so as to make the union perfectly smooth and uninterrupted. The appliance for introducing the tube serves also for expelling the gum-elastic tip. It consists of a very slender rod enclosed in a cannula. The latter is expanded and flattened below and is perforated for a screw above. The former has fine hooks and a thread at its lower end to serve as a wool-carrier.

To prepare the equipment for use the following procedure is necessary—namely,

1. Lightly fit the gum-elastic tip to the tube; on no account must the union be firm, as it requires to be easily broken when the tube has been placed in position.
2. Affix wool to the wool-carrier in bulk sufficient just to engage the lumen of the tube and support its weight.
3. By means of the screw adjustment extend the wool-carrier so that the little wool piston just touches the gum-elastic tip when placed inside the tube, whilst at the same time the flattened lower end of the cannula makes contact with the tube.
4. Fix the wool-carrier in this position by tightening the screw.

The apparatus being assembled and prepared in this way is ready for use. The oesophagoscope is now passed and the face of the stricture brought into view. One or two rubber-tipped Jackson's bougies are now passed to dilate the stricture and to determine the exact position. Everything is now ready for passing the tube. The gum-elastic tip, being soft and pliable, easily and safely finds its way through the stricture, carrying with it, harmlessly and unerringly, the metal tube. When the expanded upper end

of the tube reaches the face of the stricture the downward movement is discontinued and the gum-elastic tip expelled. This is achieved by loosening the screw which fixes the wool-carrier, so that it is free to push out the tip. After so doing the final step consists merely in withdrawing the wool plug into the expanded upper end of the tube. In doing this the tube must be held in position with the flattened lower end of the cannula until the wool plug, having reached the tubal expansion, is quite free and the introducing mechanism comes away unimpeded. It will be seen that the use of the oesophagoscope is unfortunately essential, but the actual placing of the tube is easy and safe, only requiring one simple action and occupying but a few seconds.

The efficiency of Souttar's tubes is surprising. Even the smallest size, with a diameter of 4 mm. at the lower end, is fully adequate for fluids and may continue to function well for months. Trouble can arise from displacement of the tube downwards or obstruction of the lumen. I have little experience of displacement upwards of Souttar's tubes, but on a number of occasions I have known a tube to work its way harmlessly through the stricture and pass into the stomach.

The maximum length of service of an intubation tube is obtained when the largest size possible, within the limits previously stated, is used, and when nothing but thin fluid nourishment is given, succeeded on each occasion by a drink of water to flush out the tube.

All the appliances referred to in this communication are made by Messrs. Mayer and Phelps of London.

COMPARISON OF A THOUSAND SERUMS TESTED BY THE WASSERMANN AND KAHN METHODS.

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In the series of investigations of 1,000 serums now reported the Wassermann technique used was that devised by Colonel Harrison; Kahn's technique¹ was closely followed, as laid down by the inventor. The antigen was supplied by Messrs. Parko, Davis & Co., London. An attempt was made to use symbols in expressing the comparative strengths of the reactions in either case. A list of equivalents is given in Table I.

TABLE I.—Comparative Strengths of the Kahn and Wassermann Reactions.

Reaction.	Comparative Strengths.				
Wassermann ..	++	+±	+	±	—
Kahn	++++	+++	++	+	—

For diagnostic purposes the two tests were in agreement in 98.4 per cent. of cases, and they appeared to be of equal strength in 94.6 per cent. In 3.8 per cent. the cases showed quantitative differences; 40 per cent. of these were treatment cases. In 87 per cent. the Wassermann reaction appeared to be the stronger of the two. Disagreement between the two tests was apparent in only 1.6 per cent. of the 1,000 cases; these are listed in Table II. Of these, it will be noted that 50 per cent. are treatment cases, and that the Wassermann test appeared to be the more sensitive. In two doubtful cases—one of general paralysis, and another of pernicious anaemia—the serums were in bad condition, and the results should not, perhaps, be included. In both instances, unfortunately, we have no further knowledge of the cases.

TABLE II.—Disagreements.

Clinical Description Given.	Wassermann Reaction.	Kahn Reaction.
Gonorrhoea and pregnancy	+	—
? Congenital syphilis... ..	—	+
Treatment case	+	—
Previous ++ (Wassermann reaction) treated	±	—
Arthritis case	Trace	—
Treatment case	±	—
Ulcer of lip	+	—
Treatment case	+	—
Treatment case	+	—
? General paralysis	—	++++
Previous positive (treatment case)	—	+++
Treatment case	±	—
Rash and alopecia (four months)	+	—
Addison's anaemia	—	+++
Treatment case	±	—
Adherent placenta	—	++

Summary.

1. This series would seem to suggest that the Kahn test and the Wassermann reaction can be fairly strictly compared.

2. In this series the results are in favour of the Wassermann reaction.

3. It is valuable to test a serum by both methods.

4. The convenience, simplicity, and rapidity of Kahn's method make it a very useful test where conditions would render a Wassermann test difficult or impossible.

5. The Kahn test should not supplant the Wassermann.

6. The Kahn test is more difficult to read, and is more affected by external temperature than is the Wassermann test—that is, apart from tropical conditions.

REFERENCE.

¹ Kahn: *The Kahn Test: A Practical Guide*, Baillière, Tindall and Cox.