3. That extra esophageal disease rarely gives rise to serious dysphagia.

4. That spasmodic obstruction, apart from hysterical form, has always, when decided, an organic cause; and this would be better called intermittent dysphagia.

5. That with regard to the three special districts it may be said: (*a*) That all organic obstruction in the upper third is malignant, and has a special tendency to cicatrize. (*b*) That in the central half of the gullet a sarcoma or a myoma, both rare diseases, may cause fatal obstruction; that here also a pouch may give rise to difficulty in diagnosis, but can generally be excluded. (*c*) That in the lower end alone does simple stenosis occur, and that here there may be difficulty in distinguishing from cancer of the stomach, causing great reduction of the cavity (leather bottle stomach). Finally, that in estimating the extent of the disease, the special value of the steel bolt is noted, and also the use of the Condé bougie in obstruction at the lower end.

With regard to treatment, Mr. Symonds believes in letting the patient alone as long as swallowing can be carried on with sufficient freedom to adequately support life. While bougies can be readily passed, operation is not justifiable, but when dysphagia becomes extreme, a tube should be introduced or gastrostomy performed. He also offers the practical suggestion that a dose of opium being taken the preceding night by the patient, enables the operator to pass the tube more readily.

The treatment varies with the situation of the disease. In the upper third the introduction of a long, soft rubber feeding tube, when possible, was the best. If that failed, or could not be accomplished, gastrostomy was the only other resort.

The central portion of the esophagus is the most suitable for the use of short tubes (Symonds'). They should be four inches long, should terminate like a straight catheter, with two large lateral eyes. The contraindication for the use of this tube is the presence of cough and hemorrhage.

In disease of the lower end no tubes of any kind are tolerated, being rejected by the action of the diaphragm. Hence when swallowing can no longer be accomplished, nor bougies introduced through the stricture, gastrostomy becomes imperative. It is a hopeful operation also, as the stricture in this region may be simple and an ultimate cure made.

When tubes are passed under an anesthetic, Symonds says there is great danger of them entering the larynx. To guard against which he insists upon the advisability of the use of the laryngoscope. When gastrostomy becomes necessary it should be done as early as possible.