the tube is passed along the side of the finger until it is upon the epiglottis. Now in all the text-books I have at hand, it is directed to keep the finger in this position, pass the tube on till it engages in the glottis and then push it on down. I believe, however, that I have been taught a better method which simplifies the entrance of the tube. When the tube is introduced as far as the epiglottis it is held firmly against that structure to keep it in position, and the finger is then passed into the oesophagus behind the larynx, or rather just behind the arytenoids which, although small and delicate, can usually be distinguished. This supports the larynx, and the tube being kept in front of the finger passes into the glottis. Then the index finger is raised to the head of the tube, the obturator loosened and the introducer withdrawn, while at the same time the tube is pushed down with the finger until the head is well into the larynx. As soon as it is seen that the obstruction to breathing is overcome, the thread is to be removed, this being done by reinserting the gag and the index finger is passed in till it is upon the head of the tube to keep it in position while the thread is withdrawn. Some European operators leave the thread in position during the whole time that the tube is worn, tying it around the ear and fastening it upon the cheek with adhesive plaster. This is not necessary. It is uncomfortable, causes ulceration of the epiglottis if worn long, incites cough and may be the cause of the tube being pulled out if the patient gets his hands free. On the other hand the thread prevents the loss of the tube into the trachea or by swallowing; and of course it greatly facilitates the removal of the tube.

Extubation—This is regarded as more difficult than intubation when it is done with the extractor. If the thread is left in the tube there is no difficulty, or the tube may be coughed out. This is more likely to occur when an undersigned tube is used. When the extractor is used the directions which have been given for intubation apply with equal force. The epiglottis is raised by the finger, then held by the point of the extractor while the finger is passed on into the oesophagus, the point of the extractor then advanced to the finger when it readily drops into the tube.

Feeding an intubated patient—This is a most important subject. The plan which I consider the best is to pass a catheter through the nose into the oesophagus and by a funnel, pour into the stomach from four to six ounces of milk every four hours. Dr. O'Dwyer advises the method introduced by Dr. Casselberry, of Chicago, in which the