As to the diagnostic errors, seven patients were operated on presumably for an ectopic pregnancy. Pyosalpinx was present in four, chocolate cyst in two and a fibroid uterus with intra-uterine pregnancy in one case. As surgery was indicated, no harm was done to the patients.

More serious, diagnostic errors were those made in cases in which the symptoms caused by the ectopic pregnancy were not correctly interpreted. This happened in fifteen cases, or 9 per cent of our 153 cases. Fortunately, the assumed pathologic condition indicated operation, so that the patients were not handicapped by an improper delay.

CONCLUSIONS

1. In 153 cases of ectopic pregnancy there was a mortality of two, or 1.96 per cent; there were three deaths, none due directly to operation or to its immediate performance.
2. Prompt diagnosis is of great importance.
3. Careful previous history, intelligent evaluation of uterine bleeding, repeated bimanual examination and the relation between temperature and pulse rate are essential to the elimination of most diagnostic errors.
4. Incorrect interpretation of laboratory observations is the chief source of diagnostic errors in hospitals.

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ABSTRACT OF DISCUSSION

DR. THEODORE H. ASCHMANN, Kansas City, Mo.: The results of the authors are gratifying. The mortality rate of ectopic pregnancy is rather high. The doctors' mortality rate reported here was very low. It is known that ectopic pregnancies occur more often than is recognized. Fortunately they do not occur as frequently in the rural districts. One reason is that there is less pelvic inflammation in the rural districts. About 33 per cent of the cases reported by the authors followed pelvic inflammation. About 50 per cent of the patients had previous normal pregnancies. The bleeding is the high point in the paper presented. Continuous red bleeding and the dark brown flow two or three days after the onset of the pain signify that the case is one of extra-uterine pregnancy. One additional diagnostic point that I might add is frequent urination or frequent attempts to urinate followed by a little bleeding.

DR. WALTER T. DANNREUTHER, New York: Except for acute appendicitis, ectopic pregnancy supplies more emergent and tragic cases than any other lesion of the lower abdomen. Few cases conform with the typical textbook description, and correct diagnosis is not always easy. Tubal gestation is most often confused with uterine abortion, salpingitis and spontaneous rupture of an ovarian cyst with intraperitoneal bleeding. The authors are to be commended for their frankness in admitting an erroneous preoperative diagnosis in 9 per cent of 153 cases, and the difficulties they experienced in avoiding additional mistakes. Comparatively, their incidence of error is not high, as Falk in reporting a series of 304 cases recently confessed to an inaccurate diagnosis in 20 per cent. However, it is better to operate on five patients and find that the diagnosis is wrong in four of them than to jeopardize a single one by undue procrastination. The authors made no attempt to review the symptomatology and objective evidence of ectopic pregnancy in their entirety and have not referred to exacerbations of pain with interval soreness in the lower part of the abdomen, the frequent paroxysmal character of the pain, the characteristic discomfort excited by manual traction on the cervix, and the rapidly developing anemia and progressive decline in blood pressure hour by hour which parallel the blood leakage from the tube, all of which are of great significance. The application of the Aschheim-Zondek test is practical and reliable only in the minority of cases in which the gestation sac in the tube is intact. There is a material difference in the clinical picture when the sac is unruptured, after a tubal abortion has begun, and following a sudden perforation of the isthmic portion of the tube with a tear in the mesosalpinx. Usually the severity of the patient's collapse is directly related to the site of implantation; the nearer the sac is to the uterine cornu, the more serious is the effect of rupture. The statement that there was no previous menstrual disturbance in 53 per cent of the patients is surprising. Only 15 per cent of Falk's patients failed to admit a previous amenorrhea. I have found that a delay in the onset of bleeding, an amenorrhea of even one day, is an extremely reliable subjective manifestation in the majority of cases. If every patient suspected of harboring an ectopic pregnancy is hospitalized, a critical history is taken promptly and the available subjective, objective and laboratory data are correlated by an experienced clinician, the incidence of error will be reduced to a minimum.

DR. ERWIN VON GRAFF, Des Moines, Iowa: Dr. Aschmann has mentioned the symptom of frequent urination. We never paid much attention to it. The closest guess would be that the frequent urination is caused by the peritoneal irritation. I am pleased that Dr. Aschmann agrees with the diagnostic importance of the brown discoloration of the discharge. Dr. Dannreuther has criticized us because we did not sufficiently emphasize the symptom of pain and the fact that the bleeding occasionally may be delayed only a few days past the menstrual term. We omitted these points purposely to reduce the size of the paper. It is understood that if there is any delay in the monthly bleeding at all and strictly localized pain, it should not be difficult to make a correct diagnosis. As to the white count, we agree that the higher white count is more in favor of pelvic inflammatory disease and a minor degree of leukocytosis is in favor of ectopic pregnancy. This is quite true. We wanted to emphasize that the presence of leukocytosis should not be indiscriminately used as an argument against the possibility of ectopic pregnancy and in favor of some pelvic inflammation. I am grateful to Dr. Dannreuther that he has emphasized again, as one of the more important points in the diagnosis of ectopic pregnancy, that we should always be suspicious in every case of irregular bleeding in a woman during the child-bearing age; in other words, that the more ectopic minded we are in examining patients with bleeding, the fewer mistakes we make.

CANCER OF THE LIP

RESULTS OF THERAPY IN FOUR HUNDRED AND TWENTY-FIVE CASES FOLLOWED FROM ONE TO TEN YEARS

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Over the ten year period that ended Jan. 1, 1935, 425 cases of carcinoma of the lip were seen at the University Clinic. As far as possible by frequent check-up examinations, by contact with the home physicians, and by answers to questionnaires sent to the patients or their families, an attempt has been made to follow to the present time the cases treated.

There has long been an irreconcilable difference of opinion between most dermatologists, surgeons and radiologists regarding the most efficacious method of treatment to be used in this condition. From this group of cases observed over a ten year period and treated by local destruction, surgery and radiation therapy furnish a material from which one may take stock, as it were, of the results achieved to determine a fair and unbiased plan of treatment to be followed in the future in carcinoma of the lip.

Studies and contributions from the Department of Dermatology and Syphilology, University of Michigan Medical School, service of Dr. Udo J. Wile.
Owing to lack of space, this article has been abbreviated for publication in THE JOURNAL. The complete article appears in the authors' reprints.
Read before the Section on Dermatology and Syphilology at the Eighty-Seventh Annual Session of the American Medical Association, Kansas City, Mo., May 14, 1936.