the patient was placed on a meat-free diet and given 5 grains of carmin. Soon he passed a very red urine that contained carmin crystals, but no longer any muscle fibers. This proved conclusively the absence of a rhabdomyoma and the existence of an intravesicular fistula. A positive diagnosis of a malignant intestinal tumor with a fistulous communication into the bladder was made. The case came to operation and proved to be an inoperable lymphosarcoma of the ileum adherent to and rupturing the bladder. A later post-mortem examination confirmed all the findings given.

In duodenal intubation and feeding it is important to know whether the distal end of the tube lies within the duodenum or stomach. It is not always possible to obtain secretion by suction, and when the secretion is of a golden yellow color and gives a strong Congo reaction, it may come from either the stomach or the first portion of the duodenum. The question can readily be settled by allowing the patient to drink a small amount of clear, fresh, watery solution of carmin and, attaching the feeding syringe, at once making suction. If the distal end of the tube is within the stomach, carmin solution will be withdrawn; if in the duodenum, no fluid at all, or characteristic bile-colored duodenal fluid, will appear.

Although roentgenoscopy is by far the best method for the diagnosis and differential diagnosis of esophageal dilatation and diverticulum, the suggestion is made that carmin be used in this connection in the same manner as some of the more or less distinctly colored food fluids (black coffee, milk, etc.), heretofore employed for this purpose. It has the special advantages of being bland, acceptable to all palates and of not changing its physical or chemical properties.

CONCLUSION

I would state that in the carmin test we have a simple, harmless, reliable and convenient means for the demarcation of stools, the estimation of gastro-intestinal motility and patency, for the detection of fistulous communications of the alimentary canal with the exterior or with other hollow organs, for the location of the distal end of a duodenal tube and to aid in the differentiation between esophageal diverticulum and dilatation.

With the more universal employment of this method, no doubt further fields of usefulness will suggest themselves.

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A CASE OF BRAIN SYPHILIS

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The course of the case of brain syphilis previously reported by me¹ has been interesting and for correctness a further report is necessary.

Previous History.—The previous report stated that the patient, F. M., aged 34, married, a laborer, having a positive syphilitic history, was admitted to the hospital Dec. 28, 1912, in coma with convulsions and a transient left-sided hemiplegia. He had a strongly positive Wassermann and was treated by repeated injections of salvarsan, neosalvarsan and mercury salicylate. For the time being his recovery was complete and on Feb. 8, 1913, he was discharged from the hospital, apparently in perfect health. During February and the first part of March the patient returned weekly for intramuscular injections of mercury salicylate, one grain being injected each time. About the first of March he went to work in an iron foundry.

Second Attack.—April 14, 1913, while at work, he suddenly fell to the ground in a general convulsion, which was fol-

lowed by deep coma, and at 9:40 a. m. of the same day he was readmitted to the hospital. His condition was much the same as on his previous admission except that no sign of paralysis was present. He could not be roused. The pupils were equal and regular, though small and inactive. The pulse was full but not rapid and without high tension. All reflexes were diminished, those on the right side slightly more than those on the left. Otherwise physical examination was negative.

Because of the previous history the patient was given neosalvarsan, 0.9 gm., intramuscularly, the same afternoon. The blood and spinal fluid taken the same day were examined and both gave a strong Wassermann reaction. As before, recovery was prompt and continuous so that the patient was rational and comfortable, April 24, and was up and about, May 4.

The injection of neosalvarsan, 0.9 gm., was repeated, April 28, and the patient received the weekly injections of mercury salicylate as well as potassium iodid up to 90 grains three times a day. May 9, the patient felt so well that he insisted on going home, promising to return every week for injections. He was seen but once about two weeks later. At that time he was at work, though he seemed restless and rather silly.

Third Attack.—June 25, 1913, following excessive alcoholic indulgence, the patient was again seized with convulsions and was brought to the hospital at 12:30 p. m. He had a severe general convulsion shortly after admission. He was in coma with no sign of paralysis, and as before the coma cleared up rapidly, leaving him violent and noisy.

He was given salvarsan, 0.3 gm., intravenously, July 3, with only slight change in his mental condition, and mercury salicylate, ½ grain, intramuscularly, July 5, 9, 12, 16, 19 and 23. A Wassermann reaction, July 7, was strongly positive and a Wassermann reaction on the spinal fluid the next day was equally positive. A cell-count of the spinal fluid at this time showed 105 cells per cubic millimeter, the majority of which were epithelial cells with very few polynuclears. The fluid was perfectly clear and under pressure. The condition of the patient resembled alcoholic delirium, and varied from day to day from silly docility to noisy violence, but at no time was he rational. He had one more convulsion at 5 p. m., June 30.

Repeated examinations of the urine were entirely negative in result, showing no apparent effect on the kidneys of the many injections of salvarsan and mercury. His temperature was generally flat normal with an occasional rise to 99 or 100 F.

July 23 his temperature rose abruptly to 104 F. and his condition became much worse. He was drowsy and stupid and took fluids with difficulty. July 24 his temperature rose to 106 F. There were neither convulsions nor signs of paralysis. He became rapidly weaker and died in coma the next day, July 25, at 11:30 a. m. Necropsy was refused.

This case brings out the prompt response of a patient to strong antisyphilitic treatment in an undoubted case of brain syphilis, but the equally prompt relapse, increasing in severity following each interruption of treatment. At the same time I think there is no doubt that the patient's life was prolonged six months, a part of which time he was able to work, and much more might have been done had it been possible to keep him constantly under treatment.

992 Tiffany Street.

A METHOD FOR ASEPTIC URETERAL CATHETERIZATION

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The sterilizing and aseptic handling of ureteral catheters has always been more or less of a problem to the cystoscopist. The method that I here present is one that I have used lately and have found simple and efficient.

The boiling or immersion of the catheters in various solutions renders them soft and difficult to handle. Formaldehyd

¹ Eddy, Nathan B.: Recovery in Brain Syphilis after the Use of Salvarsan, THE JOURNAL A. M. A., April 26, 1913, p. 1296.