THE ALABAMA
MEDICAL JOURNAL.

VOL. 12. NOVEMBER, 1901. NO. 12

Original Communications.

A PLEA FOR GONORRHOEICS.*

By JAMES EDWIN DEDMAN, A. B., M. D.

BIRMINGHAM, ALA.

Some time ago I had the pleasure of reading a paper before this body on the subject of Endoscopy and Cystoscopy. Since that time I have had the opportunity of observing a large number of cases of specific urethretis, and have been deeply impressed with the necessity for a more thorough treatment than is usually given, and a more definite recognition of the gravity of this disease and its far-reaching pathological possibilities.

I desire first to call attention to the following law enacted by the legislature of the State of Michigan in 1899: "Any person who has been afflicted with syphilis or gonorrhoea, and has not been cured of the same, who shall marry shall be deemed guilty of a felony, and upon conviction thereof in any court of competent jurisdiction shall be punished by a fine of not less than five hundred dollars or more than one thousand dollars, or by imprisonment in the State's prison at Jackson not more than five years, or by both such fine and imprisonment in the discretion of the court." Evidently it was through the labor of the medical profession in that State that such a law was passed, and it shows conclusively that they have become thoroughly awakened as to the seriousness of venereal diseases. While commending our Michigan colleagues for their humanitarian spirit, and their unselfishness in allowing the glory to be credited perhaps to the legislator who framed the bill, I desire to enter a plea for the gonorrhoeic himself—the man, who having had the disease, and having

*Read before the Jefferson County Medical Society, October 8, 1901.

been treated and dismissed as cured, runs the risk by a hasty or unscientific diagnosis on the part of his physician of carrying the odium of a felony.

In making a plea for the gonorrhoeic, I desire to present four propositions for your consideration:

1. Gonorrhoea is not generally treated upon rational or scientific principles.

2. There is a too great tendency on the part of both the laity and the profession to overlook the seriousness of the disease.

3. Gonorrhoea, through the medium of its sequellae, is responsible for a large and growing percentage of our cities' mortality reports.

4. Gonorrhoeal patients are as a rule dismissed too early, are oft-times only apparently cured, and have the coccus latent in the urethra capable of reproducing the disease in acute form many years afterwards—perhaps appearing after the patient has married, and thus infecting an innocent wife.

I cannot within the scope of this paper, enter into the details of each of these propositions, and therefore will briefly call attention to the first three, and lay especial emphasis upon the last.

The first proposition is that "Gonorrhoea is not generally treated upon rational or scientific principles." We are all prone to get in a rut, and oft-times to stay there with disastrous persistency. Many practitioners have a favorite astringent or demulcent prescription which they use in almost every case of gonorrhea, and let the patient inject it with the ordinary piston syringe. Or if he is an advocate of the irrigation method of treatment, he will apply that to every case regardless of structural changes or complications. If the case perchance be a chronic one, the surgeon may have a penchant for sounds, and rely upon these exclusively to effect a cure. Every case of specific urethritis is a study per se, and very rarely it is that any one method of treatment will effect a cure. While I shall speak of treatment later on, I desire to say just here that personally I am satisfied that the use of the piston syringe in acute cases should be condemned, esespecially when it is used by the patient himself—as is nearly always the case. The natural tendency of all gonorrhoeas is to become posterior, and I know of no way in which they can become so as quickly as when the purulent secretion in the anterior urethra is forced back by the fluid injected with one of these syringes. Another thing that I wish to condemn most strenuously is the practice of wearing absorbent cotton over the meatus in acute cases of urethritis. Even so high an authority as Valentine recommends placing a pledget of cot-

ton saturated with a 1 to 6000 bichloride solution over the glans after each urination. I am at a loss to understand this advice, for it will surely dam up the urethra and allow the discharge to flow back into the posterior tract.

My second consideration is that "There is a too great tendency on the part of both the laity and the profession to overlook the seriousness of the disease."

To the lay mind (that is to the mind of the other fellow) a case of gonorrhoea is nearly always regarded as a great joke—an occasion when the unfortunate victim is compelled to open a cold bottle to celebrate the event. It is no uncommon thing to hear some men say that "they would just as soon have a case of clap as a bad cold." These are the fellows that carry in their vest pocket or memorandum book, a prescription that will "knock it out" in three days. They are also the same fellows that are peculiarly unlucky, for "every time they have sexual intercourse, they happen to catch a case." If asked how long they were getting well with their first case, they will say: "Well, that was the hardest one I ever had, for it stayed with me six or eight weeks that time, but I ran across this little prescription since, and now get well in three days." Little does he dream that ever since his first attack, Neisser's pets have been holding high carnival in every crypt and cranny of his urethra, and have the "Standing room only" sign out.

Even we of the medical profession often enter into this spirit of levity with our gonorrhoeal patients, and fail to impress them with the real gravity of their affliction. We see the simple, uncomplicated case, and do not look into what might be—into the far-reaching tendencies of this apparently benign disease. It is now a well established fact that the gonococcus can be transmitted through the medium of the blood to any part of the human economy, and there set up its characteristic inflammation. It has been recently shown that a goodly number of cases of ulcerative endocarditis are from a systemic gonorrhoeal infection. Weichselbaum reports a case in which an autopsy showed ulcerative endocarditis and where gonococci and also streptococci were found. Ely mentions a similar case. I have also seen a report of a case of gonorrhoeal arthritis where the cocci were found, a pure culture made from them, and a human subject was infected with a second culture. To demonstrate that the blood itself and not the lymphatics carried the infection, Shayer and Bloom report a number of cases where blood cultures taken during life show colonies of the gonococcus Neisser. Cushing of Johns Hopkins Hospital, in a paper (May, 1899) entitled "Acute Diffuse Gonococcus Peritonitis," shows conclusively that serous as well as mucous membranes can be affected by this germ. Even the

fourth ventricle of the brain has been found to be a dwelling place for this ubiquitous bacterium.

Now gentlemen, when we pause and reflect upon these things, when we have it shown so conclusively that this benign local infection can be transmitted to any part of the system, and there set up such serious lesions as to cause death, do I exaggerate when I state in the beginning that even the medical profession on the whole overlooks the seriousness of this disease?

My third consideration is that "Gonorrhoea through the medium of its sequellae is responsible for a large and growing percentage of the mortalities of our cities." I have just called attention to the serious results that may ensue from a general systemic infection, but have not as yet alluded to the various sequellae that follow from a direct infection—from continuity of kindred tissue. While it is my belief that more deaths really occur from systemic infection than direct infection, still there are many of the latter class that are sufficiently serious to cause death. Of course it is not that the germs carried away from the focus of the disease become more virulent, and hence produce more deaths, but that lesions are set up in vital organs, such as the heart and brain.

The most serious sequellae from direct infection are Nephritis, Pyelitis, Cystitis, Prostatitis, Vesiculitis, Orchitis and Epididymitis. In the female a large number of cases of Cervicitis, Endo-metritis and Salpingitis, are merely gonorrhoeal sequellae. I would that I had the time to consider each of these conditions at some length, but the mere mention of them is sufficient to support my argument, as we all know their tendencies when we have to cope with them in acute form. Lydston says, that many a man afflicted with Bright's disease, owes it to a gonorrhoea contracted in earlier life, and which has never been cured. If we take the above array of diseases, and then remember that Endocarditis, Peritonitis, Cerebral, Hepatic and Nephritic lesions may result from gonorrhoea, it becomes a self-evident fact that specific urethritis is responsible for quite a large mortality. Lydston says in his recent work upon Genito-Urinary diseases, that he considers gonorrhoea the most serious of all venereal diseases, and that through the medium of its sequellae it causes more deaths than syphilis. Personally, I am decidedly of the same opinion.

My fourth consideration, and the one which prompted the writing of this paper, is that "Gonorrhoeal patients are as a rule dismissed too early, are oft-times only apparently cured, and have the coccus latent in the urethra, capable of reproducing the disease in acute form many years afterwards, perhaps appearing after the patient is married, and thus infecting an innocent wife." Under this topic I shall report a few cases to better substantiate the proposition:

F. H., Jeweler, age 22. Came to my office to be examined for life insurance. A scrofulitic history was elicited. Specimen of urine passed in my presence showed numerous pus shreds, and muco-purulent filaments, and the applicant was informed that he had gonorrhoea, which he of course strenuously denied. He finally told me that one year previously he did have the disease, but was treated in South Dakota (where he was living at the time), and dismissed as cured. Eight months later he married, moved to Birmingham, and had been living here four months when I saw him. If the Michigan law had made a felon of this man, it would certainly have convicted one innocent of any wrong doing. Strange to say he had never noticed any discharge whatever, and had not the least suspicion that he had any remnant of the old trouble. I gave him an anterior irrigation of potassium permanganate 1 to 1000—sufficiently strong to stimulate a discharge. He returned next day with a fairly copious urethral discharge—muco-purulent in character, and which upon microscopic examination showed numerous gonococci. He was then convinced that he had a gonorrhoea, and placed himself under my treatment. This case was undoubtedly the most obstinate one that I ever handled. Examination with the urethrameter showed a stricture sized 17 French about five inches from the meatus, and another an inch and a half down, sized 22. I did not make an endoscopic examination at the time, for I felt satisfied that I had located the seat of the disease, and that I would have no trouble in effecting a cure. As the meatus was rather small, I did a meatotomy, and commenced the use of steel sounds, followed always by intra-vesical irrigations of potassium permanganate solution 1 to 5000 in strength. The sounds were passed every other day, and the irrigations given every day. I got him up to 30 French, and was unable to go any higher without considerable hemorrhage following.

Granular patches were then suspected, and upon endoscopic examination, two were found on the floor and right lateral aspect of the posterior urethra. These were touched up through the endoscope with silver nitrate twenty grains to the ounce, and the urethra swabbd out every day with a solution of resublimed iodine, eucalyptol, tannate of glycerine and carbolic acid in a boro-glyceride medium. The patches under this treatment began to disappear, as did also the pus shreds in the urine. Sounds were again resumed so as to get his stricture to dissolve, but anything over 32 French still caused some bleeding, and considerable ardor urinae afterwards. About this time I purchased an Oberlander dilator curved for the posterior urethra, and I must say that it is an indispensible adjunct in the proper treatment of this class of cases. The man's normal urethra according to my estimate was

38, and in three or four seances I easily carried him up to this and with no hemorrhage except the first time.

Now that I had attained to the full size of the urethra, and the patches had practically disappeared, I expected to see an early disappearance of the muco-purulent shreds, but in this I was disappointed. Intra-vesical irrigations were resumed, and the dilatations given three times per week, and still I could not get the filaments to disappear. As there was nothing abnormal to be seen in the urethra by most diligent endoscopic examination, it dawned upon me that perhaps the scrofulitic history might have some bearing upon his case, and he was accordingly put on cod liver oil and the three chlorides (Iron, Mercury and Arsenic). He did well upon this, and after continuing the local treatment three weeks longer, I was able to dismiss him. I kept him under observation a month longer, at the end of which time he was all right. He has gone to another city to reside and I received a letter from him a month after he left in which he wrote that he looked for shreds in his urine frequently, but had not found any up to that time. It is needless to say that the "leucorrhoea" (?) which his wife had been troubled with since shortly after her marriage, disappeared when I gave her daily permanganate irrigations for three weeks.

E. M., Car Foreman, aged 27. Anticipating matrimony, this man presented himself at my office for a life insurance examination. General physical examination and famiiy history first-class. When he passed a specimen of urine for my analysis, I noted many pus shreds and tripper-faden in it, and showed them to him, explaining their significance. He said that he did have clap a year or so ago, but was treated by a physician and pronounced well. I urged him to postpone his wedding, and to go to his physician and explain the situation to him, telling him what I had said. He left my office indignant at my diagnosis, was rejected by the company, married two weeks later, and I suppose ere this the gonococcus of Neisser has added one more victim to his appallingly long list of innocent wives. This man ought to reside in Michigan and get the full penalty of the law.

W. H., Groceryman, aged 48. Applicant for life insurance. Numerous tripper faden found in urine, and gonococci present. This man gave a history of having had gonorrhoea fifteen years previously, was supposed to have been cured, and had never noticed anything since that would cause him to think he had any return of the old trouble. He said that he often noticed that the meatus was glued together in the mornings, but he did not attach any significance to this. He put himself under my treatment and was dismissed in seven weeks. I have seen him several times since and he has never had any recurrence of the disease. The remarkable feature of this case is that although it

extended over fifteen years there was comparatively no stricture whatever.

M. M., Saloon keeper, aged 35. Two weeks after his marriage he came into my office with an acute case of gonorrhoea. He told me that he had had clap a dozen times, which of course means that he never had it but once. Three years prior to his marriage was the last attack he noted, and after that he had been as sound as a dollar (to use his words). Fortunately this man was sufficiently intelligent to understand that his acute attack was merely a recurrence of the old one, brought on by excessive intercourse and alcoholic indulgence, and that he had infected his wife instead of his wife infecting him. I treated both of them and dismissed the woman in four weeks and the man in six. This has been eight months ago and he has had no trouble whatever since.

W. S., Street Car Conductor, aged 25. Came to my office to consult me about his wife, who had been troubled with a profuse vaginal discharge, and severe pain upon micturition. I questioned him closely as to whether he had ever had urethritis, and finally got it out of him that he had a case about fourteen months previously, which was several months prior to his marriage. I could not get him to allow me to examine him as he insisted that he was perfectly sound, nor could I obtain a specimen of his urine, as he claimed to have urinated just before coming to my office. However he sent his wife up next day, and I found just what I had suspected—a typic case of gonorrhoea. The woman made a good recovery, but I suppose that she perhaps became re-infected, as the man never presented himself for treatment.

I think that these cases will quite forcibly demonstrate the point that I have taken, and explain perhaps the appropriateness of the title of my paper. My plea for the Gonorrhoeic is that we should never dismiss him until we have exhausted all means of diagnosis to determine his eligibility for dismissal, explain fully to him the gravity of the disease, and the probability of its recurrence if he does not abstain from sexual intercourse and alcoholics for several weeks after all treatment has been discontinued. Of course after his dismissal, if he disobeys our injunctions we have none of the onus to bear, but when a man is turned out as well and made to believe so, and then spreads the disease abroad because he was not well when dismissed, we certainly have all the blame upon our shoulders. This then, gentlemen, becomes a very serious subject when all these facts are taken into consideration, and when I say facts, I use the word in the fullest intensity of its meaning: for they are clinical facts which I have no doubt have been brought to the observation of many of the gentlemen present here tonight. The old saw "an ounce of prevention" was never more apropos than when applied here.

The important question of course is "What is the best means of curing these cases, and how are we to know when they are well?" To sum up my experience, it has been my rule to never dismiss a case—1. Until all discharge has ceased. 2. There must be no goutte militaire, or agglutination of the meatus upon awaking in the morning. 3. There must be absolutely no traces whatever of stricture in any part of the urethra, or any evidences of prostatitis. 4. There should be no tripper faden. Often, however, a few mucous shreds will persist after the urethretis has disappeared, and these may be distinguished from the pus shreds by the fact that they float at once to the top of the tube and exhibit no tendency whatever to sink. If these contain no gonococci, their presence is of no special significance.

To dismiss a case when there was any discharge whatever would of course be gross mal-practice, so we can eliminate that from our discussion. The second consideration is one, however, that is frequently violated. Unless a man has had urethretis before, he will scarcely ever notice the goutte militaire or morning drop. He would be more likely to have his attention attracted to the occluded meatus. This occlusion is nearly always partial, and merely amounts to a sticking together as it were. The goutte militaire will not be noticed unless the patient is directed to look for it, and instructed to milk out the urethra. If the least particle of matter is expelled out by pressure the evidence is quite conclusive that the disease still persists. There is one exception to this, however, and that is in those cases where the patient becomes neurasthenic over his case and persistently milks his urethra to discover some evidence of discharge. This constant manipulation will oft-times set up a slight urethrarhoea, and the patient is at all times able to bring forward to the meatus a drop of secretion. Upon microscopical examination this will show mucous filaments and a few epithelial cells, but no gonococci.

The third consideration was that there must be absolutely no traces whatever of stricture. If there is the slightest stricture, of course irrigation is futile towards effecting a cure. The stricture itself demands separate attention, and then the urethretis can be handled afterwards. Perhaps the most important means of judging whether or not a patient is ready to be dismissed is by noting well the urine from day to day, watching carefully the character of the shreds. If there are any shreds at all, the case should still be watched with suspicion, but as previously mentioned, sometimes there may be a shred or two that will float to the top, and whose presence may not affect the favorable prognosis, as they are composed entirely of mucous, caused by a slight hyper-secretion from the mucous glands, and will in all proba-

bility subside after the treatment is discontinued. When we pronounce a case well, we are assuming quite a responsibility, and hence each one of these prognostic points should be taken into consideration. They should be weighed collectively and individually, the patient should be kept under the surgeon's eye for at least a week, his urine examined macroscopically each day, and strict injunctions laid down as to diet, drink and habits. Just here occurs an important consideration, and one that may cause a correct diagnosis to go wrong. Let us suppose that the man is well, and that he is told so and dismissed. So far he has obeyed the surgeon, and abstained from sexual intercourse. As soon as he is told that he is well he commences his rounds again, his long pent-up sexual appetite must be satiated, and as conviviality goes hand in hand with this, and whereas vinous and malt liquors are conducers of conviviality, ergo, the old, old story. This man may really have been well when discharged, and the prognosis of the surgeon a correct one, so therefore it is a most important consideration that we thoroughly impress the patient with the fact that all his treatment will have been for naught if he does not take the strictest care of himself after he is dismissed.

As to treatment of course that all depends upon what the character of the case is. If it is in the acute stage, it is my custon to commence at once irrigations twice daily of either permanganate of potash, cupric sulphate, protargol, argonin, silver nitrate, or mercurol. I do not hesitate to say that my preference is decidedly for the permanganate of potash. I use it in hot solution, say about 100 degrees, and prefer the tablets (3 and 5 grains) pulverizing them in a glass mortar as needed. At first I give the irrigations twice daily, say at 9 a. m. and 4 p. m., the strength being about 1 to 5000, gradually increased up to 1 to 2000 or 1 to 1500. About the third day I commence the intra-vesical irrigations, using a solution about 1 to 5000 to start with, and going up as high as 1 to 3000, keeping these up until the patient is well. After the first ten days I give the treatment only once a day, but use a double injection, viz: give an intra-vesical irrigation 1 to 3000 and afterwards an anterior irrigation 1 to 1500 or even 1 to 1000. In uncomplicated cases where the patient carries out instructions as to diet, etc., a cure can generally be effected in from 3 to 4 weeks. Some authors report cures in fourteen days, but I have never been able as yet to accomplish this, although I have adhered strictly to the plans used by these men.

As for the so-called specifics, I have certainly given them, or many of them, a fair and impartial trial, and always return to the permanganate of potash.

I have been repeatedly asked the question, "Why is it that if the case

is confined to the anterior urethra, you use the intra-vesical irrigations?" In the first place as 90 per cent. of cases are posterior, and we rarely ever see the case until three or four days have elapsed, the chances are that the posterior urethra may be involved and hence it is absolutely essential that the intra-vesical injections be given. Even, however, if the inflammation is entirely in the anterior urethra, it is the correct thing to use the intra-vesical irrigations, because the nine foot hydraulic pressure baloons up the urethra, and this mechanical distension exerts the same influence that a sound does in stricture, viz: promotes absorption, and besides this the balooning process opens up the crypts and allows the fluid to come into more intimate contact with every part of the membrane. Another theory is that an artificial oedema is produced which makes the urethra an unfavorable medium for the propagation of the cocci.

In a previous paper I called attention to the differential diagnosis between anterior and posterior urethretis. The two-glass test is not always reliable, and where it is necessary for a positive opinion on this point, I use the following: A 1 per cent. solution of methylene blue is injected with sufficient force to carry it up to the cut-off muscle, after which the man urinates in two glasses. The first glass will contain all the washings of the anterior urethra plus some few shreds from the posterior urethra. The second glass is supposed to contain the washings of the posterior urethra. All shreds that are stained by the methyl blue are from the anterior urethra, while all unstained shreds are from the posterior urethra.

In chronic cases irrigations are of little value per se, for the reason that these cases are nearly always associated with more or less stricture. If the stricture is not so large that operative interference is necessary, my plan is to use a combination of dilatation and irrigation. The dilatation may be gradual, as with the use of sounds, or rapid as with the use of some of the various dilators. For the past year I have been using an Oberlander dilator which as heretofore mentioned is curved for the posterior urethra. A rubber cover is fitted over the instrument so as to prevent injury to the urethral mucous membrane upon its withdrawal, and a dial plate indicates the amount of dilatation attained. With the use of this instrument and combined daily irrigation, I have had most gratifying results. I never introduce a sound, dilator or catheter in the urethra without giving an intra-vesical irrigation afterwards. No matter how sterile we may imagine these instruments, severe urethral fever will frequently follow their introduction, but I desire to state that I have never as yet seen a case of urethral fever where an intra-vesical irrigation of permanganate of potash was given immediately afterwards.

Very often we run up against cases that do not yield a particle to either irrigation or to the combined irrigation and dilatation, and of course we must then suspect that we have some complication—perhaps a stricture, or an infiltration of the mucosa or mucous glands, a granular patch at some point in the urethral canal, or else some peri-urethral complication, such as a Vesiculitis, a Prostatitis, a Cowperitis, etc. If a careful digital examination per rectum and otherwise has excluded any peri-urethral trouble, there is absolutely no way to arrive at an intelligent diagnosis except by means of the urethrascope—a direct ocular examination. For this purpose it is my custom to employ the Otis endoscope, which is merely a Klotz tube with an electric attachment to furnish the illumination. I find that it requires considerable experience to make a proper use of this method, as histological structures are quite liable to be mistaken for pathological ones. For example, a lacuna of Morgani is apt to be construed as a granular patch, the deeper color of the posterior urethra for an inflammation, etc., but as is the case with the opthalmoscope and the laryngoscope, a little practice under the guidance of one who has done much of this work, will soon enable a beginner to grasp the various pathological changes that may be found; and the certainty of making a positive diagnosis that cannot possibly be made in any other way will amply repay the observer for all the time, study and expense incurred. The fact is that when one is treating a case of chronic urethretis in any other way than by means of the endoscope, he is fighting his battle in the dark—he is like a mid-wife at the accouchement who knows nothing whatever of the mechanism of labor or the anatomy of the parts, and yet attempts to deliver a child. As an example of what endoscopy will accomplish after other means have failed, permit me to cite a case which recently came under my observation:

T. B. D., aged 25.—Had been affected with gonorrhoea for six months, during the last two of which he had received daily irrigations of potassium permanganate. Although maintaining a strict diet, etc., the inflammatory process still continued, and the discharge appeared and disappeared at intervals. Nocturnal pollutions were quite frequent, and were always followed by an exacerbation of the discharge. As the patient was to be married in two months, he began to grow neurosthenic over his case and succeeded in imparting much of this to a colleague who was treating him. He was brought to me in consultation, and a course of treatment mapped out. This was carried out two weeks without any noticeable improvement, and as the time for his marriage was drawing dangerously near, and the disease was still in evidence, he was turned over to me for treatment. Endoscopic examination had

been made at the time of the consultation, and infiltrations noted, and the use of full sized sounds to break them up advised—the daily irrigations to also be kept up. At the second endoscopic examination a large granular patch was noticed. The infiltrations seen at the first examination were melting away to some extent. As the doctor had previously done a meatotamy full sized sounds were passed under cocaine twice a week, hot intra-vesical irrigations were given twice daily, and the granular spot touched every other day with silver nitrate, 20 grains to the ounce. After the spots were touched, the entire urethra was swabbed out via the endoscope with odorless iodoform in a medium of compound tincture of benzoin and balsam peru.

In three weeks all traces of the disease had disappeared, the patient enjoined very strictly as to his habits, and advised to come to my office every other day for me to examine his urine. At this time a few mucous shreds were observed, there was no morning drop, no morning agglutination of the meatus, and no gonococci. I had him under observation several weeks longer, at the end of which time he was married. I confess that although I felt fully satisfied that he was well, I realized the danger that was incurred by a marriage so early after his dismissal, and tried to persuade him to postpone it another month, explaining to him fully the risk that he was running. I asked him to keep me informed as to the nature of things, and especially to report to me at once if any trouble whatever appeared. I have seen him several times since, and am glad to say that he has never had the slightest symptom of a recurrence so far.

Such good luck, however, may not always crown our efforts, and it is our duty to impress most forcibly upon every gonorrhoeic the great risk he is running in marrying, within six months even though we can positively assure him that he is well at the time. Noeggerath asserted some years ago that 800 men in every 1000 had gonorrhoea. Lawson Tait went him several better and assertel that every man had clap at least one time in his life. The statistics of the German Empire for 1894 show that of all women who died of diseases of the uterus or its appendages, 80 per cent. were proven to be of gonorrhoeal origin. Also that of all children who became hopelessly blind after having been born with healthy eyes, 80 per cent. of them could attribute their affliction to gonorrhoeal opthalmia. It is a hard matter to gainsay these figures, but even if they are too large, still we must be impressed with the fact that this disease is one of the most serious with which we have to cope, for when faithful wives are dying by the hundreds in consequence of it, and scores of innocent babes are consigned to a life of miserable darkness, it is time for us to more comprehensively wage a

scientific warfare against this hydra-headed monster. To sum up my plea for the gonorrhoeic:

1. Let us impress him with the gravity of his disease, and its far-reaching pathologic possibilities.

2. Let us treat him upon more rational and more scientific principles, avoiding the routine, and remembering that, as in other diseases, each case has its own pathological peculiarities, and hence requires individual therapeutical endeavors.

3. Let us employ every diagnostic means at our command to be thoroughly convinced that the patient is well before we dismiss him, remembering that it is these apparently cured cases that do more subsequent damage than all others combined, not only to the patient himself, but to the trusting woman who thereafter becomes his wife.