

Zingher. "It appears earlier, is more infiltrated and less sharply circumscribed" than the true positive reaction. It usually disappears in from three to four days, leaving "only a faintly pigmented area" which soon becomes invisible and "is not followed by true scaling." This form of pseudopositive reaction, according to Park, Zingher and Serota,<sup>3</sup> is "probably a local sensitization phenomenon of a general protein character."

Of the first 106 cases tested by us, four showed an anaphylactic pseudopositive reaction by the Schick technic, while only one responded this way by our method. Inasmuch as the total number of such reactions, in very large series, is only about 8 per cent. one must have performed thousands of tests before a sufficient number of these reactions are obtained to draw definite general conclusions. At any rate, our present experience is that about 75 per cent. of all anaphylactic pseudopositive reactions are obviated by our method. Since in both methods, theoretically, 0.00014 c.c. of toxin is used, one would expect an equal number of reactions due to the protein constituents of the bouillon. Actually, as we have stated, this did not occur. This would seem to show that all the *so-called* anaphylactic pseudopositive reactions are not due *solely* to the protein constituents of the bouillon, but that a coexistent trauma plays an important rôle.

The simplicity of the technic we have described, the elimination of the traumatic pseudopositive reactions, and the reduction of the number of anaphylactic pseudopositive reactions enhance the value of an already invaluable test.

## REINFECTION IN SYPHILIS

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Since the introduction of salvarsan, many cases of a second infection with syphilis have been reported, more especially in Europe; but while cases undoubtedly have occurred in this country, not many have been carefully studied and reported. Such a case occurred recently in my private practice, and as I had the opportunity to see and treat both infections, I feel it of enough value to report.

A traveling man, aged 36, came to see me first, Nov. 6, 1911. He had a large, very typical sclerosa on the right side of the coronary sulcus, and a beginning right inguinal adenopathy. He had been exposed some weeks previously, and had been treating with his family physician. November 7, he received 0.9 gm. salvarsan intravenously. From November 16 to December 25 he received seven injections of mercury salicylate; being out of town part of the time, he did not get these regularly. A rest was given, and Feb. 22, 1912, the Wassermann test was positive. During the remainder of 1912 he took two courses of mercury rubs—sixty in all—and also about 120 c.c. of potassium iodid. Dec. 16, 1912, the Wassermann test was negative. Fearing that he would disappear, I urged him to take more treatment. Dec. 21, 1912, he received 0.9 gm. neosalvarsan, and early in 1913 took three injections of mercury salicylate, and later in the year a course of rubs.

I next saw him Jan. 28, 1916. Thirty days before he had been exposed, and in three weeks a small sore appeared on the foreskin. Becoming suspicious on account of his previous experience, he finally came to see me. I found a typical

sclerosa on the top part of the foreskin, which looked to be about a week or so old. Numerous spirochetes were found, and the Wassermann test was negative. A slight enlargement of the inguinal glands could be made out.

I immediately put the patient on neosalvarsan, and the sclerosa is at present, February 15, just about healed.

This case shows that syphilis can be cured at times with what I should call a very small amount of treatment. I usually give at least twelve treatments with neosalvarsan, and treat with hypodermics of mercury for two or three years.

I am certain that the second lesion was a reinfection because it was in a different location from the first—barring out chancre redux—and the finding of numerous spirochetes together with the negative Wassermann make me absolutely sure of it. Between the two infections he was the father of two healthy children.

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## A SIMPLE METHOD OF DRAINING EMPHYEMA

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It is probable that this little technical device, which I believe of advantage in draining the chest, has been described before. If so, it has escaped my attention, and since a number of surgeons who have seen it used in my clinic have found it new, I take the liberty of describing it:

It is a method of preventing the ingress of air in cases in which drainage of the chest is made necessary, and at the same time by negative pressure it tends to diminish any pneumothorax that may be present. As drainage is usually established, there is ample opportunity for the escape of the purulent effusion from within, but there is no way of preventing the entrance of air through the tube, unless the siphon method is adopted by inserting the end of a long tube in some antiseptic solution in a receptacle placed by the side of the patient. Such, for example is the method of Bulau, modified recently by Holt.<sup>1</sup> Bryant<sup>2</sup> described what appears a very complicated method of aspiration drainage in which he used a collapsible rubber Politzer bag, with thumb screw and valve.

Unless some such method is adopted to prevent the inrush of air, the noise which attends the suction may be most distracting to the patient and attendants for two or three days after the operation. Furthermore, the ingress of air through the drainage tube is detrimental to the furtherance of the lung expansion, which is so essential a factor in the definitive cure of emphyema. Both of these factors are cared for in the following manner:

An ordinary drainage tube is slipped into a collapsible soft rubber tube, which must fit accurately about the harder one for a distance of 1 inch or more. The soft tube is that ordinarily employed for cigaret drainage. When the harder tube is accurately fitted into the wound, any effort at inspiration will cause the soft outer tube to collapse and prevent the ingress of air. On the other hand, the pressure of the lung from within, with the normal respiratory movement, will be sufficient to open the collapsible tube and permit the escape of whatever pus may be within the chest.

1. Holt: Am. Med., 1913, p. 381.

2. Bryant, J. D.: Surg., Gynec. and Obst., 1906, p. 298.

3. Park, Zingher and Serota: Arch. Pediat., 1914, xxxi, 489.