certain evidence, is to ignore scientific truths and to foster false pathology."

I agree with Dr. Bovée as to the fact that there are cases of hæmatosalpinx which are not due to ectopic pregnancy, and that