tomy, to offset the prejudice that existed against it." This was a unique experience, but it is the misfortune of many skilful operators to be unable to report any recovery following tracheotomy.

The *technique* of intubation is so thoroughly a matter of literature that it is unnecessary to describe the operation in detail here; but there are certain points which may properly be discussed.

When to operate—When a progressive dyspnoea, despite treatment, allows any considerable portion of the lungs to become non-inflated, and the labored breathing begins to produce exhaustion, intubation should be done without delay. If air cannot be inspired, pneumonia is invited, and nothing but harm can come to the lungs and heart.

How to operate—It is quite unnecessary to strip the child naked, as ordered by some operators, before winding it in a light blanket. The elbows should be pinioned to the sides and the hands down across the abdomen. There must be no bulky roll under the chin to interfere with the movements of the operator. The nurse who is to hold the child should sit upright in a high straight-backed chair, and should firmly grasp the child at the elbows, keeping the legs between her knees. This will bring the child's head on a level with her own and above the shoulder. The physician assisting stands behind the chair of the nurse, grasps the child's head between his hands and holds it firmly with the chin in the median line, and extending the chin slightly, raises the head up, to extend the neck, just as though he were supporting the weight of the child. When the gag is introduced it is included in the grasp of the assistant to insure its firmness. Another plan is to have the child upon its back on the table. The manipulation is rendered easier in this position by allowing the head to drop slightly over the end of the table, and placing a small firm pillow under the neck. Where the heart is enfeebled the prone position has much to recommend it, and no doubt the skilled operator will introduce the tube as readily in one position as the other. When the patient is held by the nurse and assistant, the operator should stand directly in front. Most of the text-books say he should be seated, but to stand is better because his eyes are not endangered by the coughing of the patient. As soon as the gag is introduced the child begins to worry; but from this to the end of the operation should be only a few seconds, though it takes much longer to describe it. The introducer with the proper sized tube threaded is at hand. The index finger is inserted and the epiglottis hooked up, then