The patient sits, or stands, facing the physician. The œsophageal tube having been dipped into warm water or warm milk, is placed within the entrance of the œsophagus, and then is propelled by successive pushes into the stomach; the process being facilitated by efforts at deglutition on the part of the patient.

Many patients quickly learn to introduce and swallow the tube without assistance. A mark on the tube shows when a sufficient length has been introduced (say eighteen or nineteen inches). The funnel is then elevated to the level of the patient's forehead, and from a pint to a quart or more of the lavage solution is slowly poured in; the glass junction tube permitting its passage to be watched, and obstruction or attempted regurgitation to be detected. The patient's sensations will usually inform us when a sufficient quantity of the solution has entered the stomach. As the last portion of liquid disappears from the funnel, the soft-rubber tube is pinched near the extremity, the funnel is rapidly inverted over a receptacle placed upon the floor; and the contents of the stomach are thus removed by siphonage. These manœuvres are repeated until the returned fluid is clear.

The first introduction of the tube, and possibly the second and third, will occasion more or less dyspnœa, often nausea and retching, rarely vomiting. The effects, though partly physical, are largely psychical; and will disappear with tolerance. The dyspnœa may be immediately checked by insisting on full inspirations. Nausea is overcome as soon as the water enters the stomach, floating the tube away from immediate contact with the mucous membrane. In highly neurotic subjects, it may be well to prepare for the operation, at first, by administering full doses of bromides. I have tried anointing the end of the tube with a solution of cocaine in glycerine, but cannot claim any striking benefit from the procedure. Firm but skilful handling of the tube is the best sedative.

Sometimes during the withdrawal of the solution, solid particles of food (grains of corn in one of my cases) may become impacted in the eyes of the tube, and the flow of liquid will cease. A little more of the solution must then be introduced, both to wash away the obstruction and to re-establish the siphon current. If the tube should be pushed too far into the cavity of the stomach, it may curve upon itself and the siphon will not work. Withdrawal of the tube for a few inches, will remedy this; if the flow is not readily established, it is said that it may be favored by manipulation of the stomach, and efforts at coughing may be made by the patient. I have not had occasion to resort to these devices.

When lavation (washing) alone is the object of the procedure, a weak alkaline solution is employed; a drachm or two of sodium sulphate, sodium chloride, sodium borate, or sodium bicarbonate, in a quart of warm water, at about 110° F.

Should it be considered necessary, however, various sedative and antiseptic medicaments may be added to the lavage solution. Those most highly recommended are resorcin (one per cent.), boric acid (one per cent.), creasote (one per cent.), carbon disulphide water (one part of a solution containing fifteen minims to the quart. to two parts of water), charcoal powder (two to four tablespoonfuls), chloroform water (saturated), bismuth subnitrate (two tablespoonfuls to the pint).

In the use of agents like resorcin, carbolic acid, etc., the liability to absorption if the solution be not all removed, must not be forgotten. In using what we term "milk of bismuth," Dujardin-Beaumetz advises that the solution be allowed to remain a few minutes in the stomach, so as to allow the bismuth to be deposited; after which the supernatant liquid may be withdrawn.

Lavage should be performed when the stomach is empty; therefore, some authors recommend the hour of rising in the morning. I have found noon —say four or five hours after a light breakfast—or the same interval after lunch or dinner to be more convenient for myself, and to answer as well in most instances.

One lavation daily is usually enough. After a while the intervals may gradually be lengthened, until the process is discontinued.

The therapy is sufficiently obvious. The effects are said to be most marked in cases of dilatation of the stomach, in which delayed digestion, retention and putrid fermentation of the contents of the stomach, give rise to distressing symptoms. In all cases, where the gastric mucous membrane is in a catarrhal condition, coated with the glairy mucus which is seen amid vomited matters, or bathed in the sour liquid ejected as "water-brash;" where the production of the gastric juice is impeded, or the secretion altered in quality by an abnormal condi-