gruntled woman. Perhaps the best method of deciding whether artificial termination of pregnancy would benefit a patient's health when the practitioner and consultant disagree would be for the doctor to take the opinion of a second independent specialist and abide by a majority vote.—I am, etc.,

STANLEY W. WRIGHT., M.B., M.C.O.G.

Newcastle, Staffs, Sept. 29.

SIR,—I quite agree with Dr. F. M. R. Walshe's letter (*Journal*, October 2, p. 678) in which he states "we may be thankful that in this country it [the Law] will never hand over to us the power of life and death over our future fellow-citizens." I have expressed similar views elsewhere, but feel that two types of case need consideration—namely, cases of rape and of incest. Unpleasant as this subject is, it must be faced, since these cases are more commonly followed by pregnancy than is generally realized. Clearly in these cases it is against the interest of the State for pregnancy to continue, and, in my view, with legal safeguards induction of abortion should be allowed.—I am, etc.,

London, W.1, Oct. 3. JOHN H. HANNAN.

SIR,—Dr. F. M. R. Walshe is surely wrong in holding that the nation would fetter itself with the chains of a potential medical tyranny if it allowed doctors to accede to any woman's request to have her pregnancy interrupted. What is tyrannical is the present ruling that only seriously diseased women may legally have the operation. It is a tyranny which a rapidly increasing number of women are determined to abolish, and which is openly deplored even by some Conservative Members of Parliament.—I am, etc.,

London, S.W.15, Oct. 2. B. DUNLOP.

Diagnosis of Ectopic Gestation

SIR,—The interesting paper by Dr. W. C. W. Nixon on aids in the diagnosis and treatment of ectopic gestation (*Journal*, September 18, p. 579) recalls a method I adopted sometimes to confirm the diagnosis of ectopic gestation in doubtful cases. As Dr. Nixon says, acute tubal rupture with severe internal haemorrhage very seldom calls for any additional diagnostic measures. The puncture of the posterior vaginal fornix is certainly, in the majority of cases, an appropriate means of confirming the diagnosis. But because of the danger of infection or intestinal adhesions I should think it is not always safe unless immediately followed by laparotomy.

The occurrence of shoulder pain is also a very useful sign, and the patient ought to be questioned about it, though in my experience most patients do not feel any such pain. To induce this symptom by irritating the phrenic nerve I put the patient on the operating table in the Trendelenburg position, preferably under very light general anaesthesia. If there was but a small extravasation in the pelvis some blood came in contact with the inferior surface of the diaphragm, and within a few minutes the patient started a regular singultus. The hiccup stopped of course with deeper anaesthesia—for which chloroform was never used.

In several cases in which I applied this test with a positive result the laparotomy showed an ectopic gestation with some extravasation into the pelvis, and often only a trace of blood in the upper abdomen. I have had no opportunity of trying the same test in cases of ascites, in which I should think it would also be positive. Whenever I find the peritoneal cavity containing free old blood I do not perform appendicectomy or any other operation on the gut, unless the need is urgent, because of the danger of infection of the peritoneum.—I am, etc.,

London, N.W.6, Sept. 25. H. G. LIEBMANN.

Continuous Negative Pressure in Surgery

SIR,—May I be allowed to compliment Mr. M. S. Bennett-Jones on his well-thought-out paper on continuous negative pressure in surgery (*Journal*, September 25, p. 613). There are one or two statements, however, to which he has committed himself I think unfortunately because, while not really contributing to his argument, their accuracy is open to challenge. If Mr. Bennett-Jones will consult my note on page 624 of the same issue he will see that the use of intercostal drainage by no means "entails" the use of a "small drainage tube." The internal diameter of the cannula which I there describe is 10 mm.

Then again, he says, "In narrow intercostal spaces the pressure of large drainage tubes *may* cause necrosis of adjacent ribs." One has also heard it said that necrosis of rib *may* occur after rib resection for empyema. I suppose as a humble scientist I must admit that anything *may* happen, but as a practical surgeon I do not consider that either statement need cause us any concern, whether we believe in rib resection or intercostal stab. Personally I believe in the latter as the first step at least in almost every case. I am sure Mr. Bennett-Jones is wrong when he says that "it is better to resect a rib in all cases." Even when he weakens so far as to say "in most, if not in all, cases" I think he is making a considerable overstatement. I could say much about the efficacy of the comparatively weak suction of the simple water-seal method in drainage both of empyemata and of the chest after lobectomy, but I do not want to suggest that the stronger suction secured by Mr. Bennett-Jones is not an excellent thing too; in more chronic cases it is admirable. His presentation of the case for closed drainage of the chest could hardly be bettered.—I am, etc.,

Liverpool, 1, Oct. 1. JOHN T. MORRISON.

The Scope of Orthopaedic Surgery

SIR,—I would like a ruling on a discussion as to the limits of orthopaedic surgery. Do the following cases come under orthopaedic or general surgery? Gunshot wounds of arm; all amputations; osteomyelitis; sarcoma of knee; finger amputations; motor accidents to limbs; lacerations.—I am, etc.,

Grimsby, Sept. 23. S. E. DUFF.

The Dangerous Area of the Face

SIR,—In connexion with the annotation which appeared in the *Journal* of September 25 (p. 629) may I point out that the venous or lymphatic anatomical peculiarities of the upper lip are not in themselves sufficient to explain the high mortality which attends complicated facial furuncles. The lachrymal sac is much nearer to the cerebral veins and is often infected, yet the mortality is probably *nil*—at least I never saw or heard of a fatal issue. To a lesser degree the same applies to hordeolum. I remember seeing two fatal cases of thrombosis of the cavernous sinus following a hordeolum of the upper lid, but in view of the frequency of hordeolum the mortality must be nearly *nil*, or at least very small indeed. These are facts pointing to the solution of the problem. The lachrymal sac is so situated that the action of the facial muscles in talking and eating does not affect it. Only the orbicularis palpebrarum participates in the movement