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The Old Corner Book

SERUM DIAGNOSIS OF SYPHILIS AND LUETIN REACTION

TOGETHER WITH

THE BUTYRIC ACID TEST FOR SYPHILIS

BY

HIDEYO NOGUCHI, M.D., M.Sc.

ASSOCIATE MEMBER OF THE ROCKEFELLER INSTITUTE FOR MEDICAL RESEARCH, NEW YORK

23 ILLUSTRATIONS, OF WHICH 17 ARE IN COLOR

THIRD EDITION

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To

DR. SIMON FLEXNER

THIS BOOKLET IS DEDICATED BY HIS PUPIL

THE AUTHOR

PREFACE TO THIRD EDITION

As a consequence of the successful cultivation of Treponema pallidum in artificial media, much light has been thrown on the nature of the complement-fixation reaction in syphilis. With the aid of pure pallidum cultures the writer was enabled to distinguish the Wassermann reaction from the specific complement fixation and has introduced a chapter on this question in the present edition. By establishing this distinction the writer hopes to develop a new phase of serum diagnosis in this disease.

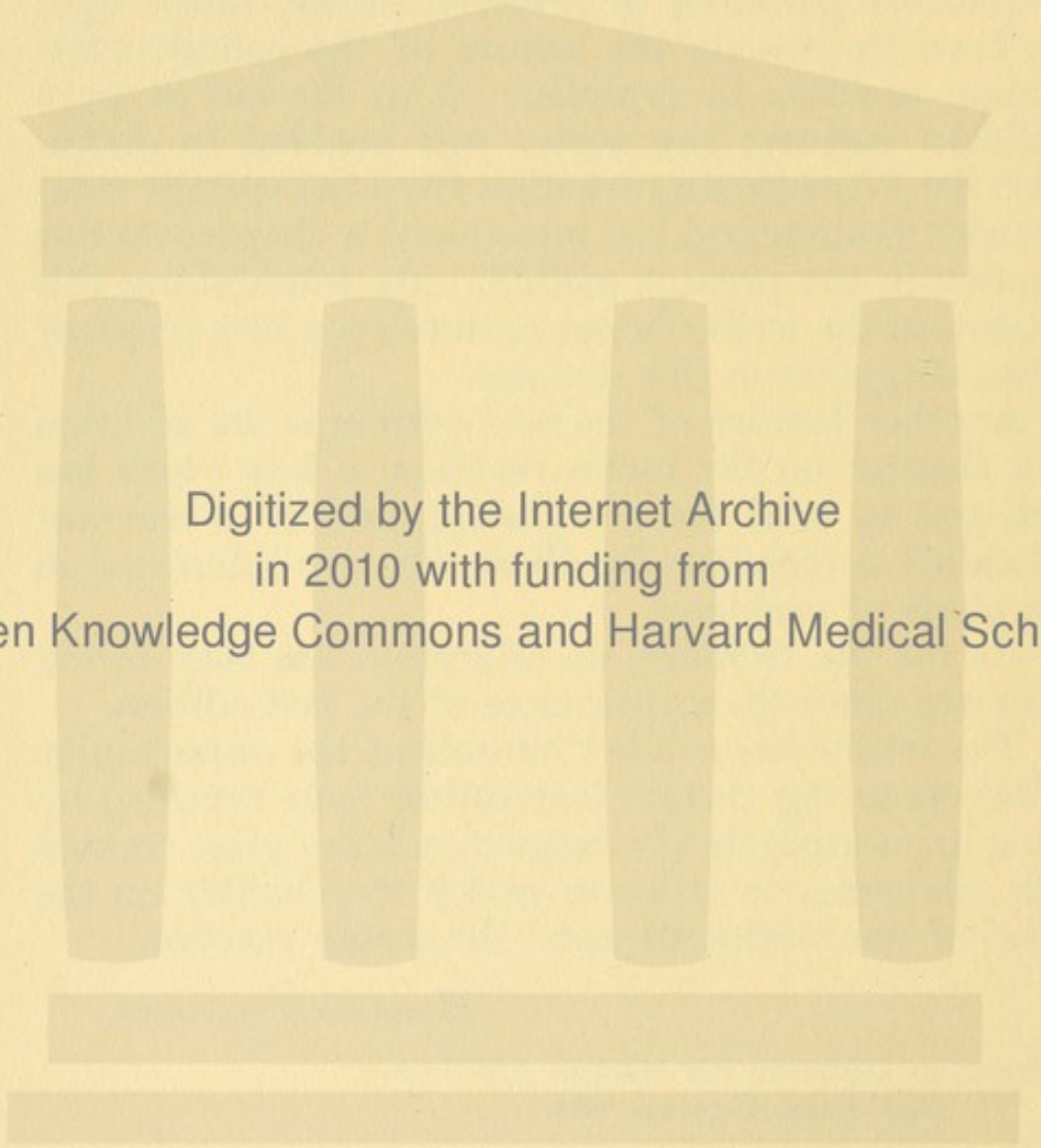
Another feature of the new edition is the addition of a chapter on the luetin reaction, a test which has been put to trial for a sufficient period to warrant a detailed description for those who are interested in this phase of problems.

As for the technics, no alteration has been found necessary since the appearance of the last edition.

The writer has availed himself of the opportunity of incorporating certain interesting facts revealed by Craig in his analysis of a large number of cases treated with salvarsan, in order to enrich the chapter on the effect of the treatment upon the serum reaction.

HIDEYO NOGUCHI.

ROCKEFELLER INSTITUTE FOR MEDICAL RESEARCH,
NEW YORK, OCTOBER, 1912.



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PREFACE TO SECOND EDITION

A FEW alterations and many important additions necessitated by the growth of the subject have been made in the present edition. Instead of the single method of performing the complement-deviation test for syphilis described in the first edition two procedures are given in order to widen the application of the test under various conditions. Both methods yield exactly the same results.

The subject of the syphilitic antigen has been almost entirely rewritten. The question of the antigen has long been one of the most difficult problems in the whole syphilis reaction, and for the selection of a suitable antigen upon which much of the reliability (and a wider adaptability) of the reaction depends the serologist has been forced to resort to a tedious empiricism on account of the lack of a definite standard. After a systematic analytical study of more than one hundred organ extracts the author is now able to supply this want by giving a definite quantitative and qualitative standard for a reliable antigen. The method of selection, which is extremely simple, and the best mode of preservation are fully described.

A technical improvement will be noticed in the method for quantitative determination of the intensity of the reaction; and the results of its application

to the study of a large number of patients treated with the Ehrlich-Hata arsenobenzol will be found in a later chapter.

In the chapter dealing with the clinical value of the Wassermann reaction many interesting new observations made by Craig, Kaliski, Pedersen, Fox, Atwood, M. Cohen, Orleman-Robinson and others, have been introduced. The reliability of the author's method has been fully confirmed by the publications of numerous investigators, comprising a study of more than 10,000 cases of syphilitic, parasyphilitic and other diseases. The small number of irregular results obtained by one or two early workers have been adequately accounted for by their failure to observe accurately the author's directions. These irregular results were much fewer in number than those obtained with the original Wassermann reaction during the early period of its use.

The practical value of the author's butyric acid test has been augmented through its successful application and adoption by numerous workers in psychiatry and neurology. Flexner has employed the test as an aid to the recognition of the early stage of acute anterior poliomyelitis in man and in experimentally infected apes.

Practically all of the literature to date has been incorporated in this edition.

HIDEYO NOGUCHI.

FEBRUARY, 1911.

PREFACE TO FIRST EDITION

SINCE the application in 1906 by Wassermann and others of the Bordet-Gengou phenomenon of complement fixation to the diagnosis of syphilis, the large number of publications on the subject, while establishing the test as a diagnostic method of real value, have, unfortunately, aided the general medical reader little in gaining a clear conception of the principles involved; and the rapidly growing literature has become too voluminous to enable the average clinical laboratory worker to obtain exact data on the test, in its various forms.

The object of this book is, first, to give a brief yet adequate account of the principles of serum hæmolysis and of the behaviors of the combinations of antigens and antibodies towards hæmolysis, so essential for a proper understanding of the subject, discussing at some length the quantitative relationship of the factors playing a part in these phenomena, an aspect of the subject that has not perhaps received the consideration that it deserves; and, secondly, to give in detail the technic of Wassermann's method and of the method recommended by the author.

The author has endeavored to treat the subjects of this book in such a manner as to make it suitable for the use of practising physicians and students, and at

the same time with sufficient comprehensiveness to render it useful to laboratory workers.

The last chapter is a digression from the main subject, being devoted to a description of a chemical test for syphilis. The application of this test in the examination of cerebrospinal fluids is very simple and numerous trials have shown it to be an actual aid in the diagnosis of parasyphilitic affections of the central nervous system.

In the appendix the author has given an extensive bibliography, which should be of value to readers desiring further knowledge on the subject of the complement-fixation test for syphilis and certain closely allied problems of immunity, as well as on the cytological and chemical examination of cerebrospinal fluids, so useful in the diagnosis of parasyphilitic conditions.

The author wishes to express his indebtedness to Dr. Paul Lewis and Dr. David J. Kaliski for valuable assistance in the preparation of this book. He desires also to thank those who, by furnishing specimens for examination, facilitated completion of his methods, the early co-operation of Dr. Victor C. Pedersen and of Dr. J. W. Moore having been especially valuable.

HIDEYO NOGUCHI.

ROCKEFELLER INSTITUTE FOR MEDICAL RESEARCH,
NEW YORK, FEBRUARY, 1910.

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Serum Diagnosis of Syphilis

I.

SERUM HÆMOLYSIS.

The red blood-corpuscles of animals when put in contact with many different substances are so altered that their hæmoglobin is set free, the stromata also going into solution, as a rule. This phenomenon of solution is now generally known as *hæmolysis*. The substances which cause hæmolysis are said to be hæmolytic for the blood-corpuscles which they dissolve. Fresh blood-serum of many animal species is hæmolytic for the erythrocytes of some, but not all, other species. Hæmolysis by serum results from the coöperated (coördinated) action of two distinct serum principles or factors. The first is called *amboceptor*,[1] the second *complement*.[2] The latter is always present in all fresh sera: the former, on the other hand, is inconstantly so, frequently being absent from normal blood-serum. If erythrocytes are added to a serum which contains only amboceptor they absorb the amboceptor and

[1] Bordet's *substance sensibilisatrice*, and Metchnikoff's *fixateur*.
[2] Bordet's *alexin*, and Metchnikoff's *cytase*.

retain it so firmly that even repeated washing with physiological salt solution cannot detach it from the corpuscles. The erythrocytes laden with amboceptor are said to have been *sensitized.* If complement be added to cells so prepared they promptly dissolve. Erythrocytes do not absorb complement from a serum if there is no amboceptor present. The function of the amboceptor is to prepare or *sensitize* the erythrocytes for the attack of the complement, and that of the complement is to *dissolve* the sensitized erythrocytes. Amboceptor alone cannot dissolve the cells and complement likewise is ineffective if the cells are not prepared for its action. The particular constituent of the erythrocytes capable of uniting with the specific amboceptor is usually called the *receptor.*

A suspension of erythrocytes in physiological salt solution presents a bright orange-red, opaque appearance. The cells may be sedimented to the bottom of the receptacle, either by centrifugalization or by being allowed to stand for many hours, leaving above a clear, colorless fluid. After hæmolysis, however, the suspension becomes deep pinkish red and transparent, being now a solution of hæmoglobin diffused out of the hæmolysed erythrocytes. (See Fig. 1.)

These two essential hæmolytic components, amboceptor and complement, not only differ in their biological function, but also show differences in resistance to spontaneous deterioration, destruction by heat, and various other physical and chemical influences. Complement is liable and deteriorates gradu-

ally, disappearing from serum within a few weeks when kept on ice and within a few days when kept at room temperature. Exposure to a temperature of 55°–56° C. for one-half hour completely destroys the activity of complement. Amboceptor is much more stable. It is usually still active in serum which

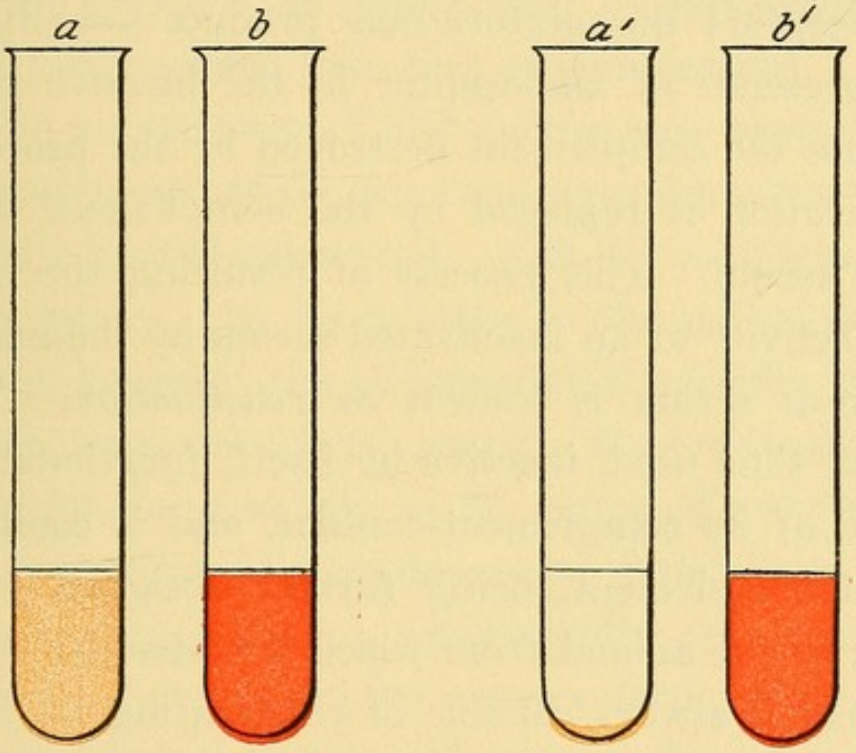


FIG. 1.—*a* shows a saline suspension of blood-corpuscles before hæmolysis; *b*, the same after hæmolysis. *a′* and *b′* present the appearance of *a* and *b* after sedimentation of corpuscles.

has been kept for more than a year, and is not destroyed or markedly injured by exposure to a temperature of 55°–56° C. Serum is technically known as "fresh" or "active" serum within a day of its collection, while the complement is still fully active. The process of depriving a fresh serum of its complement by heating it to 55° C. is called

inactivation of the serum. By an *inactivated serum* we mean one from which complement has been removed, but in which the amboceptor is left unchanged. If to an inactivated serum we add fresh serum (in a quantity inactive by itself because of the minute quantity or complete absence of its amboceptor) the mixture may produce hæmolysis in the presence of amboceptor in the inactive serum, because the complement destroyed by the process of inactivation is replaced by the complement of the fresh serum. This process of restoring the hæmolytic activity of an inactivated serum by the addition of fresh serum is known as *reactivation.* Fresh serum, thus used, inactive by itself, functionates by virtue of its complement-content, and is commonly called complement, being further designed by the name of the animal from which it is derived. Complement is always capable of reactivating the serum of the species from which it is derived, but not every complement can reactivate the sera of other species. In fact, there are only a few animals known whose complements can reactivate the inactivated sera of alien species. Otherwise stated, complement of one animal species is not identical in its action with that of another species. The interchangeability of complements, or the substitution of one for that of another species of animal, is only possible in a limited number

of instances. The complement of the guinea-pig is distinguished by an unusual ability to reactivate the sera of alien species and is consequently most often used when it is necessary to substitute the complement of one serum for that of another which has been inactivated or which has deteriorated.

The presence of amboceptor in blood-serum is much less constant than that of complement.

The amboceptor of any species acts always with the complement of the same species and less regularly, and to a limited extent only, with the complement of other species. In its relation to the red blood-corpuscles, however, the amboceptor is *specific:* that is, an amboceptor which can sensitize the erythrocytes of the rabbit, for example, to the action of complement cannot sensitize the erythrocytes of the sheep, dog, or any other animal. Amboceptors are named by prefixing "anti-" to the species-name of the cells against which they act. Thus an amboceptor active against sheep-corpuscles is known as antisheep amboceptor, and unites with the receptors of the former.

In any serum there are usually present many varieties of amboceptor. Thus in one serum there may be found amboceptors active against the blood-corpuscles of the sheep, dog, hen, rabbit, frog, man, etc. Different sera vary widely in the number of amboceptors present and in the relative quantity of

each. Among different specimens of serum from the same species the relative quantity of amboceptor can also vary considerably.

Amboceptors existing naturally in normal serum are known as *natural* or *normal amboceptors.* For example, human serum is frequently, though not always, quite hæmolytic for sheep's corpuscles, because it may contain natural antisheep amboceptor; but rabbit's serum, on the other hand, is incapable of hæmolysing human erythrocytes because of the absence in the rabbit of natural antihuman amboceptor.

As already stated, the serum of a given species may not contain amboceptors for the blood-corpuscles of some other species. If we select, for example, the rabbit, whose blood-serum contains no amboceptor for the erythrocytes of man, we may by repeated injections of the human erythrocytes into this animal produce specific amboceptor for human cells. This process of repeated injections with foreign cells (or any other suitable substance) is, in general, known as *immunization.* By a similar process we can also *increase* the amount of an amboceptor naturally present. Amboceptors thus artificially produced or increased are known as *immune amboceptors.* Amboceptors which act with the erythrocytes of the same species are known as *isohæmolytic amboceptors,* or, in short, *isohæmolysins.* It is extremely difficult to pro-

duce an amboceptor for the erythrocytes of the same species by immunization.

The amount of complement is not perceptibly increased by immunization.

Summary.—We have learned that the fresh serum of an animal can hæmolyse the erythrocytes of another species or of as many species as its serum contains specific amboceptors for. The intensity of hæmolysis is, of course, proportional to the amount of each amboceptor present in the serum. The variety of natural amboceptors varies considerably according to the animal species.

The hæmolysis is caused by the specific, coördinated interaction of the amboceptor and complement of the serum on the erythrocytes. Complement is destroyed by heating to 55°–56° C. for half an hour, the serum being thereby inactivated. Amboceptor is not destroyed by this process. The hæmolytic activity of the serum can be restored by replacing the destroyed complement by the addition of complement contained in fresh serum of the same species or in that of a limited range of alien species whose complements are suitable for use. By immunization we can create a specific amboceptor for any kind of foreign erythrocytes. This immunization product possesses the same biological properties as the natural amboceptor and is called *immune amboceptor.*

II.

QUANTITATIVE FACTS ABOUT HÆMOLYSIS.

THE phenomenon of hæmolysis, as pointed out in the previous chapter, is dependent upon the action of complement and amboceptor upon erythrocytes. The first is contained in every fresh serum, the second may be contained in a given serum or can be artificially produced by immunization.

The hæmolytic activity of any serum is determined by mixing, in a series of test-tubes, a uniform quantity of a suspension of red corpuscles (erythrocytes) in a physiological salt solution [1] with graduated amounts of serum and bringing the whole to a constant volume by the addition of salt solution. The mixtures are placed at a temperature of 37° C. for a sufficiently long time to allow a complete reaction. The *titre* of the serum is usually expressed by the smallest amount of serum which is found to be necessary for the complete dissolution of all the corpuscles. With ordinary normal serum, complement is usually present in excess of the amount needed to activate all the amboceptor contained in the serum. The titre

[1] For hæmolytic work 0.85 per cent. (Ehrlich) to 0.9 per cent. (Madsen) salt solution is universally employed. The writer uses the latter concentration.

of the serum in this case can be readily obtained by the above method; and it is dependent entirely on the amount of amboceptor present, for, as will be pointed out later, the activity of amboceptor is fully revealed only in the presence of an excess of complement. The conditions in dealing with an immune serum are more complicated. In it the normal complement-content is found associated with a great excess of amboceptor. A titration by the above method of simple dilution would disclose only the amount of complement in the serum, and a large, variable amount of amboceptor would remain inactive in the mixture, on account of the dilution to a minimum of complement. In order to arrive at the value of the serum in terms of its amboceptor another procedure must be adopted. There is placed in a series of test-tubes, as before, a definite and equal amount of corpuscle suspension and to each tube is then added an amount, also definite and equal, of a normal serum which has been found incapable in itself of causing hæmolysis (complement, see Chapter I). There are next added, in series, decreasing, graduated amounts of the immune serum whose native complement has been destroyed by inactivation. The titre of the immune serum is usually stated as the smallest amount of inactivated serum which produces complete hæmolysis in the presence of an excessive amount of a given suitable comple-

ment. It must be borne in mind that the titre of an immune serum will vary with the specific activity of the complement used. For example, an antihuman amboceptor prepared by immunizing a rabbit with human corpuscles is several times more active in the presence of a given amount of guinea-pig serum used as complement than it is when tested with the same quantity of human serum as complement. The strength of the immune serum expressed in terms of the smallest amount needed to produce complete hæmolysis will be quite different if 0.1 c.c. of complement has been used, from the value found if 0.05 c.c. has been used. *Within certain limits the quantitative relationship existing between the absolute amount of complement and amboceptor required to produce complete hæmolysis is such that an increase of one factor, say complement, permits the use of a less amount of the other factor, namely the amboceptor.*

In order to get uniform results with a reaction in which so many of the reagents are variable in activity, it is necessary to proceed in a definite order to fix standards of practical constancy. This order has been roughly outlined, but will bear restatement. A suitable suspension of erythrocytes is chosen and the amount of this suspension to be used arbitrarily fixed and kept constant. The total volume of the mixture is decided upon as another constant. A large and

uniform amount of complement is used in the first determination, an amount certainly in excess of that required for the complete activation of the minimal amount of amboceptor. With this amount of complement, in series, are combined decreasing quantities of amboceptor. The smallest amount of amboceptor required to produce complete hæmolysis is determined. This is not only, as was before stated, the titre or value of the immune serum, but it is best chosen for future work as the second fixed value in the reaction, the erythrocyte suspension being the first. In order to be sure that this is a constant value another test should now be made in which the quantity of amboceptor is still further reduced while the complement quantity is doubled. If all of the tubes in this series are not completely hæmolysed we may be certain that the complement quantity first chosen was large enough and that the amboceptor amount determined was actually the least amount which could under any circumstances produce complete hæmolysis of the corpuscle suspension used. This amount of amboceptor may be conveniently designated as one *amboceptor unit.*

Up to this point, it will be recalled, the amount of complement has been kept in excess. Now to each of a series of tubes containing the standard erythrocyte suspension one unit of amboceptor is added. If then in the series one puts decreasing amounts of comple-

ment the smallest amount of complement necessary to produce complete hæmolysis with one amboceptor unit will be determined. This amount is called one *complement unit.* The reaction could then be formulated as follows:

Standard erythrocyte suspension + 1 amboceptor unit + 1 complement unit = complete hæmolysis (time 2 hours at 37° C.).

As the erythrocyte suspension can be made of relatively constant value from day to day and as the amboceptor is stable over a period of months, the only actual variable from this point is the complement, and this can be standardized with a simple titration test.

The results, now, of varying the quantities of complement and amboceptor require the most careful consideration. If less than one unit of amboceptor is used hæmolysis will always be incomplete, even with more than one unit of complement. Likewise if with one amboceptor unit there is combined less than one unit of complement, hæmolysis cannot be complete. If with more than one unit of amboceptor there be used less than one unit of complement, hæmolysis may be complete or incomplete according to the relative amounts of each factor used. The complement may, of course, be reduced to such a degree that hæmolysis will be incomplete no matter

how much amboceptor is present. *But in the presence of many units of amboceptor hæmolysis may be complete when but a small fraction of the complement unit is present.* It is most important to note that a fraction of one unit of complement, too weak to produce any hæmolysis with one unit of amboceptor, can produce complete hæmolysis when combined with several amboceptor units. In other words, the activity of complement becomes steadily intensified or augmented by gradual increase of the number of amboceptor units until its maximum is reached. An amount of complement too small to cause complete hæmolysis in combination with one unit of amboceptor, may be sufficient to do so if two units of amboceptor are used, and an inactive quantity of complement with two units of amboceptor may no longer be inactive when four units or more are used, and so forth. Based upon this fundamental law of reduction in requirement of complement by increase of amboceptor to cause the same degree of hæmolysis, we can easily see that hæmolysis is merely the relative expression of the combined action of amboceptor and complement and is not the absolute indication of the amount of the hæmolytic components present in a fluid. The same amount of hæmolysis can be produced by one unit of complement and one unit of amboceptor or by 20 units of amboceptor and 0.1 unit

of complement, or any other appropriate combinations of these two components. *Unless the amount of amboceptor used is the same in any two sets of hæmolytic experiments the amount of complement acting in these two sets cannot be estimated by comparing the degree of hæmolysis.* In order to calculate the exact amount of complement needed to produce a given amount of hæmolysis it is necessary to know the amount of amboceptor used, because the activity of complement is different according to the amount of amboceptor present. It is therefore erroneous to conclude that equal degree of hæmolysis produced by one unit of amboceptor and by twenty units of amboceptor is the work of the same amount of complement in both instances. These facts are graphically shown in the accompanying diagrams (Figs. 2, 3 and 4).

For any given relative proportion the result can be determined experimentally, of course, and the reaction follows certain laws with sufficient regularity so that the result can be calculated. But it is exactly for the purpose of avoiding the complexities and uncertainties introduced by this quantitative variation that we take such pains to get fixed standards, and the more closely these standards are adhered to the simpler will be the conditions and the more easy and accurate the interpretation of the results.

We will now consider the fate of amboceptor and

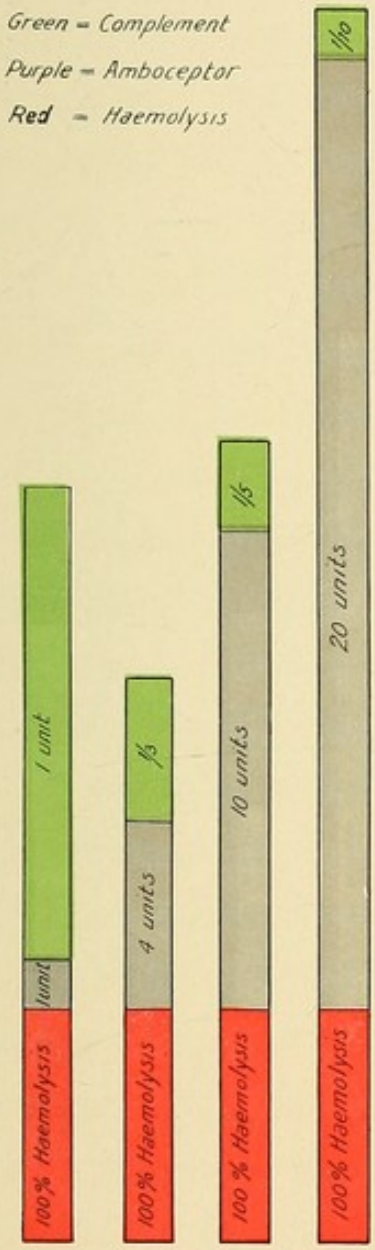


FIG. 2.

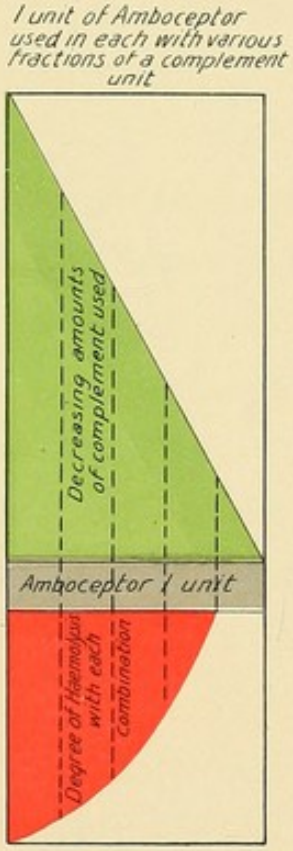


FIG. 3.

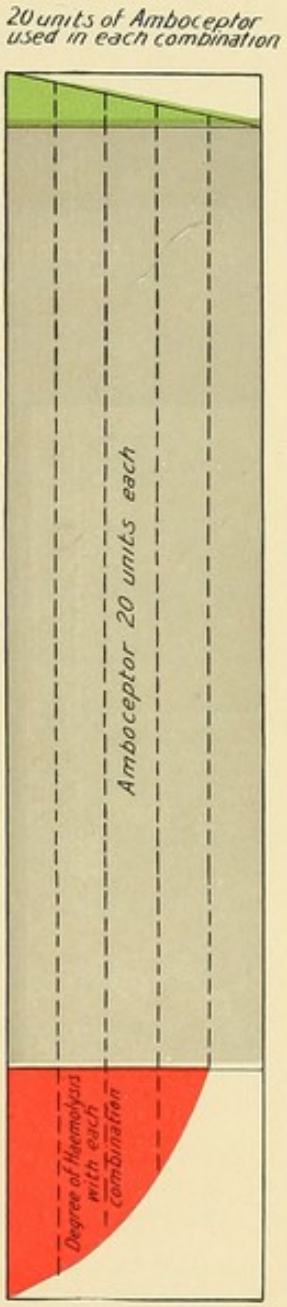


FIG. 4.

complement after the reaction has run to completion.

It has been experimentally determined that within certain quantitative limits they have disappeared from the mixture, having been used up in producing hæmolysis. The limits within which this disappearance is complete are roughly as follows: Where one unit of amboceptor has been used with one unit of complement the disappearance of both will be complete. When with one unit of amboceptor more than one unit of complement is used, an excess of complement will be found still present in the fluid after the reaction is accomplished. The same applies to the combination of one unit of complement with less than one unit of amboceptor, in which case hæmolysis will be incomplete. When with one unit of complement there is combined more than one unit of amboceptor the excess of amboceptor shortens the time necessary for complete hæmolysis. The corpuscles being capable of absorbing more amboceptor than is necessary for complete hæmolysis, most of the excess is taken up by them in this way. If the excess is very large (more than the corpuscle mass can absorb), it may be found free in the fluid after the reaction is ended. If more than one unit of amboceptor and of complement are used an excess of both may be found in the fluid after the hæmolysis is complete.

Enough has been stated to show the reader that

we are dealing with a complex reaction whose factors have a definite relationship to one another which can be accurately determined. If the co-relative values of complement and amboceptor are carefully determined and rigidly adhered to according to the outline given, precise and constant results can be obtained in the practical application of the reaction, which will be developed in the following pages. If in using the reaction these quantitative steps are not observed one cannot hope for useful or accurate results.

III.

ANTIGENS AND ANTIBODIES.

I HAVE already stated that by repeated injections of erythrocytes of one animal into an alien species we can produce in the latter an amboceptor having a specific affinity towards these erythrocytes. A similar phenomenon is observed when bacteria are injected. We call amboceptors for the blood-corpuscles *hæmolytic amboceptors* and those for the bacteria *bacteriolytic amboceptors.* Their general characteristics are the same, differing only in that they have a specific affinity towards the substances which gave rise to them. Bacteria when brought in contact with specific bacteriolytic amboceptor absorb the latter and become sensitive to the dissolving action of complement. This phenomenon of dissolution is called *bacteriolysis* and in its mechanism is comparable to that of *hæmolysis* in every respect.

It is found that when various unorganized protein substances are injected into an animal they elicit a similar response, giving rise to various specific immune substances or reaction products. Egg albumin and alien blood-serum, for example, when injected give rise to specific *precipitins.* Serum containing a

specific precipitin when mixed with a solution of the protein which was injected in order to develop it causes a precipitate to form. Mixed with any other protein solution the precipitation does not occur. The substances—erythrocytes, bacteria, or unorganized foreign protein—which when injected produce corresponding specific reaction products—are called *antigens*. The reaction products of whatever kind which are produced by the animal are called *antibodies*. Immune hæmolytic amboceptors, bacteriolytic amboceptors, and precipitins are therefore antibodies produced by injecting as antigens erythrocytes, bacteria, or unorganized proteins.

The most striking characteristic of the antibodies is their specific relationship with the corresponding antigens. Antigen *A* gives rise to antibody *A*, and antibody *A* reacts outside the body with antigen *A* and with no other. It is scarcely necessary to recall the well-known fact that the serum of a typhoid patient (containing typhoid agglutinin) agglutinates only the typhoid bacillus and none of the closely related intestinal micro-organisms. The hæmolytic amboceptor for human erythrocytes acts only with those erythrocytes, and not with the cells of any other species. Similarly, as was before stated, the precipitin obtained by injecting man, monkey, or rabbit serum causes precipitation only with the particular serum

used to produce it. The few exceptions to this general rule may be neglected in our present discussion.[1]

Taking into account this quality of specificity it will be readily seen that if we have an unknown antibody to deal with we can identify it by putting it in contact with a number of different antigens under favorable conditions and noting the one with which it reacts. With a known antibody the character of an unknown antigen can likewise be determined. This *direct method* of recognizing unknown antibody has been used in a number of different ways in recent years. Some instances, such as the Widal reaction in typhoid fever, are known to every one. Another important test dependent on this principle is the precipitation method for determining the species of animal from which a specimen of blood of unknown origin may have come. Artificial antibodies are produced by immunizing animals—rabbits, for example—with the blood-serum of a number of different animal species. The unknown blood is dissolved in physiological salt solution and put in contact with this series of known antibodies (precipitins). That antibody with which a precipitate is formed must be, according to the law

[1] For example, I found that antigoat serum (rabbit) contains precipitins not only for goat serum but also for sheep and ox serums in smaller quantity, while anti-ox serum (rabbit) contains precipitin only for ox serum. Antisheep serum contains precipitin for sheep and goat serums, but not for ox serum. This phenomenon is comparable to group reaction of agglutination.

of specificity, antibody prepared with serum of the same species as that from which the specimen in question was derived.

The effects we have so far considered have all been the direct and essential manifestation of reactions between antigen and antibody with or without the associated action of complement as the case may be.

Studying the phenomena of interaction of antigen and antibody in general, we will discover a peculiar relation which exists between the combination of antigen-antibody and complement. We have already seen that the erythrocytes (antigen) acted on by amboceptor (antibody) become so altered as to absorb complement and undergo hæmolysis. We have also learned that bacteria (antigen), after having been acted on by amboceptor (antibody), take up complement and become dissolved by the complement. Now a question arises as to whether unorganized antigens display the same characteristics as the antigens in previous instances when brought together with their specific antibodies. Through experiment this was found to be the case. Thus when a precipitable antigen (precipitinogen) is brought in contact with its specific precipitin it not only forms a visible precipitate, but also becomes capable of absorbing or fixing complement. If to a mixture of a precipitable antigen—for example, blood-serum or egg albumin—

and its precipitin, complement be added during or after the reaction period, and if the mixture be subsequently tested for the presence of complement by adding erythrocytes and their specific hæmolytic amboceptor to the mixture, it is found that the complement has disappeared; that is, hæmolysis does not take place. This phenomenon of disappearance of complement in the mixture of antigen and antibody is now generally called *fixation of complement.* Sometimes it is called *deviation of complement* on account of the fact that the complement has been deviated by the combination of antigen and antibody and prevented from participating in the hæmolytic process. These facts were first brought out by the investigations of Bordet and Gengou and the reaction is known accordingly as the Bordet-Gengou phenomenon of complement fixation.

It is found that the mixture of antigen and antibody can fix complement in a dilution in which a visible precipitation is no more obtainable. In other words, the fixation phenomenon is capable of indicating the existence of the antigen-antibody reaction beyond the delicacy that a visible precipitation can attain.

Concerning the phenomenon of complement fixation, it would be well to point out here that the sera (complement) of various animals present marked dif-

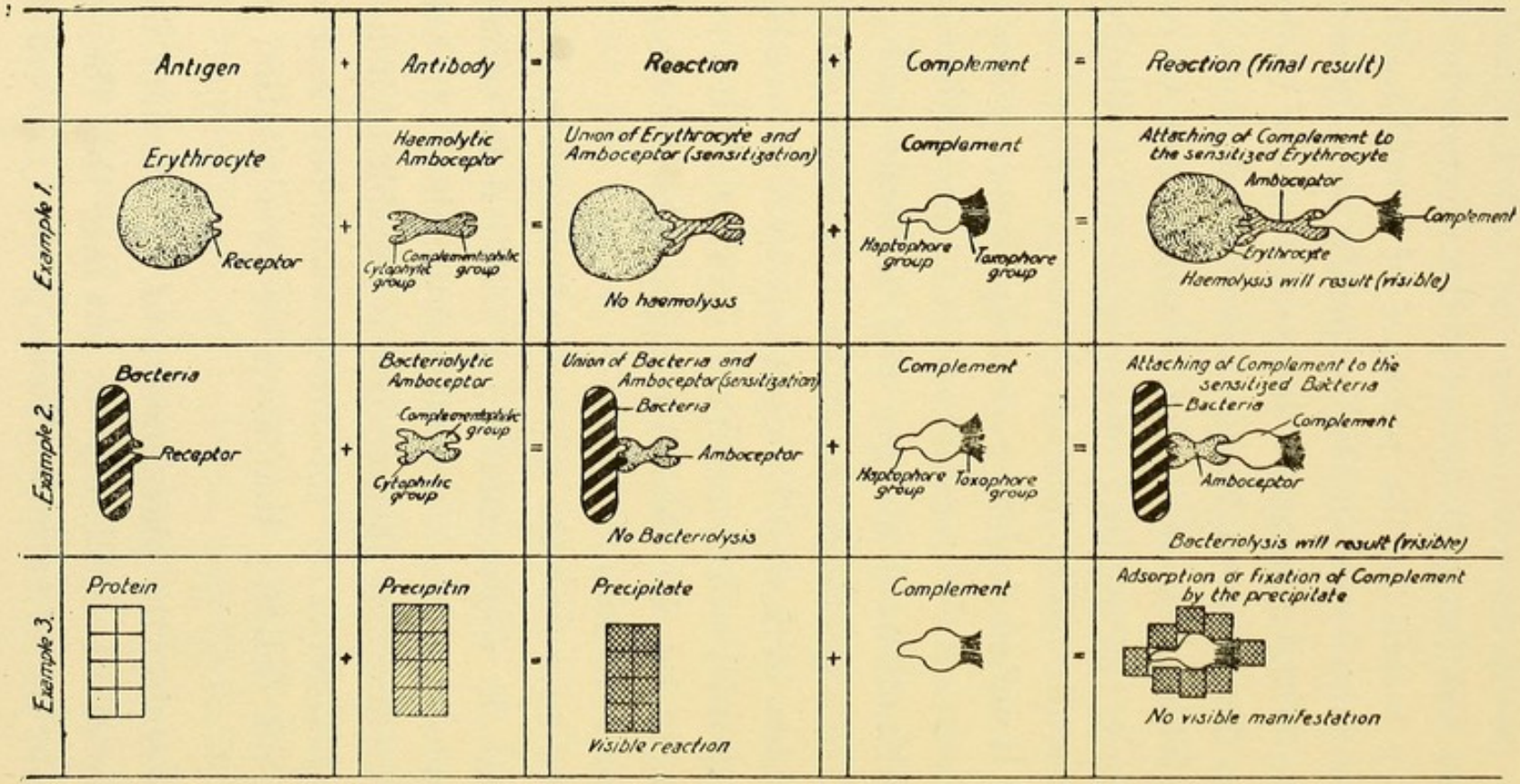


FIG. 5.—Shows the components required and the steps of reactions followed in producing hæmolysis, bacteriolysis, and adsorption or fixation of complement by a precipitate.

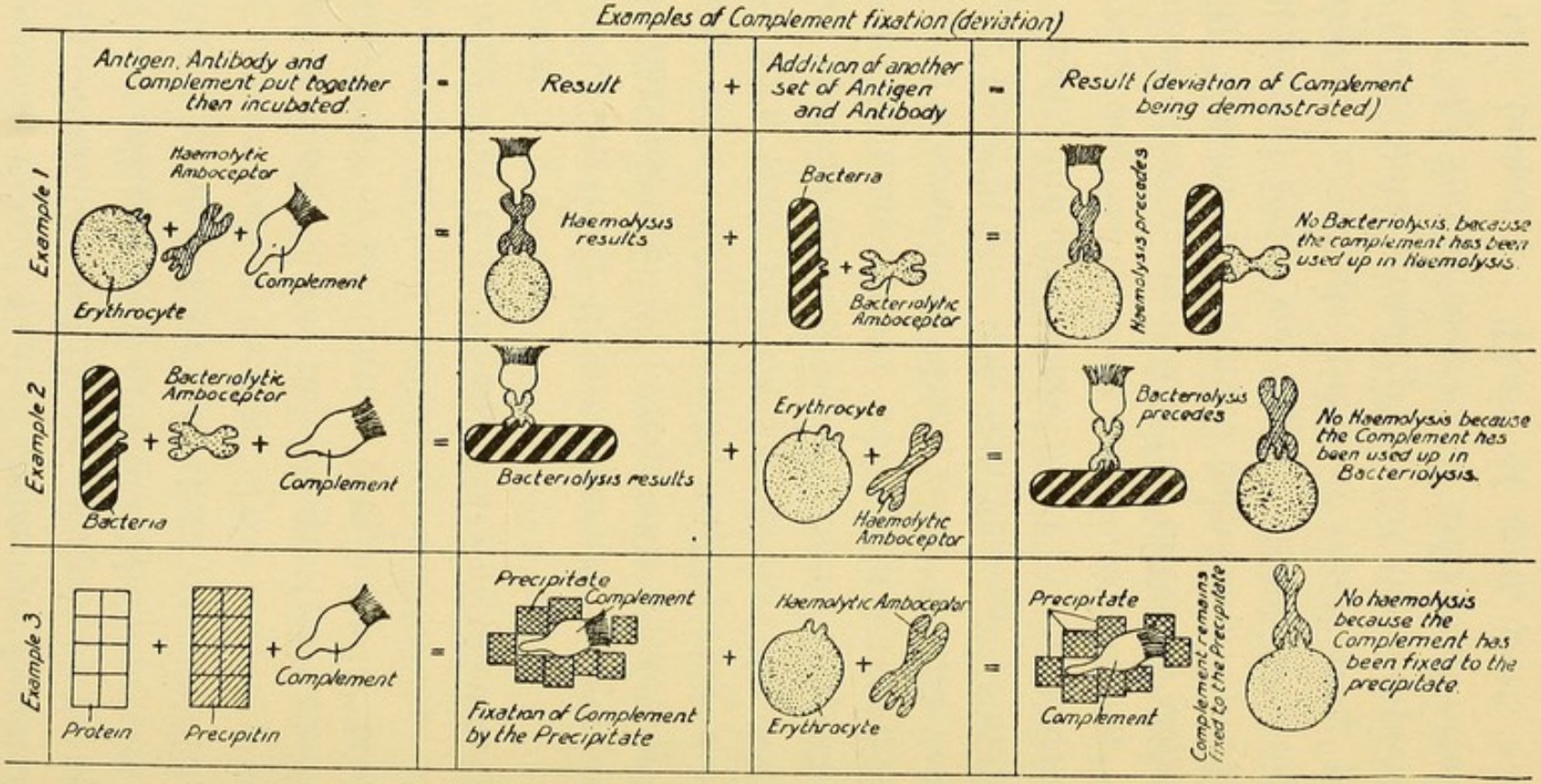


FIG. 6.—Illustrating the phenomenon of Bordet and Gengou. The serum reaction of Wassermann for syphilis is analogous to Example 3, except that the lipoidal substance corresponds with protein and syphilitic serum with precipitin.

ferences in regard to this property. Some complements are easily fixed in the presence of the antigen-antibody combination, others slightly or not at all. While the serum of an animal may possess the property of reactivating the hæmolytic amboceptor of an inactivated serum, yet the serum of this species may possess little or no fixation property. This fact becomes of great importance, as will be seen later, in utilizing the complement-fixation phenomenon in diagnosis.

Working with three different antigen-antibody combinations, namely, precipitates formed by mixing human serum, egg albumin, and meningococcus extract with their specific precipitins, the writer has found that the fixability of the sera (complement) of various animals differs widely. Guinea-pigs' complement is most easily fixed, goats' complement being hardly fixed at all. The complements of man, horse, ox, sheep, and rabbit are fixed in intermediate and varying degrees to those mentioned before. In performing these experiments two different amboceptors (both specific for human corpuscles) produced in rabbits and goats were used. Rabbits' complement possessed, as a rule, the best reactivating property for the rabbits' amboceptor, but the complements of sheep, pig, and ox seemed far inferior or often devoid of this property. Those of man, goat, and horse

are weakly reactivating for this amboceptor. The amboceptor from goats could be reactivated by all of the above sera excepting that of pigs, although goats' serum was most effective and guinea-pigs' somewhat less so.

We have also seen the mode of detecting, by means of the precipitation reaction, an unknown antigen or antibody by direct observation. Now antigen can also be detected, by indirect observation, through the employment of the complement-fixation reaction.

To illustrate the mechanism of the Bordet-Gengou phenomena I introduce (pp. 22, 23) schematic illustrations based upon the well-known side-chain theory of Ehrlich. Fig. 5 shows three different combinations of antigens and antibodies, each capable of grasping or attracting complement.

Fig. 6 illustrates the deviation of complement by one combination of antigen and antibody preventing the complement from taking part in another reaction after such fixation.

The application of this indirect method of determining the presence of a specific reaction between antigen and antibody has been extensively applied to various infectious diseases with more or less success. The details of the application of this principle to syphilis will be developed in the following pages.

IV.

THE APPLICATION OF THE INDIRECT METHOD OF DETERMINING ANTIBODIES TO THE DIAGNOSIS OF SYPHILIS.

We have so far developed the fact that combinations of antigen and antibody which do not require complements to complete their characteristic reaction may still bind complement and prevent its taking part in other reactions. We have also noted that the property of fixing complement may be exerted by quantities of antigen and antibody which are too small to give rise to the characteristic reaction of such a combination, namely, visible precipitation. From this it was but a short step to the conception that there might be a combination of antigen and antibody for which we are acquainted with no characteristic direct manifestation but which could still exert a fixing effect on complement.

From clinical studies it has long been known that syphilis is an infectious disease which in running its course produces a specific immunity. That an immunity is developed means, presumably, that antibodies against the infectious agent are produced in the subject at some stage of the process. As the infectious agent has not up to the present time been

cultivated or by other means separated in any quantity from the diseased tissues, it is impossible to determine the presence of antibodies by the direct observation of such a reaction as bacteriolysis or agglutination. Moreover, even though we accept the *Treponema* (*Spirochæta*) *pallidum* as the cause of the disease, the detection of its presence is not to be relied upon as our only means of diagnosis. In the late manifestations of the disease, at a time when it is still infectious and still amenable to specific treatment, the treponemata are present in such small numbers as to be most difficult of detection. In exactly these cases a measure of immunity may be supposed to have developed and specific antibodies to have been formed.

The idea, then, was to take syphilitic tissues at a stage when the treponemata were most numerous and use this as the known antigen. Tests against this known antigen with blood-serum of other patients might, it could be hoped, reveal the presence of antibody. As has been said, the direct method of observation had nothing to offer and the indirect method was tried from the first.

The earliest publication on this indirect method of detecting the syphilitic antibody is that by Wassermann, Neisser and Bruck on May 10, 1906, and the next article is that by Ladislaus Detre on May 24 of the same year. These investigators were working

on the same subject independently during the same period of time and obtained exactly the same results.

The technic employed by Wassermann, Neisser and Bruck, on the one hand, and by Detre, on the other, was almost identical except in small details and will be stated here in a general way.

Extracts of syphilitic tissues in the active stages of the disease were made and used as antigen. Wassermann, Neisser and Bruck used the liver of a congenitally syphilitic fœtus, and Detre employed chiefly condylomata for this purpose. Serum of known syphilitics, inactivated at 56° C., was used as antibody. To this combination complement was added. So far there was no visible change. If after a short time a quantity of immune hæmolytic amboceptor was added to the mixture, and then the cells for which this amboceptor was developed, no hæmolysis took place. It can be shown by suitable experiments that the failure of the erythrocytes to dissolve is not due to any change in the cells. Neither is it due to interference with the amboceptor. The complement has been prevented from acting, has been fixed, or deviated. If in place of the blood-serum of a known syphilitic there had been used as unknown antibody the blood of a person known never to have had syphilis, hæmolysis would occur, because the complement was not interfered with. The erythrocytes used by Wassermann,

Neisser and Bruck were those of the sheep, and those used by Detre were from the horse. The amboceptors employed were of course an antisheep serum in the first instance and an antihorse serum in the second, both being derived from rabbits immunized with the erythrocytes of the corresponding animals.

In the beginning it was supposed that the antigen also was specific; that is, that the serum of the syphilitic patient would only fix complement in the presence of extracts of syphilitic tissues. By experiments of Landsteiner, Müller and Pötzl; Levaditi; Weil and Braun; of Meier; and also of the writer, it has, however, been determined that when such a serum is combined with the alcoholic extracts of certain normal organs or with a preparation of crude tissue-lecithin complement is also fixed. Because they are easier to obtain such nonspecific extracts are now commonly used as antigens in this reaction. When the diseased tissues are used as the source of antigen the liver of a syphilitic fœtus is commonly chosen.

Summary.—It has been found on the basis of thousands of comparative tests that if the blood-serum of a patient suffering from syphilis be mixed in the presence of complement with extracts of syphilitic livers, with alcoholic extracts of certain normal organs, or with crude tissue-lecithin preparations, the complement will be fixed and prevented from taking

part in a subsequent hæmolytic reaction. Starting with the extracts given and mixing with them, in the presence of complement, serum of unknown origin, if complement be fixed it can be stated with assurance (with certain reservations to be discussed later) that the unknown serum was derived from a case of syphilis.

To those who have carefully considered the quantitative relationship of the factors in a simple reaction with a hæmolytic serum as presented in the first chapters of this book, it will at once be apparent that in a test in which the hæmolytic reaction is to be used as an indicator of a second reaction not otherwise visible, the quantitative values of all the factors must be accurately determined and rigidly adhered to if the results are to be relied upon. The following chapter is devoted to the consideration of the quantitative relationship of these factors and to certain other precautionary measures which must be observed.

V.

QUANTITATIVE RELATIONS OF THE FACTORS IN THE SERUM DIAGNOSIS OF SYPHILIS.

It will be recalled that in the complement-fixation reaction there enter into operation five distinct and essential factors. Enumerated, they are: syphilitic antigen, syphilitic antibody, erythrocytes, hæmolytic amboceptor and complement. Two of these factors are antigens, the erythrocyte and the organic extract; two of them are antibodies, the hæmolytic amboceptor and the syphilitic antibody. To avoid confusion in the discussion of the reaction it has been customary to group these factors according to their functions as follows: the erythrocytes, the hæmolytic amboceptor, and the complement are collectively referred to as the *hæmolytic system*. Speaking of the first two factors of the hæmolytic system it is customary to avoid the terms antigen and antibody and speak of erythrocytes and amboceptor. When in connection with the test we refer to antigen and antibody, we mean only the two factors outside the hæmolytic system, the syphilitic antigen and the antibody present or absent in the serum to be tested. In principle any hæmolytic system can be used as an

indicator for the test, provided the complement used is sensitive to fixation.

Whatever system be chosen the relation of amboceptor, complement, and erythrocytes as outlined in the second chapter must be observed. That is, one must work with a suspension of erythrocytes of definite value, the amboceptor must be carefully titrated with respect to that erythrocyte suspension, and with respect to the complement employed. Then definite amounts of amboceptor must be used, and the quantity of complement to be employed must be constant, and so adjusted as to act with the quantity of amboceptor and erythrocyte suspension determined upon. If, for example, we use in the hæmolytic system one amboceptor unit, at least one complement unit must be combined with this in order to obtain complete hæmolysis. If less than one complement unit were added to the antigen-antibody mixture in the fixation test, then hæmolysis would certainly be incomplete and one might imagine that complement was fixed when it was merely deficient in quantity, from the beginning. If many amboceptor units are used hæmolysis may be complete in the presence of much less than one unit of complement. Theoretically the test for fixation of complement might be made much more delicate by uniting two units of amboceptor with only a fraction of one

unit of complement. In practice, however, there are certain extrinsic factors which may interfere with the action of small amounts of complement, and it is therefore not safe to use minimal quantities. These factors will be more carefully and fully considered later.

A more common quantitative error is the following: Suppose that the antigen-antibody combination in any given test is capable of binding one and one-half units of complement. The one-half unit of complement remaining, two units being used in the test, would be incapable of completing hæmolysis with the amount of amboceptor which should be added, but with a high multiple of that amount could easily do so. We would then obscure, by an excess of amboceptor, a positive reaction. If, on the other hand, with a small amount of syphilitic antigen and antibody we use an excessive amount of complement, the antigen-antibody combination may bind complement up to its capacity and still leave a sufficient quantity to act in conjunction with the amboceptor to produce hæmolysis. We would then again have a false negative instead of a positive reaction.

It was stated that certain factors not directly involved in the reaction might interfere with it if small amounts of complement are used. There are at times substances in the extracts other than the specific an-

tigen which prevent complement from acting. They are commonly known as anticomplementary substances. Anticomplementary substances may also exist in the serum to be tested. In order to guard against error from this source when making the test with preparations with more or less anticomplementary action it is necessary to add antigen alone, and the test serum alone, to the hæmolytic system in somewhat larger quantity than they are to be used combined in the test. Human serum may contain natural hæmolytic amboceptors for the erythrocytes in use when the erythrocytes belong to alien bloods. Thus if we add one unit of *immune* amboceptor to a mixture already containing six units of *natural* amboceptor, it would produce exactly the same discrepancy in result as though the immune amboceptor were added in excess. This source of error is to be avoided by choosing a hæmolytic system for which human serum contains no natural hæmolytic amboceptors. There may also be hæmolytic substances in the antigen preparations. These must be tested for each time when dealing with unknown or freshly prepared extracts.

Complements of different species of animals behave differently toward the fixation by antigen-antibody combinations. Certain species of animals contain in their sera complements which are readily

fixed, while in other groups of species their complements are quite refractory or not at all susceptible to the fixation. The writer, with Bronfenbrenner, made an extensive series of comparative study of various complements and has arrived at the conclusion that the complement contained in guinea-pig's serum is the best for the fixation tests.

Coming now to the exact quantities to be used; the determination of the strength of amboceptor and complement has been described in detail (see Chapter II). It is customary to use a slight excess of each, usually two units. This makes the reaction somewhat less delicate, but allows a margin for error due to anticomplementary substances and in the long run makes the test more reliable. The amount of serum to be tested for its antibody content must be large enough to bind all complement in the presence of sufficient antigen if the serum be from a known syphilitic case. *The proper quantity of the serum to be used depends, therefore, upon the quantity of the complement used in the hæmolytic system.* It is obviously of advantage to construct a system in which as small an amount as possible of patient's serum can be employed without diminishing the delicacy or reliability of the reaction.

VI.

VARIOUS FORMS OF THE COMPLEMENT-FIXATION TEST AS APPLIED TO THE SERUM DIAGNOSIS OF SYPHILIS.

As was pointed out in the last chapter, it is erroneous to think that almost any hæmolytic system can be used to test the binding power of antigen-antibody combination for complement. On the contrary the experimenter must be aware of the disturbing effect that results from the use of a hæmolytic system in which alien erythrocytes naturally susceptible to the hæmolytic action of human serum are employed. Here the amount of the amboceptor becomes uncontrollable and extremely variable, for the reason that the amounts of the natural amboceptor contained in the serum to be examined are unknown and variable. The second important point which the experimenter must always bear in mind before employing a hæmolytic system is the quality of complement in regard to fixation phenomenon. As was stated in the last chapter, different complements vary considerably in their activity and fixability. The selection of the hæmolytic system is, therefore, one of the most important problems that involve the comple-

ment-fixation tests and demands the utmost care and consideration on the part of the experimenter.

Unfortunately, chiefly owing to the lack of exact experimental knowledge of these facts in the earlier period of evolution of the complement-fixation tests, various investigators proposed the use of this or that hæmolytic system as long as they could produce the phenomenon of hæmolysis.

When one proceeds to consider one hæmolytic system after another from a quantitative view-point he will not have much difficulty in judging the real merit of each method. Some of them are such as to permit a qualitative determination of the reaction, while others are so crude that even this much can not be accomplished. If we are to advance in the serological field it is our duty to advocate that system in which every factor entering into the fixation tests is under a perfect quantitative control by the experimenter. At least twelve different systems have been proposed up to the present time. These systems can be divided into two groups according to whether foreign or human corpuscles are used as the hæmolytic indicator. A brief critical review of these will perhaps make clearer the principles of the test.

Wassermann, Neisser and Bruck use sheep blood-corpuscles, an immune hæmolytic amboceptor made by immunizing a rabbit with sheep's erythrocytes, and

guinea-pig complement. In making the test the syphilitic serum is inactivated. The quantity used is 0.1 c.c. and 0.2 c.c. for each specimen of serum. Two units of the amboceptor and 0.1 c.c. of guinea-pig's complement are used against 1.0 c.c. of a 5 per cent. suspension of the washed sheep-corpuscles. The resultant volume of the whole mixture is brought up uniformly to 5 c.c. There is but one large factor of error and that operates as follows: There is in human serum a variable amount of natural antisheep amboceptor. In the cases in which such an amboceptor is present in appreciable quantity it serves to increase the total effective amboceptor in the mixture. This, according to the relationship existing between the amount of amboceptor and complement respectively required for complete hæmolysis, tends always to make hæmolysis complete even when antigen-antibody has fixed a considerable amount of the complement (Figs. 2, 3, and 4, and references to previous chapters). It is also possible that the complement which has been completely fixed by a moderate amount of antigen-antibody combination may become once more detached if the amount of the hæmolytic amboceptor introduced be very large, and produce complete hæmolysis. As the occurrence of hæmolysis means a negative reaction, or absence of syphilitic antibody, the error in this case is always in the direction of

throwing sera with smaller amounts of syphilitic antibody into the negative class. If an error in diagnosis is inevitable it is of course safer to have it in this direction; but, as will be pointed out later, this source of error can be avoided by a change in the hæmolytic system.

Bauer in his test relies entirely for amboceptor upon the natural antisheep amboceptor in human serum, which, as has been pointed out, is a source of error in Wassermann's system. This is merely a makeshift and does not eliminate the error, because amboceptor is not always naturally present and when present varies greatly in quantity. For this reason the test is unreliable, because of oversensitiveness, since, as pointed out, amboceptor may not be present at all or only, as may happen, in a fraction of one unit.

Hecht relies not only on the natural antisheep amboceptor of human serum but also on human complement. It will be seen at once that if this were a system whose factors were regular in quantity, it would be much simpler in practice than Wassermann's system. All that would be necessary would be to add antigen to the patient's own serum, which would contain complement and antibody to be detected, and amboceptor. After a period of incubation sheep erythrocytes would be added and the test read " posi-

tive" or "negative" after another period of incubation. However, not only is the amboceptor a factor varying from zero to ten units or more, but human complement is far less regular in activity and fixability than is guinea-pig's complement. Further, the test would have to be done with fresh serum or the complement would surely be reduced or totally lost by spontaneous deterioration. There is not in this system a *direct* way of testing the anticomplementary action of antigen alone.

M. Stern proposed a system in which there were added a few units of immune antisheep amboceptor to the fresh serum to be tested, utilizing the complement of the patient's serum. This still retains all the defects inherent in the use of unknown and often excessive amount of the hæmolytic amboceptor, and makes it impossible to test a specimen that has been kept a few days after collection.[1]

Detre and Brezovsky used horse corpuscles, an immune antihorse hæmolytic amboceptor derived from a rabbit injected with these erythrocytes, and rabbit's complement. As human serum contains

[1] According to my recent investigations certain proteins, such as pepton, albumoses, nucleoproteins, and certain peptids can often produce complement fixation when mixed with unheated human serum, closely resembling specific fixation. For this reason no active serum should be used for the test with aqueous or even alcoholic extracts of liver, especially of macerated organs. Pure lipoids free from above mentioned substances do not give this false fixation with active serum (Noguchi).

natural antihorse amboceptor to about the same degree and frequency as antisheep amboceptor, this system is no more reliable than Wassermann's system. Further, the reagents are difficult to procure.

Boas advocated a system similar to the Wassermann system, using an antigoat amboceptor produced in rabbits. Later this is abandoned by him.

Browning used an anti-ox amboceptor produced in rabbits, and claims that human serum does not contain a disturbing excess of anti-ox amboceptor.

Tschernogubow proposed a system in which the natural amboceptor and complement of human serum are utilized against guinea-pig corpuscles.

Foix used a system in which the natural amboceptor and complement of human serum are utilized against the corpuscles of rabbit. These two last mentioned systems neglect entirely the quantitative phases of hæmolysis.

Kaliski has introduced a system in which active patient's serum is used with the addition of guinea-pig complement—thus disregarding the native complement of the human serum—and antisheep hæmolytic system. This ought not to be classed with the system of Stern, for the reason that Kaliski uses a much *smaller* proportion of patient's serum and reduces the disturbing effect of the natural antisheep amboceptor and native complement contained in the

specimen and that guinea-pig complement is being employed.

These nine different systems may be considered as of one general order, having in common the use of erythrocytes of animals for which human serum contains an unknown and irregular quantity of natural hæmolytic amboceptors. When subdivided according to the varieties of complements employed it will be seen that the systems of Wassermann, Bauer, Boas, and Browning use guinea-pig complement; those of Hecht, Stern, Tschernogubow and Foix the native complement of patients' serum; Detre that of rabbit; and finally Kaliski a mixture of human and guinea-pig complements. In none of these systems can the natural amboceptors be removed or put under quantitative regulation. In fact, some systems utilize them to produce hæmolysis, while others simply disregard their presence and add to every instance a certain amount of immune amboceptors to provide for occasional absence or deficiency of natural amboceptors.

In the following we now take up the systems in which human erythrocytes are employed.

Tschernogubow, in an article published several months before his second system, discussed with the foregoing group, also proposed a system, which he has since abandoned, with quite a different set of

factors. In general, it has some resemblance to the system put forward at about the same time by the author. Both systems use human erythrocytes and antihuman hæmolytic amboceptor, but the source of complement and the manner of conducting the test are altogether different. Tschernogubow collects the patient's blood (not serum) in saline solution in such dilution that clotting is temporarily prevented. This suspension when fresh contains some complement, erythrocytes, and, if present, the syphilitic antibody. When the antigen is added the antibody unites with it and the combination fixes complement. The antihuman amboceptor is added later, when hæmolysis occurs in case the complement has not been fixed. This system shows four sources of error.[1] The amount of complement in human serum is irregular and its activity is weak in relation to antihuman hæmolytic amboceptor. The complement and erythrocytes deteriorate rather rapidly, hence no examination can be made of old specimens. The complement cannot be put in contact with antigen alone and consequently it is impossible to decide if the antigen is or is not inherently anticomplementary by

[1] A fifth source of error has since been discovered by me, that is, the use of active serum in combination with aqueous extracts of liver renders the test nonspecific. This objection applies to any other system using active serum and aqueous or even alcoholic extracts (unfractionated) of macerated livers.

a direct test (Chapter V). Strangely enough, Tschernogubow did not state the source of his anti-human amboceptor. He does say that 0.25 c.c. was added to each tube. This is nearly 125 times the amount of amboceptor I use in combination with guinea-pig complement. It is probable that in this way he overcomes, in a measure, the variations in the amount of human complement present. Still, the uncertainty in this respect, the impossibility of separating the factors in the system for control, and, lastly, the necessity of making the test very soon after the collection of the blood in order that complement may be active and the erythrocytes intact, leave abundant room for improvement and render the system as outlined too unreliable for general use.

After considerable experience with the Wassermann test in its original form, using both the aqueous and the alcoholic extracts as antigen, I became convinced of its value in the diagnosis of syphilitic and parasyphilitic conditions. I felt, however, that if the reaction was to come into general use it would have to be greatly simplified. In attempting such a simplification it was essential that nothing making for accuracy be sacrificed. It was thought that it would be of immense advantage to eliminate, if possible, the error due to the irregular presence of natural antisheep amboceptor in human serum. The directions in which

simplification was most needed will be briefly alluded to. The Wassermann test demanded the use of fresh washed sheep's corpuscles each time a test was to be made. Persons far removed from a large abattoir would have difficulty in obtaining sheep's blood. Washing the corpuscles was essential, and required a good centrifuge. The serum must be inactivated, demanding care and a water-bath. The measuring and graduation of dosage of the liquid preparations require a full equipment of laboratory glassware. On the whole, the labor was so great that even in a fully equipped laboratory a man who proposed to carry out the test as a routine procedure could do little else; and outside such a laboratory the performance of the test was not to be thought of. In the method which eliminates these difficulties, a dilute suspension of human erythrocytes is used. This is readily prepared at any time by pricking the finger of the patient and allowing the blood to drop into physiological salt solution. It has been found possible to prepare antigen, antihuman hæmolytic amboceptor, and guinea-pig complement, in the form of reagent papers, which remain stable for a long time if kept perfectly dry and air-tight. The factors, it will be noted, are each separate and distinct, more so than in the Wassermann system. By using an antihuman hæmolytic system the variable antisheep ambo-

TABLE 1.

	Systems	Hæmolytic system			Patient's serum	Antigen
		Complement	Amboceptor	Blood-corpuscles		
GROUP A	Wassermann, Neisser and Bruck.	Guinea-pig's fresh serum, known definite quantity, 0.1 c.c.	Antisheep amboceptor: that which is present normally in human serum, of variable quantity, and that which is added in form of immune amboceptor (2 units).	Sheep's washed corpuscles, known definite quantity. 1 c.c. of 5 per cent. suspension.	Inactivated before use. 0.1–0.2 c.c., requiring 5 c.c. of blood.	Liquid preparation, known adequate quantity. Aqueous extract of syphilitic fetal liver.
	Bauer	....Do	Antisheep amboceptor. From one source, namely in the serum to be tested. No immune amboceptor added.	....Do	....Do	....Do.
	Hecht	Utilizes human complement as naturally present in the fresh serum. Old specimens cannot be tested. Complement and syphilitic antibody exist inseparably in one serum if the latter is present at all. The quantity is rather variable.	As in Bauer's system.	....Do	Tested only in perfectly fresh state without inactivation. Impractical on account of inability to examine specimens several days old. Quantity definite but quite large.	Alcoholic extract of liver or heart. There is no direct way of testing its anticomplementary power on complement independent of syphilitic antibody. There is danger of obtaining nonspecific reaction.
	Stern	Like Hecht's system.	Like Wassermann's system.	....Do	Like Hecht's system.	Like Hecht's system.

GROUP A—*Continued*	Kaliski	Human complement 0.02 c.c. and guinea-pig's complement 0.03 c.c.	....Do	....Do. 0.1 c.c. 20 per cent.	Like Noguchi's system.	Like Noguchi's system.
	Detre	Rabbit's fresh serum, known definite quantity, 0.2 c.c.	Antihorse amboceptor from immunized rabbit, 2 units.	Washed horse-corpuscles.	Inactivated before use. Known quantity, 0.1–0.2 c.c.	Known adequate quantity in fluid form.
	Boas	Like Wassermann	Antigoat amboceptor, 2½ units.	Goat corpuscles 1 c.c. 5 per cent. suspension.	....Do	Alcoholic extract of human heart.
	Browning	....Do	Anti-ox amboceptor.	Ox corpuscles.	....Do	....Do.
	Tschernogubow.	Human complement	Antiguinea-pig amboceptor found in patient's serum.	Washed guinea-pig's corpuscles.	To be tested while perfectly fresh.	Aqueous extract of syphilitic liver. Danger of nonspecific reaction.
	Foix	....Do	Antirabbit amboceptor found in patient's serum.	Washed rabbit's corpuscles.	....Do	Alcoholic extract of organs.
GROUP B	Tschernogubow.	Human complement as present in the patient's blood. Variable. The same objections as in the case of Hecht's and Stern's systems.	Antihuman amboceptor. Source unstated. An enormous quantity used, hence uneconomical.	Human corpuscles, not washed and containing fibrin ferment and fibrinogen.	Tested only while perfectly fresh, otherwise impossible. Quantity not adjustable.	Dried syphilitic liver extracted before use. Danger of nonspecific reaction.
	v. Dungern	Human complement contained in 0.1 c.c. of defibrinated blood and guinea-pig complement dried on paper possessing definite activity.	Antihuman amboceptor from immunized goat. Danger of missing a positive reaction on account of its source.	Human corpuscles contained in 0.1 c.c. of defibrinated blood, unwashed.	Tested only while perfectly fresh like in Tschernogubow's system. The amount of serum is that contained in 0.1 c.c. of defibrinated blood.	Alcoholic extract of guinea-pig heart. Danger of occasional nonspecific reaction.
	Noguchi	Guinea-pig's serum, fresh. Definite quantity (2 units), usually 0.1 c.c. of 40 per cent. dilution.	Antihuman amboceptor from immune rabbits. Liquid or dried preparations used in definite quantity (2 units).	Human corpuscles washed or unwashed, but should not contain fibrin ferment. 1 c.c. of 1 per cent., or 0.1 c.c. of 10 per cent. suspension.	Fresh or old specimens can be tested. Definite, adjustable quantities. Usually only one drop from a capillary pipette. When inactivated serum is used 4 drops are required (.08 c.c.)	Adequate quantity in liquid form or dried on paper. With inactivated serum, aqueous or alcoholic extract or pure aceton-insoluble lipoids can be used. With active serum only the pure lipoids must be used, in order to avoid nonspecific reaction.

ceptor of human serum is eliminated as a disturbing factor. The advantage, in point of regularity and uniformity gained by the use of guinea-pig complement, is retained without any sacrifice in accuracy. And, further, the test can be put within reach of any physician who is engaged in doing laboratory work, after some training in this phase of hæmolytic work. Perhaps of more real advantage to the profession is the circumstance that blood-serum collected by the physician may be sent to a public laboratory and there examined. The writer's system renders the test so simple and easy that the method may well be placed on the list of regular examinations made by most hospital laboratories. The details of the method, with directions for preparing the reagents for use and the detailed directions for carrying out the test and interpreting the results, I have brought together in another chapter of this book. The matter presented in regard to the different forms of the complement-fixation test is summarized in Table 1, on pages 46 and 47.

Von Dungern has recently introduced a system somewhat similar to that of the writer. Like Tschernogubow, however, he uses the patient's blood in active state only, for the reason that inactivation is not applicable on account of his utilizing the erythrocytes of the same blood. Unlike the system of Tschernogubow the blood is defibrinated before use, but the native complement contained in it is not used as the complement constituting the hæmolytic system. He advises the use of guinea-pig's serum in dried paper form. The amount

of the defibrinated blood used for the test is 0.1 c.c., a quantity rather large, and the presence of the native-complement there, although disregarded by this author, can hardly be left out of consideration. Moreover, he uses an entire alcoholic extract (without fractionation) as antigen, thus introducing a possibility of obtaining occasional non-specific proteotropic fixation with active human sera. The amboceptor used by von Dungern he derives from the immunized goat. This adds another source of uncertainty of the result, because the writer had previously found that this amboceptor gives a much weaker fixation reaction than that derived from the rabbit. Von Dungern omits the controls with a positive syphilitic serum and also with the usual hæmolytic system. The writer believes that this omission is to be regretted. Further disadvantages inherent to this system are that there is no direct way of determining the anticomplementary action of antigen; that no specimen of blood older than a few days can be examined on account of the weakening of the erythrocytes by standing and that cerebrospinal fluid does not contain erythrocytes, hence needs addition of the latter from other source (blood). It will be seen that this system is not quantitatively constructed and offers many difficulties in obtaining reliable results. The writer warns the reader not to confuse his system with those of Tschernogubow and of von Dungern, as seems to have been unjustly done by a few German authors.

VII.

A SYSTEM OF SERUM DIAGNOSIS OF SYPHILIS, RECOMMENDED BY THE AUTHOR.

In the following pages it is my purpose to present as briefly as consistent with the necessary detail the method of making a diagnosis of syphilis by serum reaction as it has been developed in my hands. The presentation will, it is hoped, be of interest and service to two distinct sets of investigators, *viz.*, the practising physician who is so situated that he must make his own clinical laboratory tests or pass them by entirely, and those laboratory workers who are concerned either in making laboratory diagnostic tests for others, or are engaged in supplying laboratory reagents in convenient and stable form for others to use. The writer must make it clear that it is not the adjective " practising " or " laboratory " that qualifies a physician to perform the serum diagnosis. One must not overlook the fact that among the practising physicians there are as many competent laboratory workers as there are unskilled ones among the laboratory workers. A physician who has had regular clinical laboratory training early in his professional career and is now out for practice is certainly qualified to take up this special technic of diagnosis, as long as he

is willing to divide his time between his private laboratory work and practice. No matter in what laboratory, none is qualified to make a responsible diagnosis, unless the performer is sufficiently skilful in serological work. In reality the writer knows many practising physicians who after acquiring the technic correctly now make the tests with the reagents secured from others, not only for themselves, but also for others, while a great many bacteriologists and pathologists will be at a loss if they are requested to make the tests before they are trained in this special work.

It is a regrettable phenomenon, indeed, to see that certain practising physicians who learned to do this special work, present themselves now as competent workers and raise loud protests against others who intend to take up the test similarly. Another group of workers protest still louder against the diffusion of this method and these are found among the regular laboratory workers. This attitude is certainly unjustified in view of the great value of the test. We all must hope that the test will diffuse as far as it can among physicians.

The real duty of laboratory workers to-day is to improve and simplify the original method to such an extent that it can be trusted to those who, while unable to prepare the reagents themselves, can be so instructed as to be able to carry out the test reliably.

The chief cause why the original method of Wassermann was so difficult to carry out is because in that system the reagents are so unstable and associated with many other undesirable side actions that these must be used soon after being prepared. This circumstance demands that the performer must know how to prepare the reagents and to make the test all by himself. These difficulties are inherent to most of the modifications already described. On the other hand, if we develop the method in such a manner that the preparation of the most important and difficult reagents is done by competent laboratory workers in a regular biological laboratory and distributed among those who understand how to use them, it can not bring about any abuse of this test. The writer believes that his system offers this advantage, and also that the reagents as recommended in his system remain unchanged for a very long period. The performer of the test should, however, know how to determine the reliability of the reagents he secures from others.

The presentation is accordingly made in two distinct sections:

A. A presentation of the method of work to be followed by those who have obtained their reagents from others and who must make their own tests.

B. A description of the method of preparing the reagents, standardizing them, preserving them in

stable form, and using them in fully equipped laboratories.

The interpretation of results will be the same in both instances and to avoid repetition the description of this subject is confined to Section A.

Section A.

METHOD OF WORK TO BE FOLLOWED BY THOSE WHO HAVE OBTAINED THEIR REAGENTS FROM OTHERS AND WHO MUST MAKE THEIR OWN TESTS.

For making the test, aside from the reagents, the following special apparatus will be needed: Several pipettes of 1 c.c. capacity graduated to 0.1 c.c.; two 10 c.c. pipettes graduated to 0.1 c.c.; several 1 c.c. pipettes graduated to 0.01 c.c.; a number of small test-tubes, the best dimension being 10 x 1 cm. (two tubes will be required for each test and four tubes for controls in each series of tests; the total number needed will, of course, be dictated by the amount of work to be done); a number of larger test-tubes or very small flasks for mixing the blood suspension; a number of larger flasks or bottles as containers of physiological salt solution; a number of pieces of thin glass tubing about 4 mm. in bore for making capillary pipettes. A few test-tube racks with two parallel rows of holes are necessary.

In handling the preparations and glassware absolute asepsis is not required, but it is well to be

reasonably clean, bacteriologically speaking. Physiological salt solution (0.9 per cent.) should have been boiled before use and then cooled. Glassware should be thoroughly rinsed with boiling water and allowed to dry without wiping. Chemical cleanliness is essential. The erythrocyte is a delicate cell which is most easily destroyed or altered by many chemical substances in small amounts. Those which are most apt to be encountered ordinarily are soaps, weak solutions of mineral acids and caustic or carbonated alkalies, and bichloride of mercury. Test-tubes which have been in contact with any of these substances must be thoroughly washed and rinsed in clear running water, finally being boiled in pure water and dried previous to use in the test. They should be heated to 200° C. in a dry air sterilizer before use.

Direct preparation for making the test includes the following procedures:

COLLECTION OF SERUM TO BE TESTED.*

Only about 1 c.c. of the patient's blood is needed. The writer has found it very convenient to obtain it by puncturing the ventral side of the last joint of the middle finger with a sterile Hagedorn needle. Before puncturing compress the finger tightly by squeezing

* Forbid the patient to take any alcoholics 48 hours previous to the time of collecting the blood. Craig and Nichols were the first to find out that the active principle of the Wassermann reaction disappears temporarily when alcohol is given to the patient or syphilitic animals.

it in such a manner as to drive the blood towards the extremity of the finger. In small children the lobe of the ear should be punctured for greater convenience. The blood will come out in drops. For collecting the blood Wright's capsules are best suited. In order to get *enough* blood it

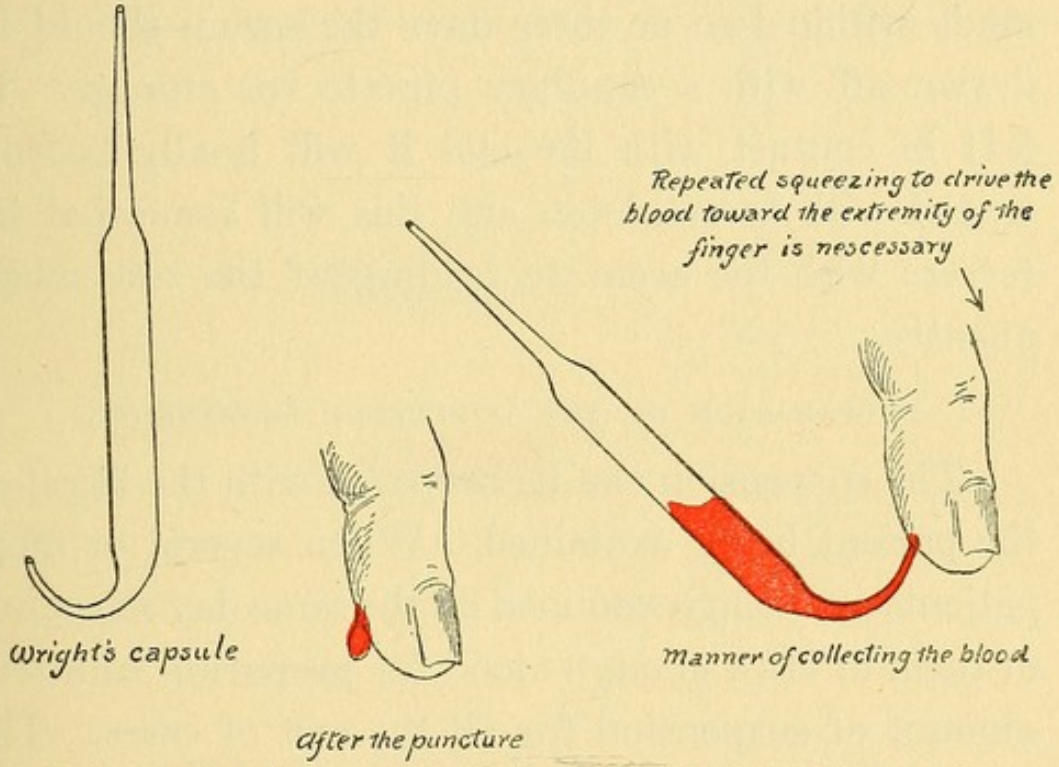


FIG. 7.—Showing the manner of collecting the blood with a Wright's capsule.

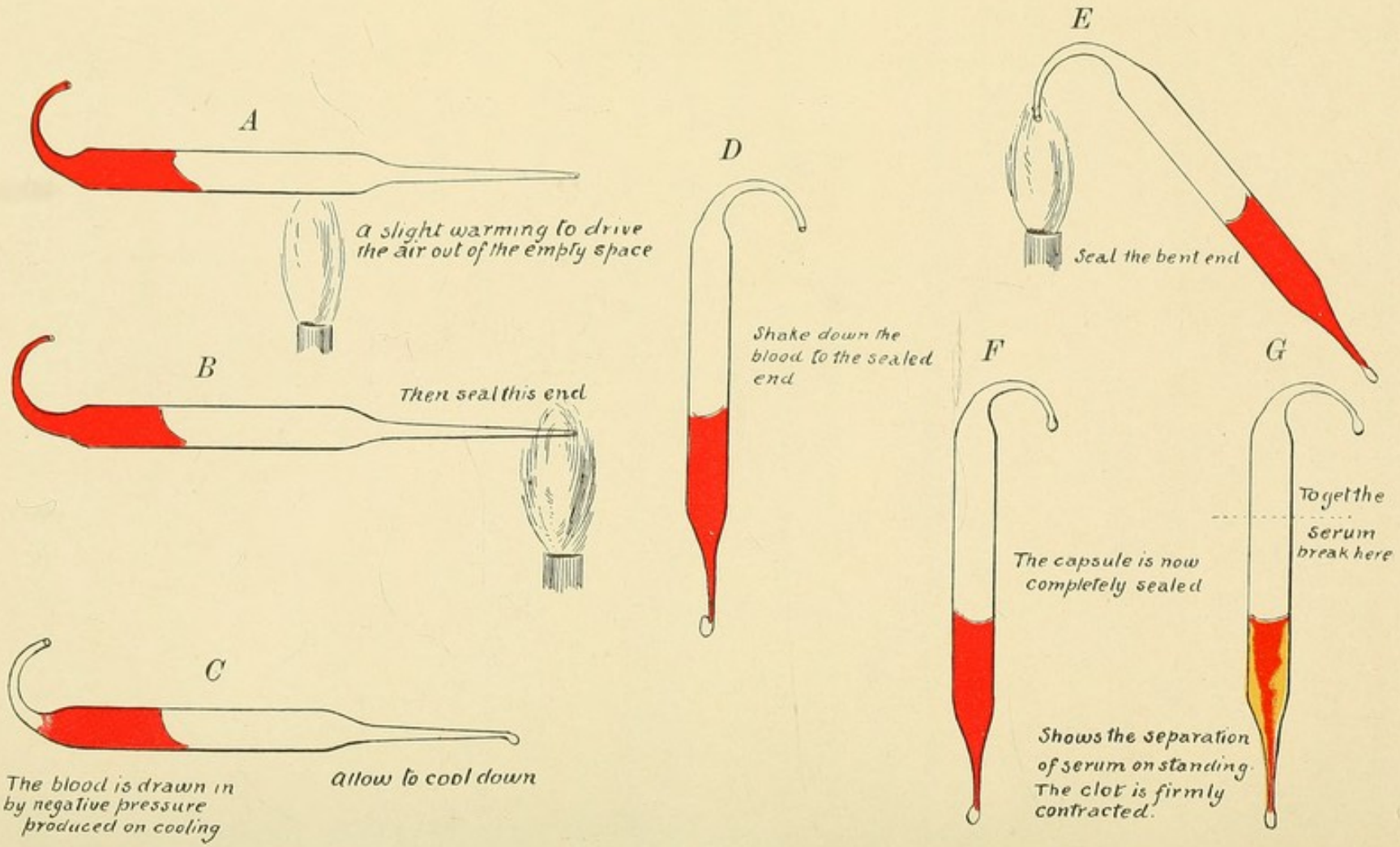
is usually necessary to massage the finger towards the point repeatedly. One puncture usually suffices. After sufficient blood is collected seal the straight, empty, capillary end with a flame, then cool that end. When cool, shake the capsule to drive the blood from the bent end to the straight sealed end; then the bent end is sealed with a flame in turn. By this means the capsule can be sealed without applying the heat to the

blood (Figs. 8 and 9). Wright's capsules may be made by drawing out ordinary thin glass tubing in the flame of a good-sized alcohol lamp, or, better, a Bunsen burner.

The blood clot and the serum separate in a few hours at room temperature. If the test is not to be made within two or three days the serum should be drawn off with a capillary pipette for storage. If left in contact with the clot it will finally become tinged with hæmoglobin and this will somewhat interfere with the accurate reading of the test subsequently.

PREPARATION OF THE CORPUSCLE SUSPENSION.

The suspension can be prepared with the blood of the patient being examined. When several or more patients are being examined on the same day select one of them to draw enough blood for preparing sufficient amount of suspension for all the rest of cases. The standard amount of corpuscle suspension for my system is 1 c.c. of a 1 per cent. or 0.1 c.c. of a 10 per cent. for each tube. Thus if we draw 1 c.c. of blood from any of the patients it will give enough corpuscles to distribute in 100 test-tubes. The most important condition that must be strictly observed in utilizing the corpuscles of other patients is the complete removal of serum from the suspension. This is easily accomplished by washing the blood by means of centrifugalization. I will describe below two different



FIGS. 8 AND 9.—Showing the steps necessary in sealing the Wright capsule without spoiling the blood while sealing with a flame. *G* shows the separation of the serum from the clot.

ways of making suspension. Take a graduated centrifuge tube (capacity 10 c.c.) and fill it with sodium citrate solution [1] up to 9 c.c. Allow the blood of patient to drop until it fills up to 10 c.c. (9 c.c. of citrate solution + 1 c.c. blood). The blood is mixed well with the citrate solution and then centrifugalized. Pour off the supernatant fluid (containing the serum) and fill up to 10 c.c. with a fresh lot of salt solution. Stir up and centrifugalize again. The supernatant fluid is once more decanted off. The deposit (corpuscles free from serum) is now resuspended either in 100 c.c. of salt solution (making a 1 per cent. suspension) or in 10 c.c. (making a 10 per cent. suspension). In the test one uses either 1 c.c. of the one per cent. or 0.1 c.c. of the ten per cent. suspension for each tube according to whether the experimenter prefers the first or the second procedure which will be mentioned later.

When one has defibrinated blood the suspension may be similarly made after removing the serum by washing with a large amount of salt solution. Here one cubic centimetre of the defibrinated blood will also give enough suspension for 100 tubes.

The use of the one per cent. corpuscle suspension necessarily introduces the maximum volume of fluid for each tube and no further addition of salt solution is required. On the other hand, the employment of

[1] This is prepared by adding 20 grammes of sodium citrate to 1000 c.c. of 0.9 per cent. salt solution.

the ten per cent. suspension introduces into each tube only 0.1 c.c. of fluid and demands the addition of further 0.9 c.c. of salt solution to come up to the standard volume 1 c.c. for each tube. The consequence of using the one per cent. or ten per cent. suspension is as follows: As various other factors, such as complement, antigen and patient's serum, are contained in very small quantities of fluid, they can not react with each other, unless they are put together in more fluid. In order to accomplish this one has to make up the total volume of each tube, at least, 1 c.c. This can be done either by adding 1 c.c. of simple salt solution or 1 c.c. of the one per cent. corpuscle suspension. Thus one will quickly see that in case of using the one per cent. corpuscle suspension the addition of corpuscles is necessarily done at the very beginning of making the test. On the other hand, when the ten per cent. suspension is used the addition of corpuscles may be made afterwards, as one can use salt solution without corpuscles at the start. The method in which 1 c.c. of the one per cent. suspension is used from the beginning will be called the first and that in which 0.1 c.c. of the ten per cent. suspension is added later the second procedure. The advantage of the second procedure over the first is that one can add amboceptor from the beginning (as there are no corpuscles yet).

With the apparatus as outlined on hand, the serum collected as described, the corpuscle suspension freshly prepared, and with the other reagents secured from a reliable source, the test can be carried out as will be described in the following pages.

TECHNIC OF THE TEST.

To facilitate the carrying out of the test a rack containing two rows of holes for the tubes as shown in the illustration on page 64 should be used. For each test two tubes are required, one in the front row and its control in the rear row. There will also be two pairs of tubes to serve as positive and negative controls.

Put into each of two small test-tubes front and rear one drop (0.02 c.c.) of the serum to be tested from a capillary pipette.[1] Add to each tube 0.1 c.c of 40 per cent. fresh guinea-pig serum[2] made by adding 1 part of complement to 1½ parts of 0.9 per cent. salt solution. In an emergency or where fresh complement cannot be obtained dried slips of paper each containing two units of complement may be substituted. To the front tube add the slip bearing the antigen in form of an emulsion (recommended) or of an impregnated paper slip. Then to both tubes add 1 c.c. of the one per cent. suspension of washed

[1] When using inactivated serum put 4 drops (0.08 c.c.) into each tube. Use 0.2 c.c. of cerebrospinal fluid not "inactivated."

[2] See under Section B, p. 74.

human corpuscles (the first procedure). In case of using the ten per cent. corpuscle suspension add 0.9 c.c. of salt solution and 2 units of amboceptor (the second procedure). Shake the tubes thoroughly from time to time to distribute the reagents evenly throughout the mixture.

With every series of tests it is necessary to carry out *two sets of controls* as already referred to in beginning the description of procedure, and for this purpose four additional tubes will be necessary. To each of the first pair of these, one in the front and one in the rear row, one capillary drop of a syphilitic serum known to give a positive reaction is added. This will serve as a positive control. To the second pair one drop of normal serum known to give a negative reaction should be added, or the tubes may be left empty. This pair of tubes will serve as a negative control. Now put into each tube complement and into the tubes of the front row only antigen, adding finally 1 c.c. of the one per cent. corpuscle suspension (first procedure), or 0.9 c.c. of salt solution and 2 units of amboceptor (second procedure) to each tube.

Place the rack holding these pairs of tubes in a water-bath, thermostat, or warm place not over 37° C. Allow an hour from the time the mixture is made for the antibody to combine with the antigen and for

complement to be fixed. If a water-bath is used, 30 minutes is a sufficient length of time. If dried paper complement is used this period of incubation should be extended to twice as long as is the case when liquid complement is used. The contents of the tube in the first procedure are as follows:

Rear: Test ser.+ complm. (2 units)+ O +1% corp. susp. (1 c.c.)
Front: Test ser.+ complm. (2 units)+ antigen +1% corp. susp. (1 c.c.)

The contents of tubes in the second procedure are as follows:

Rear: Test serum+complm. (2 units)+ O +amboceptor (2 units).
Front: Test serum+complm. (2 units)+antigen+amboceptor (2 units).

First incubation at 37° C. for 1 hour, then add to each tube of the first procedure a slip bearing two units of amboceptor as shown in the illustration, as follows:

Rear: Above+amboceptor (2 units).
Front: Above+amboceptor (2 units).

To each tube of the second procedure 0.1 c.c. of the ten per cent. corpuscle suspension, as follows:

Rear: Above + 10% corpuscle suspension (0.1 c.c.).
Front: Above + 10% corpuscle suspension (0.1 c.c.).

Allow another two hours in the thermostat or one hour in water-bath. After final incubation the tubes should be kept at room temperature for a few hours before the results are recorded.

In accompanying charts various steps of making the test by the first and second procedures are given. After the above stages have been carried out, the result of the reaction can be read.

FIRST PROCEDURE.

	Set for diagnosis. Test with the serum in question	Positive control set. Test with a positive syphilitic serum	Negative control set. Test with a normal serum	Incubation at 37° C. for 1 hour.	Addition of antihuman amboceptor, 2 units to all tubes.	Incubation at 37° C. for 2 hours longer, then at room temperature.
Rear row.	*a.* Unknown serum, 1 drop.* *b.* Complement, 2 units. *c.* 1 % Corpuscle susp., 1 c.c.	*a.'* Positive syph. serum, 1 drop* *b.* Complement, 2 units. *c.* 1% Corpuscle suspension, 1 c.c.	*a.''* Normal serum, 1 drop.* *b.* Complement, 2 units. *c.* 1 % Corpuscle susp. 1 c.c.			
Front row.	*a.* Unknown serum, 1 drop.* *b.* Complement, 2 units. *c.* 1 % Corpuscle susp., 1 c.c. +Antigen.†	*a.'* Positive syph. serum, 1 drop* *b.* Complement, 2 units. *c.* 1% Corpuscle suspension, 1 c.c. +Antigen.†	*a.''* Normal serum, 1 drop.* *b.* Complement, 2 units. *c.* 1 % Corpuscle susp. 1 c.c. +Antigen.†			

* When working with inactivated serum 4 drops (0.08 c.c.) should be employed. With cerebrospinal fluid, 0.2 c.c. (not inactivated) is used.

† When using unheated serum pure lipoids prepared by my method (page 71) should be used. With inactivated serum aqueous, alcoholic, or aceton-insoluble lipoids may also be used.

Second Procedure.

Set for diagnosis. Test with the serum in question	Positive control set. Test with a positive syphilitic serum	Negative control set. Test with a normal serum
Rear row.		
a. Unknown serum, 1 drop.*	*a.'* Positive syph. serum, 1 drop*	*a."* Normal serum, 1 drop.*
b. Complement, 2 units.	*b.* Complement, 2 units.	*b.* Complement, 2 units.
c. 0.9 % Salt solution, 0.9 c.c.	*c.* 0.9 % Salt solution, 0.9 c.c.	*c.* 0.9 % Salt solution, 0.9 c.c.
Amboceptor, 2 units.	*d.* Amboceptor, 2 units.	*d.* Amboceptor, 2 units.
Front row.		
a. Unknown serum, 1 drop.*	*a.'* Positive syph. serum, 1 drop*	*a."* Normal serum, 1 drop.*
b. Complement, 2 units.	*b.* Complement, 2 units.	*b.* Complement, 2 units.
c. 0.9 % Salt solution, 0.9 c.c.	*c.* 0.9 % Salt solution, 0.9 c.c.	*c.* 0.9 % Salt solution, 0.9 c.c.
d. Amboceptor, 2 units.	*d.* Amboceptor, 2 units.	*d.* Amboceptor, 2 units.
+Antigen.†	+Antigen.†	+Antigen.†
Incubation at 37° C. for 1 hour.		
Addition of 10 % corpuscle suspension, 0.1 c.c. to all tubes.		
Incubation at 37° C. for 2 hours longer, then at room temperature.		

* When working with inactivated serum 4 drops (0.08 c.c.) should be employed. With cerebrospinal fluid, 0.2 c.c. (not inactivated) is used.

† When using unheated serum pure lipoids prepared by my method (page 71) should be used. With inactivated serum aqueous or alcoholic extracts may also be used.

First, it is necessary to make certain that the tests in the control sets have been properly carried out. The pair of tubes containing normal serum (or without any serum) must be completely hæmolysed. These constitute the negative controls and show that the hæmolytic system used is effective (see rear tube)

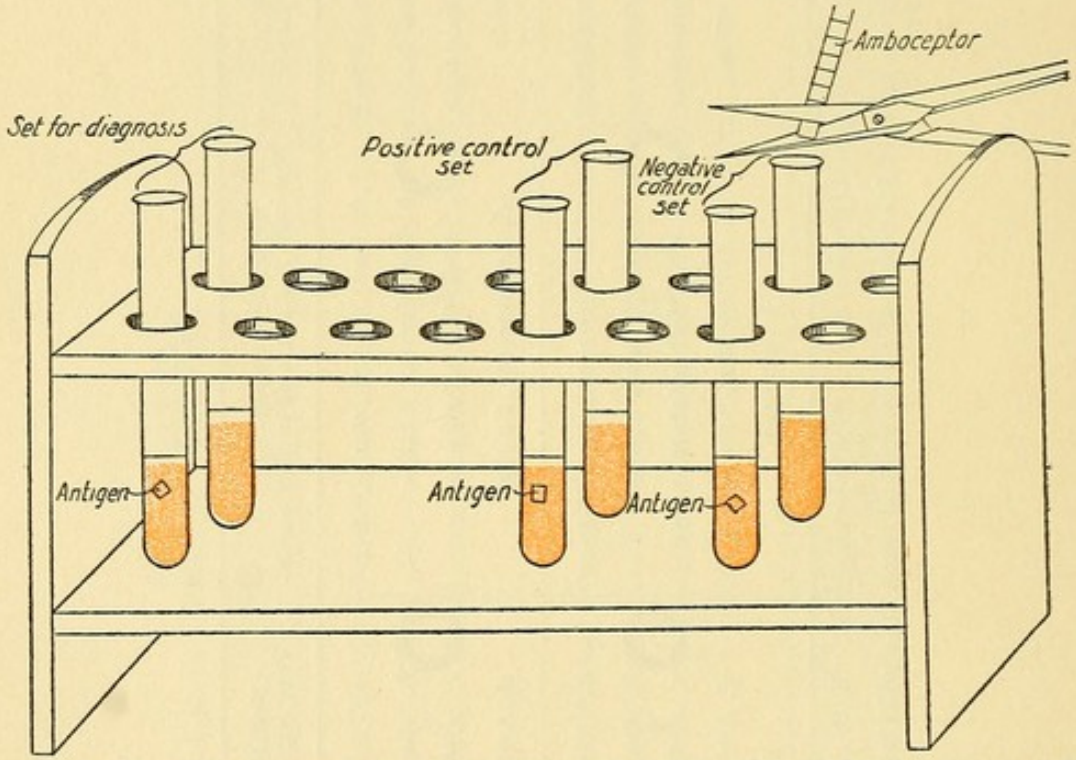


FIG. 10.—The picture shows the appearance of all tubes after the first incubation and just at the moment when the amboceptor slip is about to be added. Thus far there is no visible difference in these tubes and the corpuscles are still intact. In all front tubes there are small square pieces of paper representing the antigen, while none in rear tubes. These square slips will not be there when working with liquid antigen.

and that the amount of antigen used is not by itself inhibitory of hæmolysis (see front tube).

Next, the front tube of the positive control set, containing a known syphilitic serum, must show total inhibition of hæmolysis, while the rear tube must show complete hæmolysis. Thus we are certain by

the rear tube that the syphilitic serum itself does not inhibit hæmolysis, while the front tube, in which hæmolysis is inhibited, shows the ability of syphilitic antibody to fix complement in the presence of the antigen employed.

These essentials having been fulfilled, the tubes

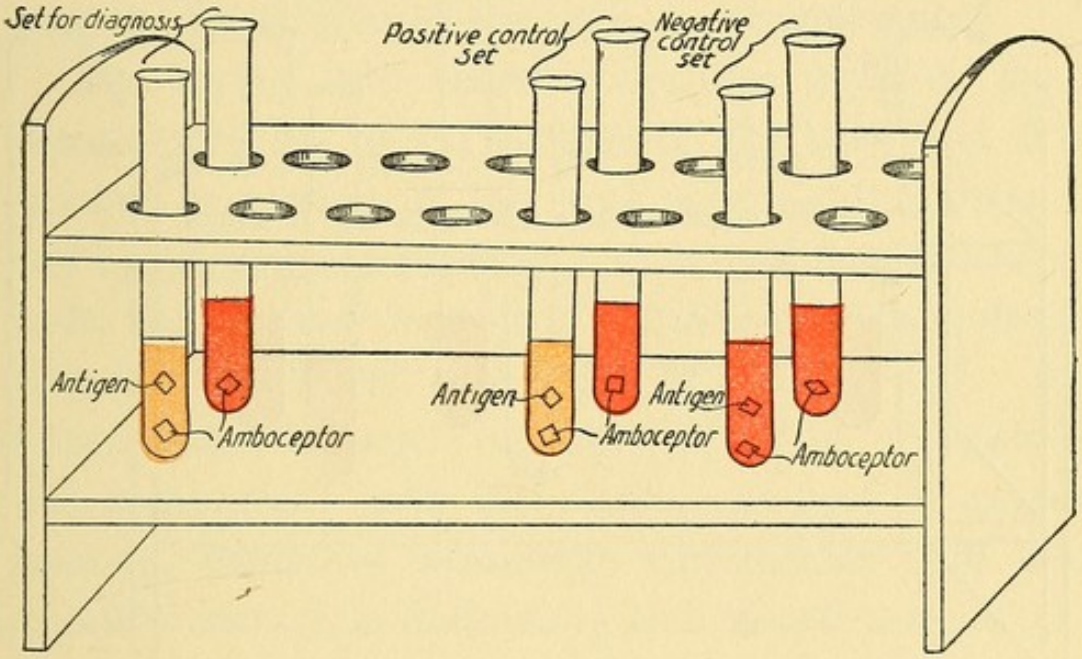


FIG. 11.—This picture shows the appearance of the tubes after completion of hæmolysis, namely, after the second incubation. In all front tubes there are two square pieces of paper, one representing antigen and the other amboceptor. In each rear tube there is but one piece, and it represents amboceptor. In negative control set hæmolysis occurred in both tubes. In positive control set hæmolysis took place in the rear tube only and not in the front. In the set for diagnosis the conditions are seen to be identical with the positive control set, hence this serum is found to be syphilitic.

containing serum for diagnosis can be scrutinized. In these tests hæmolysis must be complete in the rear row, since antigen is not present and the amount of serum used should not be inhibitory. Should hæmolysis be inhibited markedly, showing usually an anti-complementary action on the part of the patient's serum, this may be overcome by " inactivation " of

the serum for 20 minutes at 56° C. (before commencing), after which it will be necessary to use 4 drops of the serum in the test. The above irregularity is occasionally encountered in the test, especially during the summer months.

Now, the tubes containing the serum for diagnosis

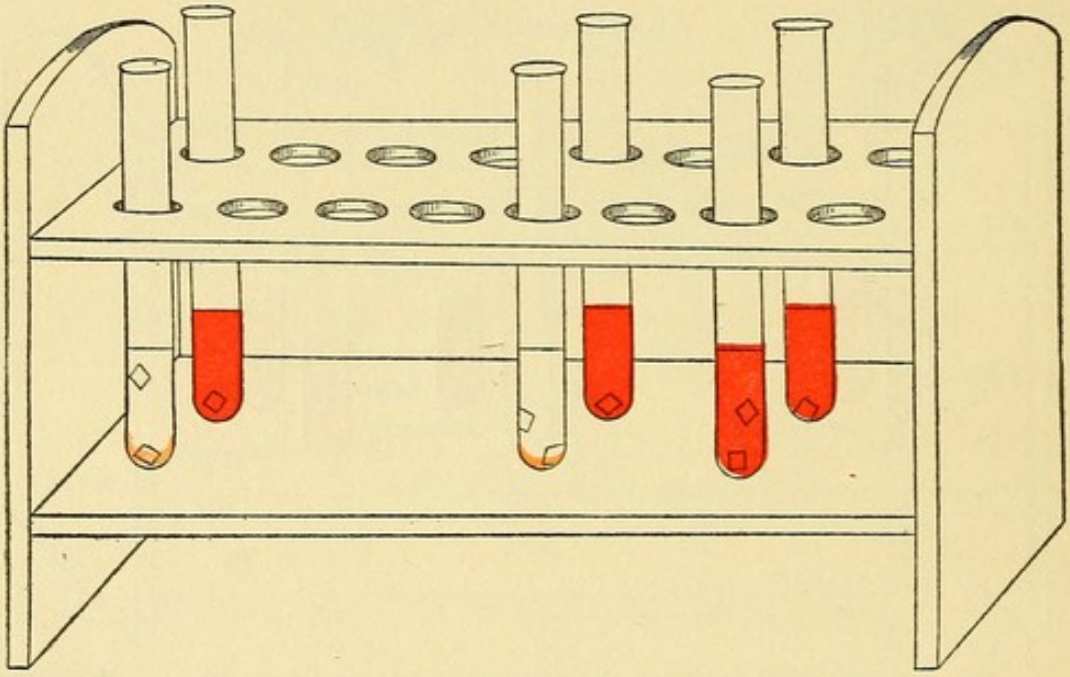


FIG. 12.—This picture shows the appearance of the tubes shown in Fig. 11 after standing for several hours. The absence of hæmolysis in the front tubes of positive control and diagnostic sets is shown by clear supernatant salt solution over the deposited ntact corpuscles. The absence of hæmolysis means positive reaction in these instances.

and antigen, the front row of tubes, may be examined for final results.

Here any degree of hæmolysis may be encountered, from total inhibition to complete dissolution of corpuscles, depending on the presence or absence of syphilitic antibodies and the number of antibody units. With complete inhibition of hæmolysis, the end reaction is easily interpreted, the corpuscles set-

tling to the bottom of the tube with the clear salt solution above (see the front tube of the pair at extreme left). Complete hæmolysis likewise gives a result easy of interpretation, for the corpuscle mass is entirely dissolved, the hæmoglobin going into solution and coloring the salt solution a deep reddish color (see the front tube of the pair at extreme right).

By taking into consideration the bulk of corpuscles settling to the bottom of the tube and the amount of tinting of the supernatant salt solution, and by comparison with the positive and negative controls, the varying degrees of inhibition of hæmolysis may be ascertained (see Figs. 11, 12 and 13). In interpreting the result complete inhibition of hæmolysis comparable with the positive control is called *positive;* complete hæmolysis, comparable with the negative control, is designated as a *negative reaction.* If 60 to 70 per cent. of the bulk of corpuscles is dissolved the reaction is *doubtful* and should not be taken into consideration for diagnosis. In a known specific case such slight inhibition should be an indication for further treatment as evidence of the continued presence of syphilitic antibodies in the patient's blood. If there is a faint trace of hæmolysis, the main bulk of corpuscles being intact, the reaction should be called *weakly positive.* A more intense hæmolysis, with about 10 to 20 per cent. dissolution of the corpuscle mass, should be called *very weakly posi-*

tive, while 30 to 40 per cent. hæmolysis is designated as *faintly positive. Neither the weakly positive nor the faintly positive reaction should be accepted as a definite diagnosis of syphilis without the presence of strong clinical evidence in favor of such a diagnosis.*

In case the reaction should be doubtful, the serum should be re-examined after a period of a week has elapsed, and if necessary several examinations in succession should be made. The reaction may sometimes be very weak in a case of undisputed syphilis. In such instance the test should be made not only with one but also two drops at the same time. Very often a good positive reaction can be obtained with two drops. The advantage of making a test in this class of cases is that the positive finding of the serum reaction furnishes the clinician with one more sign of the existence of syphilitic infection besides the other visible clinical manifestations, and enables him to detect the persistence or cessation of the active syphilitic process when the other symptoms have disappeared.

For examining the sera from known cases of syphilis for prognostic purposes the test must be made with two drops in case one drop gives no longer a positive reaction. In all cases it is a wise precaution to take the blood for examination shortly before meal-time.

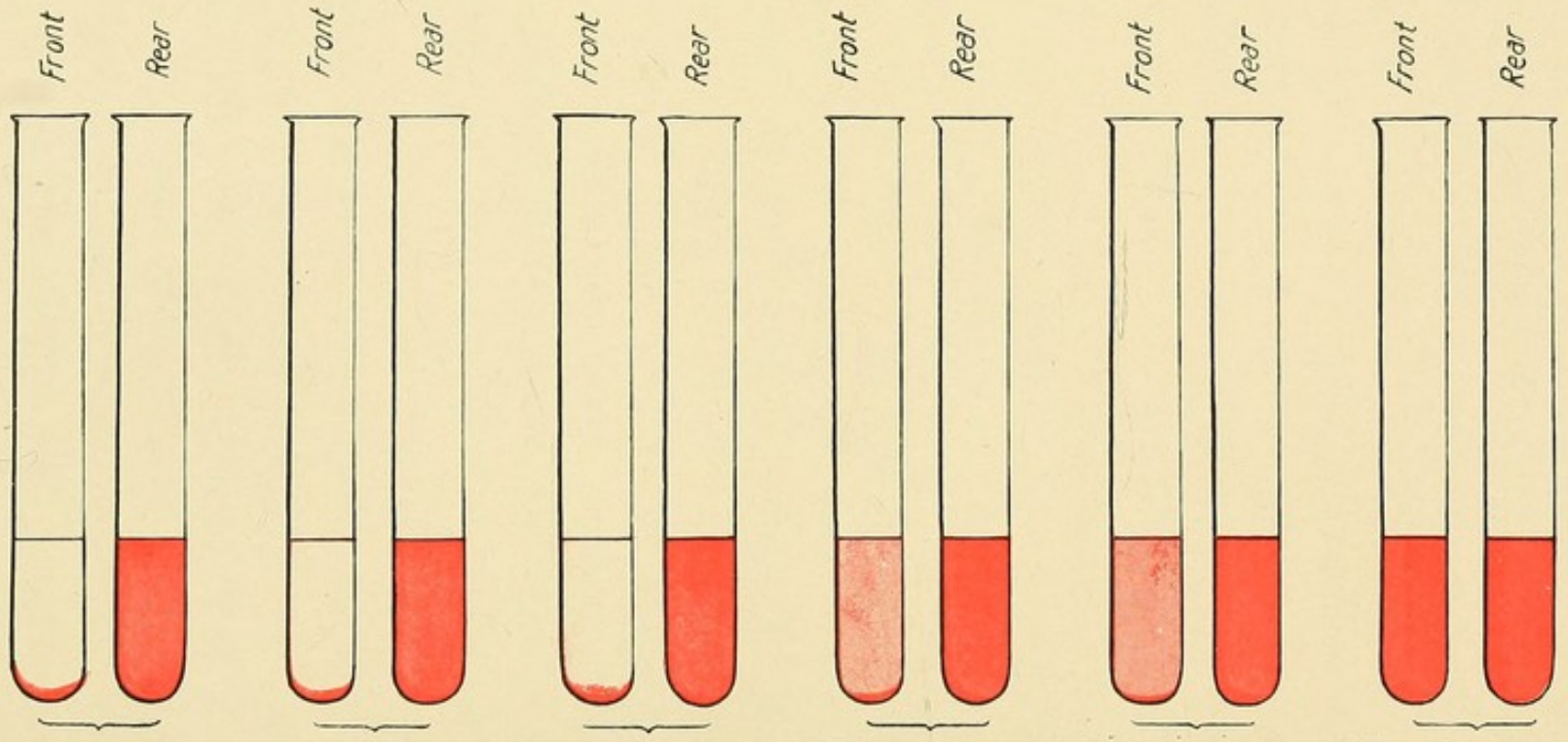

Front
Rear
Front
Rear
Front
Rear
Front
Rear
Front
Rear
Front
Rear
Positive.
Weak positive.
Very weak positive.
Faint positive.
Doubtful reaction.
Negative reaction.

FIG. 13.

It may be stated here that certain specimens of human sera gradually become anticomplementary after several days on standing, some more pronouncedly so than others. This change sets in much more rapidly at a higher temperature, say that of a room, than at a lower temperature, say of a refrigerator.

In order to have a positive control test whenever examining an unknown serum one must always have at hand a syphilitic serum known to give a positive reaction. For this purpose one has to obtain a good specimen, which can be preserved on ice for months. Should such a specimen become too anticomplementary on standing, one can remove this property by heating the serum at 55°–56° C. for about fifteen minutes.

TITRATION OF THE ANTIBODY CONTENT OF SYPHILITIC SERUM.

In the routine examination of patient's serum for the presence of syphilitic antibodies, as above described, one drop (0.02 c.c.) from a capillary pipette is used. This amount of serum is used to determine whether the serum is that of a luetic case or not. When a strong positive reaction is obtained in several specimens we are unable to distinguish the intensity of the reaction without further analysis. In fact, a positive reaction may be gotten with any syphilitic serum con-

taining many units of syphilitic antibody or that quantity which is just sufficient to deviate complement. A serum may thus contain more than one unit of antibody, and in order to determine the exact strength of each specimen, it should be titrated in the following way.

Prepare a stock dilution of the serum by mixing 0.1 c.c. of the serum with 4.9 c.c. of salt solution. This dilution is of such strength that 1 c.c. contains 0.02 c.c. of the original serum (corresponding with one drop recommended for the routine test). Thus 1 c.c. of the dilution is the maximum volume of fluid for one tube and contains the maximum amount of the serum chosen for the test. As we are going to titrate the strength of a serum giving a positive reaction in the amount of 0.02 c.c. we have to test different amounts of the same serum below 0.02 c.c. For accomplishing this end graded quantities of the diluted serum are measured into a number of tubes, as shown in the following protocol:

DILUTION OF SERUM.

Tube 1.....	1	c.c.	(equal	to 0.02	c.c. original serum).
2.....	0.5		"	" 0.01	" "
3.....	0.4		"	" 0.008	" "
4.....	0.3		"	" 0.006	" "
5.....	0.25		"	" 0.005	" "
6.....	0.2		"	" 0.004	" "
7.....	0.165		"	" 0.0033	" "
8.....	0.125		"	" 0.0025	" "
9.....	0.1		"	" 0.002	" "

Having measured the amounts of the serum into the tubes and bringing the total volume of fluid of each tube up to 1 c.c. uniformly by adding salt solution, one now proceeds to make the fixation test in the usual way. Add to every tube 0.1 c.c. of 40 per cent. dilution of guinea-pig's complement, 0.1 c.c. of the standard antigen emulsion and 2 units of amboceptor. Mix the content well by shaking and incubate the tubes at 37°C. for one hour. At the end of the incubation add to every tube 0.1 c.c. of 10 per cent. suspension of washed human corpuscles, and incubate at 37°C. for two hours. The results are then read. According to the strength of serum in question the complete inhibition of hæmolysis may occur in any of the tubes in the series. If a given specimen should give complete fixation in the first tube (1 c.c.), it would be said to contain only one unit of antibody. If this occurs in the second tube (0.5 c.c.) it contains two units; in the third (0.4 c.c.), 2.5 units; in the fourth (0.3 c.c.), 3.3 units, etc. A specimen showing complete fixation in the last tube (0.1 c.c.) must contain, at least, ten antibody units. If the serum gives a strong fixation in the last tube (0.1 c.c.) it is best to titrate it with a second dilution in order to find out its real titre.

By this means the titre of any specimen can easily be determined. The writer has examined specimens which contained as many as 20 units.

In case of titrating cerebrospinal fluid one must prepare the stock dilution by mixing 1 c.c. of it with 4 c.c. of salt solution. The process of titration is exactly the same as that described for the serum.

In titration work graduated pipettes are to be employed.

Section B.

METHODS OF PREPARING THE REAGENTS AND OF MAKING A COMPLETE FIXATION TEST WITH PREPARATIONS OF UNKNOWN VALUE.

COMPLEMENT.

The views of the author regarding the use of complement dried in paper have been modified soon after its introduction, and now he considers it advisable to use the liquid complement whenever possible. While it is quite possible to prepare the complement on paper its use should be reserved for emergencies—when the fresh complement cannot be obtained.

Guinea-pig's serum is to be used. Large animals are selected and bled by cutting the carotid artery, allowing the blood to flow into a large Petri dish. The dish is then covered and left at room temperature for a few hours for the clot to form and the serum to separate. Then the separation of the serum may be completed in the refrigerator. Within five to ten hours all the serum has separated from the clot and

should then be poured into a sterile test-tube and thereafter when not in use kept in the refrigerator. No preservative may be added. After the serum is 48 to 72 hours old the activity of complement is rapidly lost, even at refrigerator temperature, if the serum is kept in a fluid form.

The author does not advise the use of complement dried on paper if it is at all possible to obtain fresh guinea-pig's serum. However, mindful of the fact that this is difficult if not impossible of accomplishment under certain circumstances, as, for example, in out-of-the-way places, army camps, etc., the method of preparing complement paper will be described.

Preparation of Complement Slips.—Squares of thick blotting-paper are put in a sterile flat dish and serum is poured over it until the paper is thoroughly soaked and an excess remains. The saturated paper is then removed to another dish or flat tray and *quickly* dried in a current of air at a temperature not above 10° C., the lowest possible temperature being the most useful. The drying should be accomplished within an hour. According to the thickness of the paper a second impregnation is recommended. After complete desiccation the paper is standardized in the following way: Use a hæmolytic system composed of human erythrocytes and an antihuman amboceptor. The erythrocyte suspension is to be that used in

our test, that is, 1 c.c. of one per cent. suspension of human corpuscles. The amboceptor must have been first standardized with fresh fluid guinea-pig complement. Arrange a series of tubes each containing 1 c.c. of one per cent. erythrocyte suspension and one unit of amboceptor. Now, selecting a sample of the paper impregnated with complement, cut it into strips of a given dimension in millimetres, preferably 5 mm. wide. Add to the series of tubes bits of paper of increasing length, say 2, 3, 5, 7, 10, 15 mm., etc. Incubate the mixture at 37° C. for two hours. That size of slip in which hæmolysis is just complete will contain one unit of complement. As we desire to use two units of complement in the fixation test, the remaining paper will be measured off into squares having *twice* the dimension of that found for one unit. These may be marked with pencil so that they may be snipped off as they are needed. These strips must be kept perfectly dry and sealed hermetically in vacuum.

PREPARATION OF AMBOCEPTOR.

Antihuman hæmolytic amboceptor is to be used. This is made by immunizing rabbits against human blood-corpuscles. Select large rabbits and inject increasing amounts of washed[1] human blood-

[1] The corpuscles must be washed at least three times with a large amount of saline solution. If this is not done the immune serum may contain precipitin for human serum, which will interfere with the fixation reaction.

corpuscles five times in succession intraperitoneally, allowing a four- or five-day interval between injections.[1] Nine or ten days after the last injection, bleed the rabbit from the carotid artery with a blood-tube shown in the drawing on page 76.

SCHEDULE FOR IMMUNIZATION.

Injections at four- or five-day intervals. Bleeding nine or ten days after the last injection.

1st injection,	5 c.c. of	the	washed	human	corpuscles.
2d injection,	8 c.c. of	"	"	"	"
3d injection,	12 c.c. of	"	"	"	"
4th injection,	15 c.c. of	"	"	"	"
5th injection,	20 c.c. of	"	"	"	"

After the blood is collected the blood-tube is placed at room temperature for several hours before being transferred to the refrigerator. During this period the clot gradually contracts and separates from the wall of the tube, allowing a clear serum to exude in the space between the clot and the wall of the tube. If the clot remains uncontracted within four or five hours, separate it carefully from the wall by inserting a sterile stiff platinum needle or glass rod, and allow it to stand at room temperature for several hours again to promote the contraction of the clot. Then place the blood in a refrigerator for twenty-four hours. Collect the clear serum at the end of

[1] Four intravenous injections, 4 c.c., 3 c.c., 4 c.c., 3 c.c. and possibly another 4 c.c. with four- or five-day intervals, give also good results. This mode of immunization is, however, less safe for the rabbits.

twenty-four hours by decantation, and leave the tube for another day to collect serum again. Repeat this

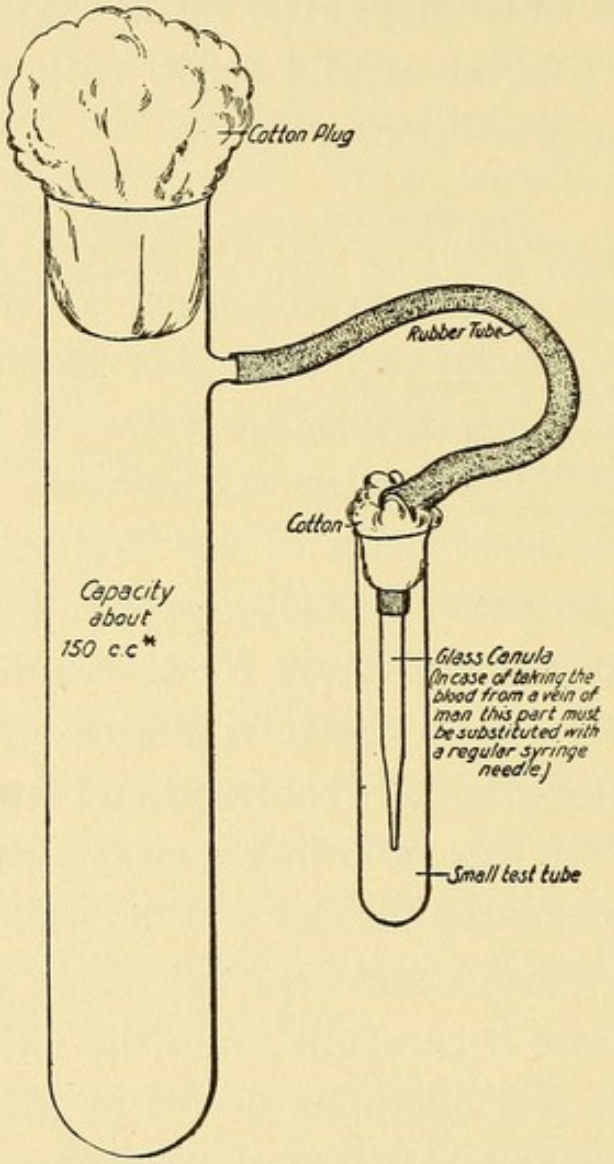


FIG. 14.—Sterilize in steam, but not in hot air. For the purpose of taking the blood from man the size of the tube should be that of ordinary test-tube and should be provided with a good-sized syringe needle instead of a glass canula.

*This can be smaller, although less convenient than a larger one.

for three or four successive days, until no more serum is given out by the clot on further standing. The portions of the serum collected in this manner over

several days may be mixed together. When the serum contains a certain amount of corpuscles let it stand for a day or longer in an ice-box to allow the latter to sink to the bottom, and collect the clear serum by gentle decantation, or centrifugalization of the bloody serum may be resorted to.

The amboceptor had best be titrated in fluid form when collected to be sure it is strong enough, before going to the trouble of impregnating paper with it.[1] The principles of the titration were fully discussed in Chapter II. A good preparation will have a value of 1 unit in something less than 0.001 c.c. of serum, that is, 0.001 c.c. of serum or less will cause complete hæmolysis of 1 c.c. of a one per cent. suspension of human erythrocytes when combined with 0.02 c.c. of guinea-pig's fresh serum (0.1 c.c. of 20 per cent. dilution).

Method of Preparing Amboceptor Slips.—When it has been determined that our preparation is of the required strength, as will usually be the case if the method of immunization outlined is followed, we proceed to the preparation of the paper. This is a more simple matter in the case of the amboceptor than in the case of complement, for the former is stable. As our slip will only contain about 0.001 c.c.

[1] Different rabbits react differently to amboceptor production and it is not seldom to get a weak serum after a long immunization, while a powerful serum may be gotten after four injections.

of serum in place of 0.04 c.c., a thinner paper is used. I have found Schleich & Schull's paper No. 597 satisfactory. The paper is cut into squares of about 10 × 10 cm. and soaked with the serum in the same general way as is the complement, but here I avoid too great an excess, seeking only to get all the sheets evenly wet, then absorbing the excess with another sheet of paper. The paper can then be dried at room temperature by placing each square separately upon a clean sheet of non-absorbent (unbleached) muslin. Several hours' drying usually suffices. The sheets when thoroughly dry are cut into convenient width, say 5 mm., and then standardized. Take a series of tubes containing one cubic centimetre of the one per cent. erythrocyte suspension as described for the titration of complement. Add to each definite amount of complement (0.02 c.c.) as one unit. Then add to the series measured increasing lengths of the amboceptor strip, *e.g.*, 1 mm., 2 mm., 3 mm., etc., and incubate the series for two hours. The shortest strip which causes complete hæmolysis in this time contains 1 amboceptor unit. The strips are then marked into sections of *twice* this length and cut off at the time of doing the test. Each section will then contain the two units to be used in the test. These papers should be kept dry and sealed, but the same extreme precautions need not be taken with them as with the complement paper.

PREPARATION OF ANTIGEN.

It is settled to-day that alcoholic extracts of certain tissues contain variable quantities of "antigen" for syphilis. There is more in heart, liver, or kidney than in nervous tissues, so far as has been determined. The liver of a congenitally syphilitic fœtus was once considered as one of the tissues richest in these antigenic lipoids, although this claim became no longer tenable through later investigations. I have found that not only selected samples of tissue lecithin, but also several other phosphatids, as well as several aceton-soluble fractions of tissue lipoids, can act as antigen. Whether the extract derives from syphilitic organs or from non-syphilitic tissues makes but little difference. Animal tissues are just as good as human in point of yielding a serviceable extract. In all cases one has to determine the extract before using it as antigen. It is possible to obtain good preparations from animal tissues just as frequently as from human organs. The method of preparing the antigenic extract will be given below.

Extract a mashed paste of liver, heart, or kidney of man, ox, guinea-pig, rabbit, or dog with 10 parts of absolute alcohol at 37° C. for several days. Filter through paper and collect the filtrate. The latter is then brought to dryness by evaporation with the

aid of an electric fan. The residue is then taken up with a sufficient quantity of ether and the turbid ethereal solution is allowed to stand for over night in a cool place; the receptacle must be covered in order to prevent evaporation of ether during this period. The next morning one will find that the turbidity is entirely cleared up by gravitation of the insoluble particles to the bottom. The clear ethereal portion is then carefully decanted into another clean beaker and condensed into a small quantity by evaporating the ether off. The concentrated ethereal solution is now mixed with about ten volumes of pure aceton.

A precipitate forms, which is allowed to settle to the bottom of the vessel, and the supernatant fluid decanted off. We thus obtain a light brownish precipitate which gradually becomes sticky on exposure to the air. This aceton-insoluble portion of the tissue extract contains antigenic lipoids and its quality and strength must be determined.

Titration of Antigen.—In order to ascertain whether a given extract is suitable for antigen or not an emulsion is first prepared and tested. If it is found suitable the extract may be made an alcoholic stock solution and an emulsion from this be prepared at the time of making the test, or it may be impregnated in paper and used in the form of dried strips. I will describe here the general way of determining the antigenic value of a given extract.

Before entering into technical details of titration of the antigenic lipoids certain properties of this fraction in general may be dealt with here. Usually the aceton-insoluble fraction of tissue lipoids as prepared by the method just described has no *hæmolytic action* upon human erythrocytes. But one occasionally encounters a preparation which causes hæmolysis in a large amount. The presence of such an injurious property in the preparation intended for antigen renders it unsuitable and it should be discarded. For this reason it is necessary with every sample of extract to test it for hæmolytic property. Another property often possessed by this fraction and rendering it unsuitable for antigen is the *anticomplementary action,* namely, the property to diminish or destroy the activity of complement. In a very large amount this anticomplementary effect may be manifest in nearly 50 per cent. of different samples. Therefore, we must examine every specimen for its anticomplementary activity. If it should exceed a certain limit the specimen is not to be employed as antigen.

These two properties, hæmolytic and anticomplementary, whether present simultaneously or singly, disqualify a given sample of the extract as a reliable antigen for the test. After eliminating those preparations which are either hæmolytic or anticomplementary or both by properly arranged series of deter-

mination one at last takes up the question of *antigenic property*. By antigenic property is meant that which produces fixation of complement in the presence of syphilitic serum. This most important property of the extract is, however, quite variable according to different samples. Some may possess exceedingly powerful antigenic action, while others may not be antigenic at all. Fortunately, according to my recent systematic analysis of nearly 100 different specimens, with Mr. Bronfenbrenner, about 50 per cent. were found to be serviceable and only about 5 per cent. were devoid of this property. This latter were all from fatty livers. The rest of the specimens were not perfect on account of the pronounced anti-complementary combined with weaker antigenic property.

As will be seen from the above general presentation of the subject a titration of antigen really includes the determinations of (a) hæmolytic, (b) anticomplementary, and (c) antigenic activities. This can be made simultaneously in a properly arranged series of experiments. The following is the method which I recommend for adoption by those who employ my system:

Stock Solution of Antigen.—Take 0.3 gram of the aceton-insoluble fraction and dissolve in about 1 c.c. of ether in a test-tube. The ethereal solution is

then mixed with 9 c.c. of methyl alcohol in which the greater part of substances goes into solution. The alcoholic solution, which contains 3 per cent. of the lipoids, remains unaltered for a long time and can be kept as stock from which the emulsion for immediate use may be prepared at any time.

Emulsion of Antigen.—This is quickly prepared by mixing up 1 c.c. of the alcoholic stock solution (see above) with 9 c.c. of salt solution. The emulsion thus prepared is a clear opalescent fluid. It is this form in which antigen is most certain in action and convenient for use. The concentration of the emulsion is 0.3 per cent. of the original lipoidal substances.

METHOD OF SELECTING A SUITABLE ANTIGEN.

In determining whether a given specimen of extract is suitable for use or not we must examine it for hæmolytic, anticomplementary and antigenic properties as already discussed in the beginning. When a specimen does not show either hæmolytic or anticomplementary action in a certain quantity it is eligible for the final examination for antigenic strength. It is found through our long experience and experiments that the quantity of emulsion for testing hæmolytic and anticomplementary properties should be 0.4 c.c., and that for testing antigenic power 0.02 c.c. In measuring such a small quantity as 0.02 c.c. of emulsion it is customary first to prepare a ten-fold dilution of the usual emulsion with salt

solution and measure out 0.2 c.c. of the dilution (corresponding with 0.02 c.c. of the regular emulsion). In the following chart I present the processes of determination.

CHART 1.

Tube 1 (Test for hæmolytic property).	
Antigen emulsion	0.4 c.c.
Salt solution	0.6 c.c.
Corpuscle suspension (10%)	0.1 c.c.
Incubation at 37°C. for 2 hours.	

Tube 2 (Test for anticomplement property).	
Antigen emulsion	0.4 c.c.
Salt solution	0.6 c.c.
Complement (40%)	0.1 c.c.
Amboceptor	2 units
Incubation at 37°C. for 1 hour.	
Corpuscle suspension (10%) 0.1 c.c.	
Incubation at 37°C. for 2 hours.	

Tube 3 (Test for antigenic property).	
Antigen emulsion (1:10)	0.2 c.c.
Salt solution	0.8 c.c.
Syphilitic serum	0.02 c.c.*
Complement (40%)	0.1 c.c.
Amboceptor	2 units
Incubation at 37°C. for 1 hour.	
Corpuscle suspension (10%) 0.1 c.c.	
Incubation at 37°C. for 2 hours.	

* One drop from a capillary pipette.

These three determinations can be made at the same time in a series of experiments; and it is not necessary to wait the result of one determination before commencing the others.

The results of determinations vary, of course, according to the quality of the specimen under consideration, and one may obtain any one of the possibilities shown on page 86.

Now scrutinizing the quantitative relationship between the amount of emulsion employed for testing the hæmolytic and anticomplementary properties and that for antigenic property one will notice that it stands 20:1. This renders the fixation test absolutely free from any possible interference by the anticomplementary or hæmolytic activity of the antigenic preparation alone. It may not be amiss to remark at this place about the requirements laid by Wassermann in selecting a preparation of extract for the test. He made it the rule that one first determines the minimal quantity of extract which inhibits hæmolysis and then test if the half of this anticomplementary dose gives a complete fixation with a syphilitic serum or not. If it does, the preparation is considered suitable. As one can easily understand this quantity of extract may contain just one antigen unit or several. One simply goes on with the fixation test without knowing how many antigen units he is employing. If the results obtained with one unit of

CHART 2.

Varieties of lipoidal preparations which may be encountered while testing for an ideal sample of antigen.

	Hæmolytic property (0.4 c.c. emulsion)	Anticomplementary property (0.4 c.c. emulsion)	Antigenic property (0.02 c.c. emulsion)	Remarks
1st group (ideal).....	−	−	+	Suitable.
2nd group (single defect).....	−	−	<+	Unsuitable because of weakness of antigenic powers.
3rd group (single defect).....	−	−	−	Unsuitable because of lack of antigenic property.
4th group (single defect).....	−	+	+	Unsuitable because of anticomplementary property.
5th group (single defect).....	+	−	+	Unsuitable because of hæmolytic property.
6th group (double defects)...	+	+	+	Unsuitable because of hæmolytic and anticomplementary properties.
7th group (double defects)...	+	−	−	Unsuitable because of hæmolytic property and lack of antigenic property.
8th group (triple defects)....	+	+	−	Unsuitable because of hæmolytic and anticomplementary properties and of absence of antigenic property.

− = absent ; + = present ; <+ = weakly present.

antigen are the same as those obtained with several there would be no chance of obtaining variable results, but, in reality, the reactions vary considerably according to whether one uses one or several antigen units. This is especially so with a weaker syphilitic serum. In my opinion it is absolutely necessary to use several antigen doses in order to get uniform results with any specimen, because the weakest reaction escapes detection, unless one employs, at least, over four antigen units. It is understood, however, that no oversensitive reaction ought to be allowed to occur in using many antigen units. Fortunately, according to our extensive experience, the use of a suitable antigen—prepared by my method—causes no such an undue sensitiveness.

One might think that the same principle can be applied also to the Wassermann system, but this is impossible because of the constant presence of anti-complementary substances in the extract used in that system.

The Quantity of Antigen for Fixation Test.—As stated above it is essential for obtaining uniform results to employ more than four antigen units. To fulfil this requirement I recommend the use of 0.1 c.c. of 0.3 per cent. suspension of the aceton-insoluble tissue lipoids whose suitableness as antigen has previously been determined in the manner already described. In this quantity of the emulsion there will

be at least five antigen doses (0.1 c.c. ÷ 0.02 c.c. = 5).

Preservation of Antigen.—When one secures a suitable specimen of aceton-insoluble tissue lipoids it may be preserved in the following manner.

(*a*) *In Solid Form.*—Put up the solid substance in a tube and seal it hermetically. It is best to put a small quantity of aceton to the tube before sealing.

(*b*) *In Alcoholic Solution.*—Dissolve 0.3 gram in small amount of ether and then add 10 c.c. of methyl alcohol. The solution is then divided into small portions (say each 1 c.c.) and sealed in ampoules. In time of use take 1 c.c. of this stock solution and mix with 9 c.c. of salt solution, thus making the 0.3 per cent. emulsion ready for use. When emulsified the antigen should be kept on ice; it is not very stable in this form. Therefore it is best to prepare just so much emulsion each time as may be used up in a week or so, and then a fresh lot of emulsion is again prepared. The alcoholic stock solution may be made at any time from the solid lipoidal substances preserved in the manner described under (*a*). The writer found that the mode of preservation above stated was the best and most reliable.

(*c*) *The Antigen Paper Slips.*—The antigenic lipoids may be impregnated in filter paper and used in form of dried slips. The impregnated paper retains its antigenic property for, at least, three months. Within six months it is apt to deteriorate, being far

less durable than the alcoholic solution, but more stable than in form of an emulsion.

The process of impregnating filter paper with antigen is similar to that used for amboceptor. Here we use ethereal solution of the antigenic lipoids for impregnation.

Method of Preparing Antigen Slips.—Weigh out about 1.2 grams of the sticky mass of the extract and dissolve in about 20 c.c. ether. Have ten sheets of filter paper of the dimensions of 10 x 10 cm. ready, laid one upon the other in a clean glass dish. Pour over these the lipoid solution and saturate the paper evenly. Separate each sheet as quickly as possible and lay flat on a clean sheet of unbleached muslin, as in the case of the amboceptor paper. Evaporation of the solvent usually takes place very quickly and within ten minutes the impregnated paper is ready for use. Before assigning the dimension for each tube in the fixation test the antigen paper should be titrated. This is done in the following manner. Cut the paper into equal width, say 5 mm., and use increasing lengths of this strip for standardization, starting with 1 mm., 2 mm., 3 mm., etc. The principle of standardization of antigen slips is the same as described for the liquid preparation, differing only in using paper instead of liquid. The strips may be marked in sections, each representing the required dimensions, and put into sealed tubes for preservation.

VIII.

ADJUSTABILITY OF THE WRITER'S SYSTEM.

UNDER ordinary circumstances the relative quantities of the different factors prescribed in my system should give uniform and reliable results; but, as the properties of the complement and the resistance of the red corpuscles sometimes vary according to their source and age, certain irregularities now to be considered sometimes arise. In view of these variables it is desirable that the worker understand how to adjust relatively the quantities of these factors. Indeed, there are no difficulties that can arise which cannot be removed by the proper use of the several reagents.

1. One sometimes meets with instances in which the hæmolysis is complete within 10 to 20 minutes, and in which the positive control tubes with antigen undergo, sooner or later, gradual hæmolysis. Such rapid progress of hæmolysis at first mentioned is a sign of imperfect reaction. If the test is properly made, hæmolysis proceeds gradually, and is complete in the water-bath within half an hour or thereabout. The causes of this accelerated hæmolytic process are either an abnormally weak resistance of the blood-corpuscles, or an exceptionally high activity or insensitiveness to fixation of the complement employed;

or it may be the result of all these acting together.[1] The corpuscles should never be older than 72 hours, and should be kept constantly on ice, except when being used for the test. They decrease rapidly in strength after the 72-hour period, and more quickly if kept at room temperature. Having even chosen suitable corpuscles, the hæmolysis may still proceed too rapidly, in which case the complement is likely to be at fault. It happens occasionally that the serum of certain guinea-pigs contains an abnormally active complement. In order to establish this point, and thus to remove this source of error, one has only to make the test with a smaller quantity of the complement, or, speaking more correctly, a quantity that corresponds exactly to two complement units.

2. There are sometimes encountered instances in which hæmolysis remains incomplete even in the control tubes in which there is no antigen. Here the causes of the imperfect reaction are found either in the weakness of the complement, or the amboceptor used, or both. Usually the cause is the weakness of the complement, which, owing to its great lability, is likely to deteriorate. Thus it is a good practice to employ complement that is not older than 48 hours, and that has been kept constantly at refrigerator

[1] Guinea-pig's complement may sometimes remain unfixed and mask the positive reaction. It is always best to use a mixture of the sera from two or more guinea-pigs.

temperature. No attempt should be made to utilize a deteriorated complement in larger quantities, because such a specimen does not give a reliable reaction. The activity of the amboceptor is far less subject to external influences which bring about its deterioration, and it is therefore extremely rare to find that the imperfection in the reaction arises from this source.

In testing several specimens of serum at one time it happens occasionally that some specimens are slower in completing the hæmolytic reaction than others. The cause of this slowness is not present in the complement or amboceptor, but in the specimens themselves. In such cases the specimens are found to contain anticomplementary substances which react with and reduce the activity of the complement. To remove this source of error, it is necessary *to heat the serum to* 55° *C. for twenty minutes and use four drops for the test.* The difficulty may be obviated in some cases by collecting specimens of serum to be tested just before meal-time, because the anticomplementary substance is closely associated with the absorption of the chyle into the circulation soon after the meal.

3. The quality and quantity of the antigen can also be sources of error. If one uses poor antigen, either there will be no positive reaction at all, or weak positive reactions will be entirely overlooked.

If, on the other hand, an excessive amount of unfractionated crude antigen is employed certain nonspecific weak reactions may become manifest, or a false positive reaction even may be obtained, as the result of the action of anticomplementary substances sometimes contained in preparations of the antigen. These sources of error can be entirely excluded by choosing an antigen that has been carefully prepared and standardized by an experienced serologist, which is, indeed, one of the advantages which the employment of my system offers.

Apart from these suggestions, which are essential in order to obtain reliable results with the present system, a few words may be added concerning the making of the reactions on a larger scale. In other words, if it is desired to make the test with larger quantities, one has simply to multiply the quantity of each factor employed. Thus one may use 0.1 c.c. of the complement, 0.05 c.c. of the patient's serum, 1 c.c. of a 5 per cent. suspension of the washed human corpuscles, and 2 units of the amboceptor (titrated with the above complement and corpuscle-suspension unit), in a total volume of 5 c.c. of physiological salt solution. This increase in the relative quantities of each constituent offers one advantage and one disadvantage. The advantage is that the intensity of the reaction can be more minutely measured through the liberation of the hæmoglobin, as the number of

red corpuscles is, of course, much larger. The disadvantage arises from the unnecessary waste of material. For the worker in a regularly equipped biological laboratory this waste may make but little difference, but for those who intend to do the test in a private laboratory the exercise of economy is highly desirable.

When the serum to be tested has previously been inactivated by being heated to 56° C., the amount of serum used must be from four to five times greater than that prescribed for the fresh or unheated serum, since one effect of the inactivation is to reduce the content of the antibody to about one-fourth or one-fifth of the original strength.

In the following chapter the writer will point out the effect of inactivation upon the antibody content of serum. This has bearing not only on what has been said above, but with equal if not greater directness upon the original Wassermann and other systems requiring inactivation of the patient's serum.

IX.

INACTIVATION OF THE SERUM IN RELATION TO THE SYPHILIS REACTION.

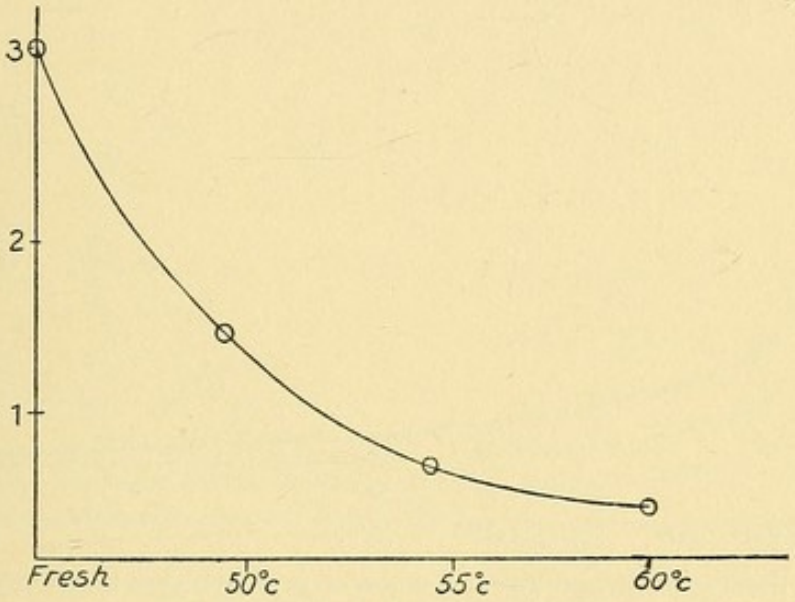
It will be recalled that the serum of patients to be tested is employed either in the fresh state or after inactivation at 56°C. According to the method used in the systems of Wassermann, Detre, Bauer, Boas, and Browning, the serum is previously heated to 56° C. for half an hour, in order to destroy all the native complement present in it. On the other hand, in the systems of Hecht, Stern, and Tschernogubow the serum is employed in the fresh state, since in these systems the native complement is utilized. Unlike these two sets of systems, the one which I offer enables one to use either fresh, or old, or inactivated serum, the only difference being that when the serum has been inactivated a somewhat larger quantity of it must be employed.

We will now consider the reasons why one set of workers employ for the reaction the inactivated, and another the fresh serum. Wassermann, Bauer, and others inactivate the serum simply to destroy the native complement, which varies in different specimens of serum, and in order to substitute this un-

known content by a uniform amount of guinea-pig complement of known activity. Hecht and Stern, however, found that when the test is made with fresh serum, so as to employ the native complement, the reaction is more sensitive than when the inactivated serum is used. On what does this greater delicacy of reaction of the fresh serum depend? Since this point has not been touched upon, I have made a careful study of it, as a result of which I am prepared to offer an explanation of the difference existing between fresh and inactivated serums.

The first question which I asked myself was: Is the so-called syphilitic antibody affected in the process of inactivation? It had previously been found that this antibody is completely destroyed at temperatures between 72° and 80° C. in about twenty minutes. I found that the spinal fluid loses its antibody when heated to from 75° C. to 80° C. for twenty minutes, as had been previously found by Marie and Levaditi. The syphilitic serum I observed to have become inactive at 72° C., but the coagulation of the protein interfered in a high degree with exact observation. We know, therefore, with fair accuracy the limit of temperature at which the total destruction of the antibody is established, but we know almost nothing of the rate of destruction which takes place at lower temperatures. Sachs states that the antibody content

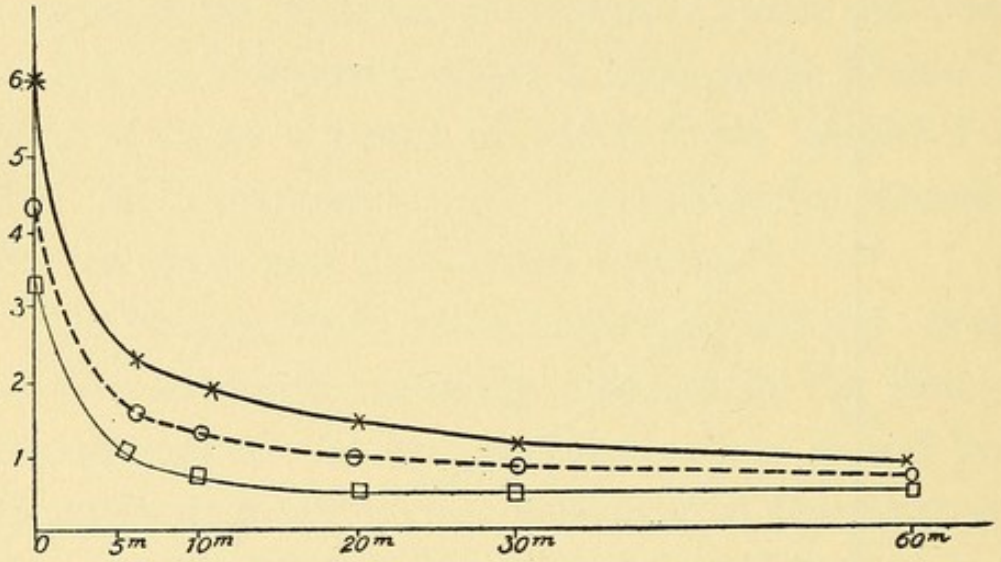
of syphilitic serum is considerably reduced by temperatures of 60° C. I have found, on subjecting a specimen of serum from a case of untreated secondary syphilis to temperatures of 45°, 50°, 55°, and 60° C. for twenty minutes and then determining, by fixation tests, the amount of the antibody available, that the



CURVE 1.—Heating of a syphilitic serum to different temperatures for 20 minutes (in a water-bath).

syphilitic antibody is greatly reduced even at 45°. At 50° C. it is reduced to about one-half, at 55° C. to about one-fourth, etc., as is shown in Curve 1. I next studied the rate of destruction of the antibody at the temperature of 55° C., at five, ten, twenty, thirty, and sixty minute periods. The results were rather unexpected, since the rate of destruction is greatest during the first five minutes, during which time the antibody strength is reduced about one-third

of the original. After thirty minutes it has been reduced one-fourth to one-fifth, and at the end of one hour to about one-tenth of the original, as can be seen by reference to Curve 2. In studying the serum from a case of leprosy, I found that the diminution of the antibody strength went on in precisely



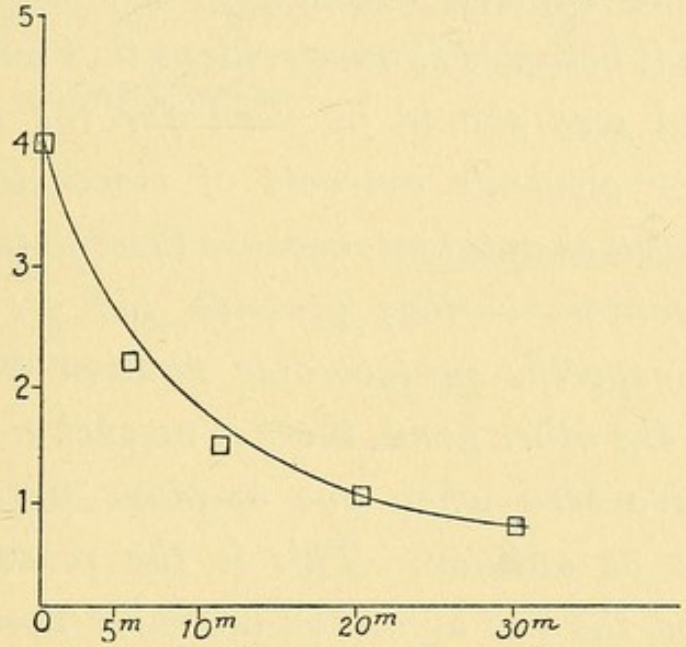
CURVE 2.— Heating of three different samples of syphilitic sera to 55° C. for varying lengths of time (in a water-bath).

the same way as in the specimens obtained from syphilis (Curve 3).

It has been stated by certain investigators that the fresh serum of nonsyphilitic cases—as, for example, cases of carcinoma—may give a positive reaction, and that this reaction disappears when such a serum has been previously heated to 56° C. for thirty minutes, and that therefore the two groups of positive reaction, specific and nonspecific, can be distinguished by the employment of inactivated serum. I have

not been able to find any very accurate studies of this topic, which on the whole is so very important.

My recent studies on the Bordet-Gengou fixation phenomena in general revealed an unexpected fact, namely, that in the majority of active human sera irrespective of sources there exists a constituent which



CURVE 3.—Heating of a serum from a case of leprosy to 55° C.

fixes complement when mixed with certain proteins such as nucleoproteins, pepton, albumoses, and many other autolytic decomposition products of proteins. I designated this phenomenon proteotropic fixation in contradistinction to lipotropic fixation due to the action of certain lipoids upon the syphilitic serum. This proteotropic fixation is of course nonspecific, but difficult to differentiate from the real specific Bordet-Gengou as well as the syphilis reactions. Fortunately

this proteotropic reaction does not occur when the serum is previously heated to 55° C. for twenty minutes, while the lipotropic fixation is not thereby abolished. Thus, no active human serum should be employed for fixation test when these proteins can not be excluded from the extracts serving as antigens. Considering the syphilis reaction in the light of this revelation it becomes at once evident that none but the inactivated sera should be used for the test when aqueous or alcoholic extracts of macerated organs are employed as antigens, because these antigen preparations contain various proteids and are liable to give a nonspecific proteotropic fixation with active sera. On the other hand, there is no such a danger in using active sera when one employs pure lipoidal substances as antigen. This is the reason why I recommend the use of aceton-insoluble tissue lipoids for antigen and the experiences of many investigators on over 20,000 cases prove that my claim is correct. Thus the introduction of pure lipoidal antigen prepared by my method rendered it for the first time possible to employ an active human serum for the diagnosis of syphilis. One can easily see how erroneous it would be to employ certain other preparations of antigen containing various proteids in my method in which active sera are principally used. In fact, one or two investigators committed this error and placed

the blame on the system. The results obtained by using active human serum, and the lipoids just referred to are comparable to those obtained by inactivated serum and any other suitable syphilitic antigens and are perfectly specific.[1]

[1] It is an erroneous conception that my system uses only active serum. On the contrary, it can use an old or inactivated serum as well. Whether the active, old, or inactivated serum is used is only a matter of personal choice, provided that the rules I prescribed for active and inactive sera are observed.

X.

TECHNIC OF THE WASSERMANN SYSTEM.

In performing the test by the original Wassermann system five different factors are required, viz.: antigen, patient's serum, complement, amboceptor, and blood-corpuscles. The source and mode of preparation of these factors will be given in detail below.

PREPARATION OF ANTIGEN.

A. AQUEOUS EXTRACTS.

1. *Wassermann's Method.*—The liver or spleen of a congenitally syphilitic fœtus is preferred. Take the organ and cut it up into very small pieces with a pair of scissors and mix the tissue with four parts of physiological salt solution to which phenol in the proportion of 0.5 per cent. is added. For example:

360.0 c.c. salt solution (0.85 per cent.)
100.0 grams liver
40.0 c.c. phenol (5 per cent.)

This mixture is thoroughly shaken in a dark bottle for twenty-four hours by means of a shaking machine. The tissue pieces are separated by centrifugalization and the brownish, opalescent supernatant fluid is used for antigen. It should be preserved in a rubber-stoppered dark flask in the refrigerator. Upon

standing a precipitate falls to the bottom of the container. This precipitate should not be used. As much of the clear supernatant fluid as is necessary for the day's work should be poured off, and the remainder put back on ice immediately.

As to the stability of this extract, there is no agreement among investigators, whose experiences differ widely upon this question. Wassermann, Neisser, Bruck and Schucht found that it is very unstable, soon becoming too anticomplementary for use. Citron once prepared a watery solution of antigen which he divided into three portions. He kept one part for his own use and the other two he sent to other laboratories. One of these reported to him after the lapse of a week that the antigen had become inactive; the other sent a similar report after four weeks. The portion which he kept was unaltered three months after its preparation. So that it would seem the stability of the antigen depends greatly upon the mode of its preservation. My own experience shows that the liver of every congenitally syphilitic fœtus does not always yield a good antigen and that when once prepared in the above manner it may deteriorate within a few weeks.

For the extract used in the control tests a normal organ should be similarly prepared.

2. *Marie and Levaditi's Method.*—Mash the liver of a congenitally syphilitic fœtus and dry in a vacuum

and then pulverize it. The powder is suspended in four parts of physiological salt solution and the mixture centrifugalized after twenty-four hours' extraction. The clear supernatant fluid is used.

3. *Morgenroth and Stertz's Method.*—Preserve the organ (syphilitic liver) in frozen state (*in Frigo*), and cut off a small piece each time for use in the test. Mash this bit of tissue with sea-sand and extract it with four parts of physiological salt solution. Filter through paper, and use the filtrate.

The most important point concerning antigen is to employ the proper quantity in the test. It has been made a general rule that that dose of antigen must be selected which does not bind complement even when the antigen is used in double quantity. The usual aqueous preparation may be used in 0.1 c.c. or 0.2 c.c. doses.

B. ALCOHOLIC EXTRACTS.

1. *Porges and Meier's Method.*—Cut up a normal or syphilitic liver into small pieces, extract with five volumes of absolute alcohol for twenty-four hours, and filter through coarse filter-paper. The filtrate is evaporated in a vacuum at a temperature below 40° C. The sticky mass resulting is then used to prepare a 1 per cent. suspension in physiological salt solution with the addition of 0.5 per cent. of phenol. This emulsion is well shaken and filtered through fine paper. The minimal dose which shows inhibition of hæmolysis is

determined by titration, and half of this amount is used for the test. With a strong syphilitic serum 0.025 c.c. may give a complete reaction, but 0.2 or 0.3 c.c. is usually necessary for the test. The authors found a preparation of lecithin (Kahlbaum) to be equivalent in antigenic property to the alcoholic extract, but later investigators have found such a preparation unreliable as an antigen.

2. *Landsteiner, Müller and Pötzl's Method.*—Extract mashed guinea-pig's heart or liver with alcohol for about ten to twelve hours at 60° C., in the ratio of one gram of tissue to 50 c.c. of 95 per cent. alcohol. Filter through paper and preserve the filtrate at room temperature. Use two drops of the solution for the test.

3. *Michaelis and Lesser's Method.*—Shake minced normal or syphilitic liver with ten volumes of absolute alcohol for ten to twelve hours. Use glass beads to facilitate thorough extraction. After twenty-four hours the clear supernatant portion is poured or pipetted off and used as antigen. Every time the test is to be made one part of this extract is mixed with four parts of physiological salt solution and 1 c.c. of this emulsion is used. The emulsion becomes milky and tends to form a precipitate on standing and should be thoroughly shaken before using. Recently Michaelis has advocated the use of an alcoholic extract of normal human heart.

4. *The Writer's Method.*—Extract minced tissue of syphilitic or normal heart, liver or kidney (man, beef, sheep, etc.) with ten volumes of 95 per cent. alcohol for about six or seven days at 37° C. Filter through paper and evaporate the filtrate by means of a fan at a temperature below 40° C. The resinous residue which results should be extracted with ether, and this ethereal solution then allowed to evaporate to dryness in the air. Take up the residue of this ethereal extract with a small quantity of ether and fractionate with ten volumes of aceton. Separate the sticky precipitate by pouring off the supernatant aceton carefully, allow the remainder of the aceton to evaporate, and preserve the resinous mass in an air-tight jar. For the test make a 0.3 per cent. solution in physiological salt solution by first dissolving the resinous mass in a small quantity of ether and then mixing it with the salt solution. Each preparation should be tested before using to determine its reliability and dosage.[1] Usually 0.1 c.c. to 0.2 c.c. is suitable. Kept on ice the emulsion is fairly stable.

C. ARTIFICIAL ANTIGEN.

Sachs and Rondoni advise the following as a suitable antigen for use in the Wassermann reaction:

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[1] The aqueous as well as the alcoholic extracts prepared by any method should be similarly tested before use.

	Mixture A.	Mixture B.
Sodium oleate (Kahlbaum)	2.5	1.0
Lecithin (Ovo-Merck)	2.5	1.0
Oleic acid (Kahlbaum)	0.75	1.5
Distilled water	12.5	5.0
Alcohol ad.	1000.0	ad 1000.0

The authors advise the use of either of these formulæ in a dilution of 1 part of the above to five of physiological salt solution, the reagent being thoroughly mixed with the salt solution. No precipitate should be formed. The test doses advised for each serum to be examined are: 0.15, 0.25, 0.4 c.c.

Schürmann's Method.—This investigator recently published this formula as an antigen: Lecithin, 0.30 gram in 50 c.c. absolute alcohol; sodium glycerophosphate, 0.3 gram in 5 c.c. physiological salt solution. Thirty c.c. of the above are mixed with 5 c.c. lactic acid and 10 c.c. of ammonium vanadinate (1 per cent.).

PATIENT'S SERUM.

To get serum for the Wassermann test blood is drawn from a vein and the serum which separates after clotting is inactivated at 56° C. for half an hour, preferably within twenty-four hours after its withdrawal from the patient. Cerebrospinal fluid should be used without inactivation. The test doses are 0.1 c.c. and 0.2 c.c.

COMPLEMENT.

One cubic centimetre of guinea-pig's serum in 1:10 dilution is used. The serum should not be older

than forty-eight hours, and it should be carefully preserved in the ice chamber when not in use.

AMBOCEPTOR.

The amboceptor for the Wassermann test is produced by immunizing rabbits against sheep-corpuscles. The writer has been very successful in obtaining an amboceptor of high titre by using successive injections of washed corpuscles in doses of two, four, eight, and twelve cubic centimetres at intervals of four or five days, and bleeding the animal nine or ten days after the last injection. The corpuscles should be centrifugalized at least twice with a large quantity of physiological salt solution and the original bulk of the defibrinated blood, which had been marked before centrifugalization, restored by the addition of salt solution. The injections should be made intraperitoneally.

One unit of amboceptor should be determined by titrating against 1 c.c. of a 5 per cent. suspension of washed sheep-corpuscles, using 0.5 c.c. of 1:10 dilution guinea-pig complement. Two units are used in the test.

CORPUSCLE SUSPENSION.

One cubic centimetre of a 5 per cent. suspension of washed sheep's corpuscles is used. The blood should be fresh, not older than three days, and should be kept on ice when not in use.

METHOD OF APPLYING THE TEST.

In applying the test according to the original Wassermann method with a watery antigenic extract, the investigator should use as many test-tubes as are indicated in Table 2.

Put the required amounts of serum, complement, and antigen into the respective tubes, and bring the total quantity of the mixture up to 3 c.c. by the addition of salt solution. Mix the contents of the tubes well and incubate in the thermostat for one hour at 37° C. At the end of this period add to every tube amboceptor and corpuscle suspension in the quantity prescribed above, mix well, and incubate again for two hours. Then remove the tubes to an ice-chest for twenty hours, when the test is complete and the results are ready for reading.

If the test has been properly carried out, there will be complete hæmolysis in every control tube excepting in the tube containing syphilitic serum and syphilitic antigen (positive control, *vide* Table 2). If the control tubes are correct, the tubes containing the sera to be examined can be read for the final result. In this series all the tubes containing other than a syphilitic organ extract should be completely hæmolysed.

In the tubes containing the unknown serum and a syphilitic organ extract, there may or may not be hæmolysis according as the serum contains syphilitic

antibodies or not. In the former event there will be inhibition of hæmolysis, either total or partial; in the latter, the tubes should be completely hæmolysed.

The degree of inhibition of hæmolysis varies according to the amount of syphilitic antibody present; if this is large in amount, or, in other words, if complete inhibition occurs in the tube containing 0.1 c.c. serum and 0.1 c.c. antigen, the result can be graphically represented, according to Citron, thus: ++++. If inhibition of hæmolysis is incomplete in the tube containing 0.1 c.c. of serum but complete in that containing 0.2 c.c., the result is expressed thus: +++. These reactions are usually called strongly positive. If the tube containing 0.1 c.c. serum is completely hæmolysed while that containing 0.2 c.c. shows complete inhibition, the result is expressed thus: ++. Incomplete inhibition in the tube containing 0.2 c.c. is expressed thus: +. The last two reactions are called weakly positive. When inhibition in the tube containing 0.2 c.c. is doubtful the result is expressed thus: ±.

THE WRITER'S METHOD[1] OF PERFORMING THE TEST WITH THE WASSERMANN SYSTEM.

The regular Wassermann method can be greatly simplified by the use of aceton-insoluble tissue lipoids as antigen. Other investigators, as well as

[1] This should not be confused with the antihuman system already described in Chapter VII.

TABLE 2.—*The Wassermann system (Citron), when aqueous organ-extracts are used as antigen.*

	Syphilitic liver, aqueous extract	Normal liver, aqueous extract	Guinea-pig's complement 1 : 10 dil.	Five per cent. suspension of washed sheep's corpuscles	Immune anti-sheep amboceptor (litre 1:2000) 1:1000 dil.	Results should be
Patient's serum (56° C.)						
0.2 c.c.	0.2 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	The degree of hæmolysis in these 2 tubes determines the nature of this serum.
0.1 c.c.	0.1 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	
0.2 c.c.	.....	0.2 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.1 c.c.	.....	0.1 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.4 c.c.	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.6 c.c.	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
Positive syphil. serum (56° C.)						
0.2 c.c.	0.2 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	No hæmolysis.
0.1 c.c.	0.1 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	No hæmolysis.
0.2 c.c.	.....	0.2 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.1 c.c.	.....	0.1 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.4 c.c.	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.6 c.c.	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
Normal serum (56° C.)						
0.2 c.c.	0.2 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.1 c.c.	0.1 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.2 c.c.	.....	0.2 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.1 c.c.	.....	0.1 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.4 c.c.	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
0.6 c.c.	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
No serum	0.4 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	No hæmolysis.
No serum	0.6 c.c.	.....	1 c.c.	1 c.c.	1 c.c.	No hæmolysis.
No serum	.....	0.4 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
No serum	.....	0.6 c.c.	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
No serum	.....	.....	1 c.c.	1 c.c.	1 c.c.	Complete hæmolysis.
No serum	.....	.....	1 c.c.	1 c.c.	1 c.c.	No hæmolysis.
No serum	.....	.....	.....	.....	1 c.c.	No hæmolysis.

The volume of each tube is now brought up to 3 c.c. with salt solution. Incubation at 37° C. for 1 hour.

The volume of each tube is now 5 c.c. Mix the contents of tubes thoroughly and incubate at 37° C. for 2 hours. Remove tubes then to refrigerator over night and read the reactions after this period.

the writer, have found that there is no essential difference between the antigen extract thus prepared and the aqueous extract, while the former in the hands of the writer has proved much more stable and does away with the necessity of using the normal organ-extract controls, which render the original Wassermann method so complicated and cumbersome.

In Table 3 (see page 113) the exact method of performing the test is given. It will be noted that all the reagents have been used in half the quantity of the original Wassermann method. A uniform dosage of antigen is used, which, in the experience of the writer, has been sufficient to show the varying intensity of the reaction.

TABLE 3.—*The Wassermann system (Noguchi), when aceton-insoluble tissue lipoids are used as antigen.*

	0.3 per cent. saline emulsion of the aceton-insoluble fraction of alcoholic extract of organs	Guinea-pig's complement, 1 : 10 dilution		Five per cent. suspension of the washed sheep's corpuscles	Immune antisheep amboceptor, litre (1 : 2000), 1 : 1000 dil.	Results should be
Patient's serum (56° C.)						
0.1 c.c.	0.1 c.c.	0.5 c.c.		0.5 c.c.	0.5 c.c.	These two tubes show variable reactions according to the nature of the serum.
0.05 c.c.	0.1 c.c.	0.5 c.c.		0.5 c.c.	0.5 c.c.	
0.1 c.c.	.....	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis.
0.05 c.c.	.....	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis.
Positive syphil. serum (56° C.)						
0.05 c.c.	0.1 c.c.	0.5 c.c.		0.5 c.c.	0.5 c.c.	No hæmolysis (positive reaction).
0.05 c.c.	.....	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis.
Normal serum (56° C.)						
0.1 c.c.	0.1 c.c.	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis (negative reaction).
0.1 c.c.	.....	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis.
.....	0.2 c.c.	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis (should be no inhibition).
.....	0.1 c.c.	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis (should be no inhibition).
.....	.....	0.5 c.c.		0.5 c.c.	0.5 c.c.	Complete hæmolysis.

Make the volume of each tube 1.5 c.c. Mix the contents well and incubate at 37° C. for 1 hour (30 minutes in a water thermostat).

The total volume is 2.5 c.c. each. Mix the contents well and incubate at 37° C. for 2 hours (1 hour in a water thermostat). Reading of the results after 4 to 6 hours at room temperature.

XI.

DIAGNOSTIC VALUE OF THE SERUM REACTION OF SYPHILIS.

The phenomenon of complement-fixation in syphilis is a type of reaction distinct in itself and differing widely from all other known examples of complement-fixation. The principal difference between the two types of phenomena arises from the nonspecific nature of the substances that functionate as antigen in the Wassermann reaction. We have already seen (see page 23) that the complement is absorbed or fixed only when brought in contact with combinations of specific antigens and antibodies. In general it may be said that the specificity of these antigens and antibodies can be compared in a way to the relation which exists between locks and keys, and it can be stated that they do not interact with one another unless they are in exact correspondence. On the other hand the phenomenon of Wassermann is produced by what appears to be a specific antibody and certain nonspecific antigenic substances. Therefore in this case the law of specificity does not operate in the same strict sense as in other known examples of the Bordet-Gengou phenomenon.

I have been able to show that several phosphorized and non-phosphorized lipoids and a few salts can act as syphilitic antigens, and that there is no necessary relation between them and a syphilitic infection. When these substances are brought into combination with the blood-serum or cerebrospinal fluid of syphilitic patients, they alter the fluids in such a manner as to render them able to fix the complement which is introduced into the mixture. It is this peculiarity of the serum of syphilitics upon which the serum diagnosis of syphilis is based. This interesting property of syphilitic serum is produced, it is believed, by certain substances existing in the serum, now generally designated as syphilitic antibody, although actually we are still entirely ignorant of their real nature. There is, however, little doubt that they are reaction products of syphilitic infection, and that they appear constantly in the serum of persons infected at certain stages of the disease.

For the purpose of estimating the value of the complement-fixation test as a clinical method for the diagnosis of syphilitic and parasyphilitic conditions, the writer presents a tabulation of the results of investigators. (See pages 116 and 117.)

In primary syphilis the results vary much, ranging from 98 per cent. (Detre) to 38 per cent. (Hoehne). This difference may be accounted for

TABLE 4.—*Blood-serum.*

Investigators	Primary syphilis		Secondary syphilis manifest		Tertiary syphilis manifest		Early latent syphilis		Late latent syphilis	
	No. of cases	Per cent. +	No. of cases	Per cent. +	No. of cases	Per cent. +	No. of cases	Per cent. +	No. of cases	Per cent. +
Wassermann, Neisser, Bruck and Schucht	25	91	101	73.3	37	78.4	41	85.4	53	88.7
Citron and Blaschko	64	90	56	98	23	91	67	80	51	57
Bruck and Stern	27	48.2	163	79.1	47	57.4	50	20	79	20
Bruhns and Halberstädter	9	88.9	50	98	16	100	39	43.3	82	28
Ledermann	19	52.6	56	100	27	92	41	75.6	19	36.8
Ledermann	46	61.2	110	98.1	78	96.2	115	83.8	78	53.8
Lesser	56	69	204	91	131	90	118	67	425	46
Noguchi**	33	66.6	120	86.6*	91	72.5	81	48.1	74	44.7
Hoehne	44	38.6	329	79.1	33	63.6	387†	31.3		
Boas	50	60	395	100	63	97	294†	47		
Detre and Brezovsky	43	98	21	81	35	73				
	416	69.8	1605	89.4	581	78.1	1233	51	861	47

* When treated cases are excluded 98 per cent. positive results were obtained.
† No distinction was made between the late and early latent cases.
** Not including 1800 cases examined by the author's new system.

TABLE 5.—*Blood-serum.*

Investigators	Hereditary syphilis		Cerebrospinal syphilis		General paralysis		Tabes	
	No. of cases	Per cent. +	No. of cases	Per cent. +	No. of cases	Per cent. +	No. of cases	Per cent. +
Boas and Thomsen	32	87.5						
Bauer	22	100						
Halberstädter, Müller, and Reiche	27	92						
Ledermann	16	100	26	88.5	23	87	68	76.4
Hoehne	24	87.5	12	16.7	30	80	45	60
Noguchi*	4	100	2	50	..	....	22	40.9
Boas	..	....	..	....	42	100	20	80
Nonne	..	....	?	(20)	?	(90)	?	(90)
Lesser	..	....	..	....	62	100	61	56
Frenkel-Heiden	..	....	7	27	14	78.5		
Plaut	..	....	4	25	180	100		
Citron and Blaschko	..	....	10	60				
Stertz	..	....	3	66	45	95.5		
Marie, Levaditi, and Yamanouchi	..	....	..	....	30	59		
Raviart, Breton, Petit	..	....	..	....	72	93		
	125	94.5	64	47.6	498	88.1	216	62.66

*Not including 362 cases of tabes, 192 cases of general paralysis, 48 cases of hereditary lues, 11 cases of cerebrospinal lues examined by the author's antihuman system. See Tables 5a, 6, 7, 8, 9, 18, 19, 20, 21.

aside from technical considerations, by the state of the infection at the time of examination. Early cases of chancre frequently give a negative reaction. However, in this stage of syphilis the test is not usually necessary excepting in those cases in which a differentiation between chancroidal and mixed infection is desirable, and in cases of suspected intra-urethral chancre.

In the following table I present the data collected by Craig concerning the time of appearance of positive reaction in primary cases.

TABLE 5A.

Date of Appearance of Positive Reaction in Thirty-one Cases of Lues.

Days after initial lesion.	No. of cases positive.
5	1
8	2
11	2
13	3
14	1
17	2
18	2
19	2
20	1
21	2
22	1
23	1
25	2
28	1
29	2
30	6

It will be seen that the earliest was five days after the initial lesion had appeared.

In secondary syphilis the highest figures are those of Boas and of Ledermann; the former got 100 per cent. of positive reactions in 395 cases, the latter a similar result in 56 cases. The lowest figures are recorded by Hoehne, who got 79.1 per cent. of positive reactions in 329 cases, and by Bruck and Stern, who examined 163 cases with similar results. The variations in these figures cannot well be accounted for unless an analysis of the stage of the disease and the treatment received by the patient at the time of doing the test are taken into consideration. The reaction in this stage of syphilis is fairly constant and a reliable index of the presence of syphilitic antibodies in the patient's serum.

In tertiary lues the figures vary from 57.4 per cent. (Bruck and Stern in 47 cases) to 100 per cent. (Bruhns and Halberstädter in 16 cases). Here again the same uncertainty as to treatment, which may so strongly affect the reaction, applies as pointed out above.

In early latent cases the figures vary from 20 per cent. (Bruck and Stern in 50 cases) to 85 per cent. (Wassermann, Neisser, *et al.* in 41 cases). By early latent cases is meant those late secondary cases without symptoms. In late latent cases, or those following the manifest tertiary stage, without symptoms, the figures show about the same results. The technic of the various investigators and the reagents used by

TABLE 6.

NOGUCHI SYSTEM COMPARED WITH WASSERMANN'S.

	Primary syphilis.			Secondary syphilis.			Tertiary syphilis.			Latent syphilis.			Congenital syphilis.			Cerebrospinal syphilis.			Total.
	No. of Cases.	W. %	N. %	No. of cases.	W. %	N. %	No. of cases.	W. %	N. %	No. of cases.	W. %	N. %	No. of cases.	W. %	N. %	No. of cases.	W. %	N. %	
Noguchi	23	73.9	86.9	79	83.7	96.2	65	80.0	87.6	59	61.0	75.5	4	100.0	100.0	5	....	80.0	235
Fox	7	100.0	100.0	37	97.0	100.0	32	71.0	84.0	54	46.0	62.0	1	100.0	100.0	..	....	....	131
Kaplan	138	90.0	97.0	281	86.0	98.0	191	73.0	81.0	79	51.0	75.0	20	90.0	90.0	..	....	....	709
Swift	16	81.0	81.0	76	92.0	97.0	45	80.0	88.0	85	55.0	62.0	4	100.0	100.0	..	....	....	226
Corson-White	14	86.0	100.0	146	98.0	99.0	47	80.0	80.0	28	60.0	64.0	39	100.0	100.0	35	80.0	80.0	309
Kaliski	10	100.0	100.0	50‡	94.0	100.0	75⁂	60.0	80.0	...	....	....	11	100.0	100.0	15	66.0	80.0	161
Total	208	88.0	94.0	669	92.0	98.0	455	74.0	83.0	305	54.0	68.0	79	98.0	98.0	55	73.0	80.0	1777
NOGUCHI SYSTEM ALONE.																			
Noguchi	70	....	92.8	197	....	96.0	177	....	88.9	270	....	74.4	17	....	100.0	5	....	100	736
Craig	90	....	72.0*	163	....	88.0	74	....	82.0	55	....	72.0	9	....	88.8	..	....	....	491
Orleman-Robinson	29	....	86.0	48	....	93.0	60	....	80.0	33	....	69.6	10	....	100.0	..	....	....	180
Potter (Alf.)	7	....	86.0	71	....	98.6	46	....	78.0	58	....	66.0	...	....	....	..	....	....	182
Groat	12	....	100.0	76	....	94.4	36	....	70.0	57	....	40.0†	10	....	100.0	1	....	100.0	186
Berghausen	....	....	....	15	....	93.0	9	....	88.0	6	....	66.0	4	....	75.0	..	....	....	34
Total	208	....	87.5	570	....	94.7	402	....	82.8	474	....	64.6	50	....	93.0	6	....	100.0	1809
Grand total	416	88.0	90.0	1239	92.0	96.0	857	74.0	83.0	779	54.0	66.3	129	98.0	96.0	61	73.0	90.0	3580

* Includes very early cases. † Majority under treatment. ‡ Untreated. ⁂ Includes latent cases.

them must be taken into account in accepting the results of their work.

General paralysis shows fairly constant positive re-

TABLE 7.

	General paralysis					
	Blood-serum			Cerebrospinal fluid		
	Number of cases	W. %	N. %	Number of cases	W. %	N. %
Noguchi	25	..	86	..	...	...
Rosanoff and Wiseman	56	..	80	44	...	86
Corson-White	11	80	80	5	100	100
Kaplan	61	65	72	..	...	...
Kaliski	3	66	66	..	...	...
Schradieck	4	..	100	..	...	...
Groat	2	..	100	..	...	...
Total	162	70	73.4	49	100	93

TABLE 8.

	Tabes		
	Blood-serum		
	Number of cases	W. %	N. %
Noguchi	125	..	68
Noguchi	8	44	72
Kaplan	205	60	65
Corson-White	49	70	75
Kaliski	10	40	60
Berghausen	6	...	66
Fox	3	100	100
Waugh	13	...	56
Total	419	62.8	72

actions, ranging from 80 per cent. to 100 per cent. of cases examined. Tabes gives a somewhat lower percentage, from 40 per cent. to 80 per cent. In

hereditary syphilis the figures are fairly constantly high, the lowest being 87.5 per cent. In cerebrospinal lues the results vary from 16 per cent. in 12 cases reported by Hoehne to 88.5 per cent. in 26 cases reported by Ledermann.

The writer interpolates the results obtained by different investigators with his system in 3580 cases of syphilis in its various manifestations and stages. Out of this total number 1771 cases were examined by the Wassermann system at the same time. The results of comparison show clearly that my method gives a higher percentage of positive reactions than with the Wassermann. (Tables 6, 7 and 8.)

Just how this difference in sharpness of reaction between my system and that of Wassermann arises has been repeatedly emphasized and there can be no doubt that this is due to the occasional excessive anti-sheep amboceptor present in some human sera under investigation. Kaliski published a series of cases where the reactions with my system were positive and with the Wassermann negative. (Table 9.) In Table 10 the results of routine examinations of the sera from different diseases by the same investigator are given.

TABLE 9.—*Noguchi method positive, Wassermann negative.*

	N.	W.	
Congenital syphilis.....	+	−	Under Hg treatment till recently.
Secondary syphilis.....	<+	−	Under Hg treatment till 3 months ago.

	N.	W.	
Secondary syphilis	+	< +	Under Hg treatment.
Latent syphilis	< +	−	Chancre many years ago.
Tertiary syphilis	< +	−	
Tertiary syphilis	+	< +	Excess natural antisheep amboceptor.
Tertiary syphilis	+	−	Gumma pyloric end stomach.
Tertiary syphilis	< +	−	Under Hg treatment.
Latent syphilis	< +	−	Chronic treatment 7 years.
Cerebrospinal syphilis	+	−	
Cerebrospinal syphilis	+	(±)	Wassermann almost negative.
Cerebrospinal syphilis	+	(±)	Wassermann only suspicious.
Tabes	+	−	Great excess amboceptor.
Tabes	+	< +	3 units natural amboceptor.
Periostitis, specific	+	−	2 units natural amboceptor.
Stricture rectum	+	−	Natural amboceptor.
Epiphysitis, specific	< +	−	
Endometritis (abortions)	+	(±)	Wassermann suspicious.
Osteomyelitis, specific	+	< +	No natural amboceptor; goes negative on addition of two units artificial amboceptor.
Hodgkin's disease, also lues	+	−	Chancre about 20 years ago.
Proctitis, specific	< +	−	Under Hg treatment till recently
Ulcus cruris, specific	+	−	Chancre 25–30 years ago.

+, Positive. −, Negative. < +, Weakly positive to moderate. (±), Only suspicious.

TABLE 10.—*Routine cases from the wards for diagnosis with Wassermann and Noguchi systems (Kaliski).*

	Neg.	Pos.	
Anemias — splenic pernicious, secondary	8	0	
Chronic endocarditis	26	0	
Chronic endocarditis and nephritis	5	1	
Nephritis, acute and chronic	21	1	Chancre three years ago.
Myocarditis	5	1	Autopsy.
Hodgkin's disease	8	1	Chancre twenty years ago.
Leukemias	4	0	
Banti's disease	4	0	
Aortic regurgitation, aortitis	3	1	
Aortic stenosis	2	0	
Aneurism	2	1	
Arteriosclerosis	6	2	
Paroxysmal tachycardia	1	0	Perforated septum, tertiary.
Arteriosclerosis	6	2	
Heart-block	1	0	
Cirrhosis liver	4	6	
Chronic cholecystitis	3	0	
Cholelithiasis	4	0	
Acute yellow atrophy	1	0	
Arthritis deformans	8	5	
Arthritic conditions—chronic infectious, Still's metabolic, etc.	25	0	

	Neg.	Pos.	
Auto-intoxication, Brill's disease, etc.	5	0	
Typhoid	4	1	Chancre twenty-eight months ago.
Dysentery	1	0	
Gastric conditions—gastralgia, hyperacidity, gastritis, ulcer	6	1	Gumma pylorus at operation. See Table 2.
Pulmonary conditions—pneumonia, abscess, asthma, emphysema, pleurisies, tumor	15	0	
Pulmonary tuberculosis	8	0	
Diabetes mellitus	3	0	
Diabetes insipidus	2	1	
Asthenia	1	0	
Achondroplasia	1	0	
Hydrocephalus	3	0	
Rickets	1	0	
Marasmus	1	0	
Craniotabes	10	0	
Varicella	1	0	
Plumbism	1	0	
Myxedema	1	0	
Gout	1	0	
Trichinosis	2	0	
	208	22	
Dermatological Conditions			
Ulcus cruris	5	3	Three specific, five varicose ulcers.
Eczema seborrheal	2	0	
Tuberculosis cutis	1	0	
Leukoplakia buccalis	4	0	No history syphilis in any.
Lichen planus	2	0	
Sycosis	2	0	
Scleroderma	1	1	Wassermann and Noguchi both weakly positive. No history of syphilis.
Leprosy	0	3	
Sporotrichosis	1	0	
Lupus erythematosus	1	0	
Psoriasis	2	0	
Herpes zoster and progenitalis	5	0	
Dermatitis	2	0	
Neurological Conditions			
Cerebral thrombosis; hemiplegia	11	1	
Cerebral endarteritis	3	1	
Myelitis	6	2	In two cases diag. = specific.
Sciatica	2	0	
Peripheral neuritis	1	0	
Trigeminal neuralgia	2	0	
Myalgia	2	0	
Neuralgia	5	0	
Neurasthenia and hysteria	15	0	

	Neg.	Pos.	
Cerebral and cerebellar tumor...	6	0	
Abscess brain.....	2	0	
Cerebellar ataxia.....	2	0	
Tumor cord and spine.....	3	0	
Spastic and ataxic paraplegia...	4	0	Spinal fluid positive in one case.
Specific paraplegia.....	1	2	
Optic neuritis.....	2	0	
Chorea.....	2	0	
Pachymeningitis.....	2	0	
Serous and tubercular meningitis	2	0	
Meningoencephalitis.....	0	2	Spinal fluid positive in both.
Myasthenia gravis.....	1	0	
Epilepsy.....	2	0	
Multiple sclerosis.....	3	0	
Mongolian idiocy, imbecility....	4	0	
Friedreich's ataxia.....	1	0	
Progressive muscular atrophy...	2	0	
Tabes.....	3	9	One case of suspected paresis.
Paresis.....	2	3	
Cerebrospinal syphilis.....	3	12	
Paralysis agitans.....	3	0	
Surgical Conditions			
Carcinomata and sarcomata.....	38	1	Chancre years ago in one case.
Tuberculous conditions (bones, glands, testis, peritoneum, etc.)	17	0	
Bone conditions (osteoperiostitis, pain, abscess, osteomyelitis, multiple exostosis, etc.).....	17	0	Positive conditions confirmed by histological examination and subsequent course.
Rectal conditions (stricture, fistula in ano, proctitis, abscess).	2	2	Both positive cases tertiary lues.
Thrombo-angiitis obliterans....	30	0	
Gynecologic conditions (endometritis, ectopics, fibroids, abortions).....	6	8	Eight out of twelve women with frequent abortions and stillbirths give positive reactions.
Genito-urinary conditions (stricture, cystitis, hernia, trabecular and atonic bladder, hematoma and tumor of testis, ren mobilis, enlarged prostate, undescended testicle, hydrocele, calculus, spermatocele, impotence, orchitis).....	28	2	Both orchitis cases positive.
Eye conditions (keratitis, iritis, cyclitis, corneal opacities, trauma, ophthalmoplegia).....	10	2	Two cases interstitial keratitis positive.
Cerebral thrombosis; hemiplegia	11	1	
Cerebral endarteritis.....	3	1	

	Neg.	Pos.	
Myelitis	6	2	In two cases diag.=specific.
Sciatica	2	0	
Peripheral neuritis	1	0	
Trigeminal neuralgia	2	0	
Myalgia	2	0	
Neuralgia	5	0	
Neurasthenia and hysteria	15	0	
Cerebral and cerebellar tumor	6	0	
Abscess brain	2	0	
Cerebellar ataxia	2	0	

In the early period after the introduction of my system the superior delicacy of the reaction aroused a suspicion among a few clinicians that it might give positive reaction in nonsyphilitic cases. That their fear was wholly ungrounded will be shown from the fact that none but an unskilled and hasty serologist obtained a positive reaction in ordinary nonsyphilitic cases, and such results are no longer obtained by any other workers. It may be well, however, to record here that the following investigators did not get positive reactions in nonsyphilitic cases.* (Table 11.)

TABLE 11.

Noguchi	1642
Kaliski	750
Jeffries and Pease	300
Schwartz (B.)	250
Robinson (Orleman)	250
Lederer	150
Fox	113
Groat	51
Corson-White	183
Craig	214
Potter (Alfred)	45
Schradieck	1500
Total	5448

* Cases of leprosy, malaria, yaws or certain cachectic conditions where the Wassermann system is also positive are not included here.

Orleman-Robinson has made an extensive study expressly for the purpose of determining whether or not the use of active serum in my system gives an occasional positive reaction in nonsyphilitic dermatological conditions. Her results with 236 cases were uniformly negative. (Table 12.) For controls 180 cases of syphilis were also examined, with the results quoted elsewhere in this book.

TABLE 12.

Acne vulgaris	18	Ichthyosis	4
Acne rosacea	6	Impetigo contagiosa	14
Alopecia areata	10	Lichen planus	10
Dermatitis herpetiformis	3	Lichen rubra pilaris	1
Dermatitis traumatica	6	Lupus erythematosus	10
Dermatitis venenata	4	Lupus vulgaris	4
Eczema	25	Molluscum contagiosum	3
Epithelioma	30	Nævus pigmentosus	3
Erythema multiforme	5	Pityriasis rosea	4
Erysipelas	3	Pityriasis versicolor	3
Erysipeloid	3	Psoriasis	15
Favus	2	Purpura	5
Scabies	6	Trichophytosis	10
Herpes zoster	10	Tuberculosis cutis	3
Hydrocystoma	3	Urticaria	13

The results of the analysis of the cerebrospinal fluid in general paralysis vary from 73 per cent. (Marie and Levaditi, and Noguchi and Moore) to 100 per cent. (Morgenroth and Stertz). The results are uniformly high, especially when contrasted with tabes and cerebrospinal lues (Table 13). In tabes the figures vary from 54.5 per cent. to 66.6 per cent. In cerebral syphilis the presence of the binding substance

is very uncertain; Plaut examined four cases with uniformly negative results, while Henderson obtained positive reactions in most of his cases.

TABLE 13.—*Cerebrospinal fluids.*

	General paralysis		Tabes		Cerebrospinal syphilis	
	No. of cases	P. ct. +	No. of cases	P. ct. +	No. of cases	P. ct. +
Marie and Levaditi	39	73	9	66.6		
Marie, Levaditi, and Yamanouchi	30	93				
Stertz	45	88.8	5	60	8	0
Noguchi and Moore	60	73	11	54.5	6	50
Wassermann and Plaut	41	88				
Morgenroth and Stertz	8	100				
Plaut	54	90	..	....	4	0
Nonne	?	90	?	50	16	25
Schütze	..	....	12	66.6		
Marinesco	35	94	15	53		
Smith and Candler	64	92.1				
Noguchi, Rosanoff, and Wiseman	56	87.5				
	432	90	52	56.2	34	19

TABLE 14.—*Examinations of blood-serum and cerebrospinal fluid in cases of leprosy.*

	Serum		Spinal fluid	
	No. of cases	Per cent. +	No. of cases	Per cent. +
Eitner	2	100		
Wechselmann and Meier	1	100		
Slatineanu and Danielopolu	26	100*	19	72
Do	21	57*	20	0
Jundell, Almqvist, and Sandman	26	30*		
Bruck and Gessner	10	50†		
Noguchi	10	70		
Fox	60	53		
	146	61	39	36

*Including weak reactions. †Five out of seven cases of tubercular form.

Certain investigators have reported a high percentage of positive reactions in leprosy (as will be seen by perusing Table 14) and in other nonspecific diseases, notably scarlet fever (Table 15), carcinoma, and diabetes mellitus.[1] In Table 16 the writer shows a study of the results of 322 cases in which syphilis does not play an etiological part. In 8 cases of pellagra Bass reported positive reactions with the Wassermann system, but later investigations by Fox on 30 cases and by Litterar on 20 cases of the same disease examined with my system failed to confirm Bass's results.

In Tables 17 and 18 the results of examination of 132 cases of diseases in which syphilis may be an

[1] A few investigators obtained positive reactions in an astonishingly large proportion of nonsyphilitic cases, while the majority of the workers do not get such results. Among those who reported a large number of positive reactions in nonsyphilitic cases may be mentioned Weil and Braun and Elias, Neubauer, Porges, and Salomon. Weil and Braun encountered 4 positive in 12 cases of pneumonia, 3 positive out of 20 cases of typhoid fever, 2 positive out of 21 cases of tuberculosis, 1 positive out of 4 cases of diabetes mellitus, and 2 positive in 11 cases of tumors. Elias and others found 5 positive in 33 cases of tuberculosis and 4 positive in 14 cases of tumors. Hancken met with 2 positive reactions in 28 control cases, one being a subject with scarlatina and one other with diphtheria. Löhlein examined 250 cases and obtained positive results in 4 cases of tuberculosis and carcinoma. Later investigators, especially those who had been working with the reaction constantly, all failed to get such results as are presented above, if not absolutely free from getting an occasional weak positive reaction in cases of carcinoma, scarlet fever, or diabetes. It should be suspected that when one obtains a high percentage of positive reactions in nonsyphilitic cases he is not doing the test properly.

TABLE 15.—*Cases of scarlatina.*

	No. of cases	P. ct. +		No. of cases	P. ct. +
Much and Eicheberg..	130	46	Seligmann and Klopstok	30**	
Jochmann and Töpfer	33	0	Boas and Hauge.....	61	1.5†
Halberstädter, Müller, and Reiche.....	10	50*	Bruck and Cohn.....	28	0
Meier.....	52	1.8†	Noguchi.....	63	1.5†
Hoehne.....	37	2.5†	Fùa and Koch.....	57	25§
			Hecht.....	106	1

* Weak reactions only, which gave negative results when tested with several other extracts.

** All negative in 13 cases examined on July 1–3, but 16 additional cases examined one month later with the same antigen gave 3 weak and 13 strong positive reactions. These investigators are inclined to think that their antigen altered on standing, hence the positive results.

† One case showed some inhibition. The case of Noguchi was subsequently proven to be a child with congenital lues.

§ Weak reactions only, which finally disappeared on standing.

TABLE 16.—*Noguchi system. Cases in which syphilis can be excluded with a fair degree of certainty.*

	Cases examined	+	—	±
Carcinoma.....	51	1	50	0
Sarcoma.....	3	0	3	0
Adenosarcoma.....	1	0	1	0
Endothelioma.....	1	1	0	0
Scarlatina.....	62	0	60	2
Varicella.....	1	0	1	0
Measles.....	2	0	2	0
Tuberculosis.....	52	0	52	0
Lupus.....	2	0	2	0
Banti's disease.....	1	1	0	0
Hodgkin's disease.....	2	0	2	0
Muscular distrophy.....	5	0	5	0
Neurasthenia.....	2	0	2	0
Dementia præcox.....	5	0	5	0
Various skin diseases.....	58	0	58	0
Miscellaneous.....	74	0	74	0
	322	3	317	2

etiological factor and of 130 cases of eye diseases of all sorts studied by Martin Cohen and Bronfenbrenner are given.

In certain nervous diseases of unknown origin the Wassermann reaction has been resorted to as a means of determining, if possible, the nature of the causa-

TABLE 17.—*Noguchi system. Cases in which syphilis is an etiological factor or cannot be excluded as a possible cause of the condition.*

	Cases examined	+	−	±
Cirrhosis of liver	7	5	1	1
Ascitic fluids	21	11	9	0
Aortic insufficiency	1	1	0	0
Chronic arthritis	10	2	6	2
Eye cases	29	14	15	0
Diabetes	5	1	4	0
Eczema	32	1*	31	0
Scleroderma	4	1	3	0
Brain tumor (?)	8	4	4	0
Central gliosis (?)	2	1	1	0
Hemiplegia	8	3	5	0
Spastic paraplegia	3	2	0	1
Raynaud's disease †	2	0	2	0
	132	46	81	4

*This case has been reported also by Fox, in Table 8. For the other 31 cases I am indebted to Dr. Daisy Orleman-Robinson.

†Kaliski and Buerger, using Wassermann's and Noguchi's systems, got negative results in 16 cases of thrombo-angiitis obliterans.

tive factor. Thus, Raviart, Breton and Petit examined various forms of insanity, aside from parasyphilitic patients, in regard to the presence of this reaction in the blood. Their results are somewhat striking, as they got positive reactions in about 30 to 40 per cent. of cases of epilepsy, idiocy, and im-

becility. In three of five cases of dementia senilis and in five out of 19 cases of dementia præcox they

TABLE 18.—*Noguchi system.* (*Cohen and Bronfenbrenner.*)

	Total Number of Cases	Undoubtedly Syphilitic +	Undoubtedly Syphilitic −	Doubtfully Syphilitic +	Doubtfully Syphilitic −	Under Recent Treatment +	Under Recent Treatment −
1. Interstitial keratitis	38	7	2	17	12	5	7
2. Iritis	16	3	2	5	6	1	3
3. Irido-cyclitis	3	0	1	0	2	0	1
4. Optic neuritis	10	2	0	4	4	2	0
5. Optic atrophy	10	0	1	2	7	1	0
6. Neuro-retinitis	6	0	2	3	1	0	1
7. Retrobulbar neuritis	1	0	0	0	1	0	0
8. Retinitis pigmentosa	8	0	1	5	2	0	1
9. Retinitis	1	0	0	0	1	0	1
10. Detachment of retina	2	0	1	1	0	0	0
11. Embolism of central artery	2	0	1	0	1	0	1
12. Chorioiditis	8	0	0	2	6	0	0
13. Chorio-retinitis	6	0		3	3	3	1
14. Scleritis	2	0	0	1	1	0	1
15. Ophthalmoplegia interna	2	1	1	0	0	0	0
16. Oculomotor paralysis	2	0	2	0	0	2	0
17. Ptosis	2	0	0	0	2	0	0
18. Paralysis external rectus	2	0	0	0	2	0	0
19. Diplopia	2	0	1	1	0	0	0
20. Corneal ulcer	1	1	0	0	0	0	0
21. Chancre of upper lid	1	0	0	1	0	0	0
22. Sympathetic ophthalmia	1	0	0	0	1	0	1
23. Acromegaly	2	0	0	1	1	0	0
24. Amaurotic family idiocy	1	0	0	0	1	0	0
25. Graves' disease	1	0	0	0	1	0	0
	130	14	15*	46	55	14	18

* Under antisyphilitic treatment.

got positive results. Raubinovitch and Levaditi examined 15 cases of dementia præcox and got positive results in 20 per cent. with the blood, but all the

spinal fluids examined gave negative results. This last fact agrees with the observation of the writer and Moore. Rosanoff, Wiseman, and the writer examined 413 cases of various forms of insanity for the

TABLE 19.—*Psychiatric cases.*

Clinical diagnosis	Blood-serum				Cerebrospinal fluid				Syphilis ascertained
	No. of cases	Reactions			No. of cases	Reactions			
		−	+	±		−	+	±	
Arteriosclerotic dementia ...	10	10	0	0	9	9	0	0	
Brain tumor	1	1	0	0	1	1	0	0	
Traumatic psychosis	1	1	0	0	1	1	0	0	
Senile dementia.....	16	13	1	2	10	8	1	1	
Infant. cerebr. palsy.....	6	6	0	0	5	5	0	0	
Epilepsy	69	48	12	9	55	50	3	2	
Huntington's chorea.....	2	1	1	0	1	1	0	0	
Uræmic psychosis	1	1	0	0	1	1	0	0	
Alcoholic psychosis.....	9	4	2	3	6	4	1	1	4
Polyneuritic psychosis	8	7	1	0	8	8	0	0	
Involution melancholia	10	8	2	0	7	7	0	0	
Dementia præcox	131	99	15	17	83	76	3	4	5
Manic depressive insanity...	14	9	2	3	7	5	2	0	1
Paranoiac condition	9	7	1	1	4	4	0	0	
Imbecility	6	4	2	0	6	6	0	0	
Constitutional inferiority....	1	1	0	0	1	1	0	0	
Unclassified	40	28	6	6	38	35	2	1	5
	334	248	45*	41*	243	222	12*	9*	15

*These cases showing positive and doubtful reactions may have had syphilis, but it was difficult to ascertain the disease in all the cases. In 15 cases at least, syphilis was proven to be present.

reaction in serum and cerebrospinal fluid and obtained the results similar to those of previous investigators.

Atwood and Bronfenbrenner, using the Noguchi system, examined 204 cases of idiots and found 14.7 per cent. positive reactions among them.

A rough classification of the cases is shown in the following list:

CLASSIFICATION OF THE 204 LOW-GRADE IDIOTS TESTED

Idiopathic idiots	120
Diplegics	47
Hemiplegics	7
Epileptics without paralysis	13
Hydrocephalics	5
Microcephalics	6
Cretins	2
Myxœdematous	1
Amaurotic family idiocy	1
Idiocy with cerebellar ataxia	2

Several (4) of the patients were blind, and several (4) mute. There were other physical disorders, not syphilitic, in other cases.

CLASSIFICATION OF THE 30 IDIOTS WHO SHOWED A POSITIVE SEROREACTION

	Positive.	Total.	Percentage.
Idiopathic	13	120	10
Diplegics	11	47	23
Hemiplegics	2	7	28
Microcephalics	1	5	20
Epileptic without paralysis	1	12	8
Cerebellar ataxics	2	2	100

Still further analyzed, one of the diplegics with positive reaction was epileptic, one hydrocephalic, and one epileptic with mutism. One of the cerebellar ataxic patients was microcephalic, and one of the diplegics was blind. One out of four deaf-mutes showed a positive seroreaction. The myxœdematous idiot, the two cretins, and the patient with amaurotic family idiocy showed negative reactions.

The percentage of positive reactions found was much greater, in proportion, in idiots with superadded

gross organic brain defect than that found in idiopathic idiocy.

Their results are in close agreement with those of Lippmann, who employed the Wassermann system in Germany.

In gynæcological conditions the reaction has also been called upon to test the validity of the laws of Colles and Profeta. Müller found that with the blood of wives of syphilitic husbands, where the former had repeated abortions and premature births, the results were usually negative and that their offspring also gave negative reaction. Knöpfelmacher and Lehndorffer examined 32 apparently healthy mothers of syphilitic children and obtained positive reactions in 18. Halberstädter, Müller and Reiche found that the reaction may be negative with children of syphilitic mothers, and *vice versa,* while Boas and Thomsen assert that the reaction can develop later in children whose blood gives a negative result at the time of birth. They all agree that the negative reaction in these children or mothers is largely due to the latency of the disease, but is not a sign of immunity against the disease. Thus, while the mother of a syphilitic infant may present no sign of syphilis, yet examination of the blood of the mother gives positive reaction in half the number of cases examined. However, much more has to be done before the dictum of Colles can be overthrown.

XII.

EFFECT OF TREATMENT UPON THE REACTION.

MERCURIAL TREATMENT.

MUCH work has been done by numerous investigators to determine the result of various forms of treatment upon the syphilitic antibodies in the blood, and it would seem that the time has not yet come to make a dogmatic statement upon this subject. It is known, however, that the reaction frequently disappears after a short course of treatment, as will be pointed out below, often to return again within a greater or lesser period of time.

Citron, who was among the first to investigate the effect of treatment upon the reaction, found that whereas before treatment the percentage of positive results obtained by him was 81, treatment had the effect of reducing the figures to 65 per cent. In about half of these cases, numbering 57 in all, but one course of treatment was given. Bruck and Stern obtained positive reactions in 81.5 per cent. of 173 untreated cases, and in another group of treated cases got positive reactions in only 28 per cent. Blaschko studied 52 positive cases of manifest syphilis and after treatment 45 of these gave negative results; of 38 cases of latent syphilis 31 gave negative results after treatment. Hoehne studied 211 cases which before treatment gave positive reactions, and found that

in 56 per cent. the reaction disappeared after therapeutic interference, but in spite of some treatment 33.9 per cent. gave a positive reaction. In five cases, after eleven to twelve injections of mercuric salicylate over a period of two months, the reaction was positive. Lesser states that a positive reaction can be made negative in about 35 per cent. of cases by giving 30 inunctions of mercury, 12 injections of an insoluble mercuric preparation, or 25 injections of a soluble mercuric preparation. The rapidity with which the reaction disappears is very variable in different individuals. Boas found that after a course of injections over two or three months the reaction became negative in 76 out of 82 cases, and states that the reaction may return within a month after cessation of treatment, indicating a recurrence.

V. C. Pedersen followed carefully the course of treatment on a large number of cases by means of my system. The clinical classification of cases by this author is most elaborate and points out very clearly how the reaction stands in relation to the clinical side of these cases.

In order to fulfil the hope of tracing the progress of this test, his records have been divided into the following classes. It will be seen at once that this refinement of study results in the apparent circumstance of having a small number of observations in each class. When, however, the class titles are

studied, it will be seen that without these or similar designations, it would be almost impossible to study the work more or less minutely.

The classes are as follows:

Class A. Chancre unhealed; no secondary symptoms.
- Group I. No local or systemic treatment.
- Group II. Local or systemic treatment.

Class B. Chancre unhealed; secondaries out.
- Group I. No local or systemic treatment.
- Group II. Local or systemic treatment.

Class C. Chancre healed recently; no secondaries out.
- Group I. No local or systemic treatment.
- Group II. Local or systemic treatment.

Class D. Chancre healed; secondaries out; duration of infection less than six months.
- Group I. No local or systemic treatment.
- Group II. Local or systemic treatment.

Class E. Duration of infection six to twenty-four months; symptoms absent. Treatment given.

Class F. Duration of infection six to twenty-four months; symptoms present. Treatment absent, imperfect or irregular.

Class G. Tertiary period; infection older than twenty-four months.
- Group I. No symptoms present.
- Group II. Lesions of mucosa, skin and appendages of the skin.
- Group III. Lesions of cartilage, bone, joint, and muscle.
- Group IV. Lesions of glands and viscera.
- Group V. Lesions of the nervous system.

Class H. Diagnosis of syphilis positive. Records otherwise too defective for accurate classification under any of the foregoing subdivisions.

Class I. Comparison of all tests repeated two or more times.

Class J. Uncertain clinical diagnosis of syphilis.

Taylor gives Ricord's subdivision of syphilis into three periods—primary, secondary, and tertiary—which is classic and accepted. The primary stage is usually separated into two periods of incubation, the first period of incubation being the time elapsing between infection and the development of hard

chancre, and the second incubatory period including the time between the development of the chancre and the appearance of the secondary lesions. The second stage of syphilis usually embraces the first two years, and the tertiary period begins at the end of the second year.

The results obtained by Pedersen are given below:

TABLE 20.—*The relation in percentages between the various degrees of the syphilis reaction (Noguchi system) from class to class.*

Classes and groups.	Total number of cases.	Number. −	Number. ±	Number. <<+	Number. <+	Number. +	Number. ++	Percentage positive test (approximate).
A I....	16	1	..	1	..	4	10	94
A II...	3	..	..	..	..	2	1	100
B I....	11	..	..	..	1	5	5	100
B II...	5	..	1	..	..	1	3	100
C I....	..	..	..	..	..	..	..	...
C II...	1	..	..	..	..	1	..	100
D I....	12	..	..	..	1	4	7	100
D II...	23	3	1	..	7	6	6	83
E	31	7	2	2	12	6	2	71
F	13	2	..	..	3	3	5	85
G I....	25	12	1	2	6	4	..	48
G II...	18	3	3	..	3	6	3	67
G III..	10	3	2	..	..	3	2	50
G IV...	7	3	1	..	1	1	1	43
G V....	12	3	..	..	3	6	..	75

It will be noticed that Pedersen's classification for his series of observations closely follows the original designation of Ricord. In order, however, to permit study of the effects of treatment, it was deemed wise to allow six months to elapse before Class D was enumerated to embrace chiefly cases of later secondary syphilis along with Classes E and F.

As the records of Classes H and J lacked in necessary details for being embodied in the above table they will not be quoted here, while a brief summary of results is made by Pedersen with Class I.

Class I is a comparison of all tests repeated upon a given patient two or more times, from which it is hoped to point out better than the foregoing classes do the direct tendency of reaction to disappear under treatment and with the lapse of time. In this class are sixty-two observations. In the majority of these observations it is found that the second tests always show a decrease in the reaction, provided treatment was active and efficient. Occasionally, the total disappearance of the test is recorded.

Craig (U. S. A. Med. School) has gathered the following data:

TABLE 21.—*The result of specific treatment upon the syphilis reaction (Noguchi system).*

Time treated	No. of cases	Positive	Negative	Time treated	No. of cases	Positive	Negative
2 weeks	2	1	1	40 weeks	1	1	0
4 "	1	0	1	1 year	4	1	3
6 "	2	1	1	14 months	3	1	2
8 "	3	2	1	15 "	1	1	0
10 "	1	1	0	18 "	2	2	0
12 "	1	3	1	2 years	6	5	1
16 "	4	1	0	30 months	1	1	0
24 "	3	3	1	3 years	2	0	2
28 "	4	1	2	8 "	1	1	0
32 "	5	1	3	12 "	1	1	0
36 "	4		1				

Total cases with treatment, 52. Positive, 32. Negative, 20.

Craig arrived at the conclusion that the disappearance or reduction of the reaction during the treatment is a valuable indicator for the effectiveness of the treatment. Irregular and inadequate therapeutic measure, no matter how long a period it may be extended, leaves the reaction still positive.

From the above it will be seen that the reaction is affected greatly by the treatment of the disease, but that some cases frequently persist in giving a positive reaction in spite of what is done for them. In hereditary lues the reaction is difficult to get rid of, often persisting in spite of most rigorous interference. The reaction may return shortly after cessation of treatment, so that it may be necessary to make frequent tests to determine whether further therapeusis is indicated. While it seems settled among the profession that a positive reaction in a syphilitic case is an indication for additional treatment, it is not definitely established that the disappearance of the reaction is justification for the cessation of treatment, especially as the reaction may be quickly affected by treatment.

SALVARSAN (OR 606) TREATMENT.

The influence of the treatment of syphilis with Ehrlich-Hata dioxydiamidoarsenobenzol or so-called "606" upon the serum reaction has been studied by various investigators.

Nichols treated the rabbits and monkeys experimentally inoculated with syphilis and yaws by means of intravenous injection of the arsenobenzol and found that the spirochætæ disappear within 24 hours and the serum reaction becomes negative within about four weeks after the injection.

The observations upon human subjects have been made by a large number of investigators on a vast syphilitic material in different clinics and hospitals. Although still too early to judge its efficacy in the treatment of syphilis this preparation has already done much in clearing up the syphilitic lesions within a comparatively short period. It is remarkable, indeed, that relapses of the disease after disappearance of symptoms by a single injection have been comparatively few.

I will review very briefly the literature on "606" with special reference to the number of relapses and the effect of the treatment upon the Wassermann reaction.

Wechselmann treated 1250 cases and observed only 40 relapses. The serological study of Wechselmann's cases was conducted by Lange, who analyzed 268 cases in detail. They found that 153 out of 268 cases became negative in five weeks after the injection. There were 18 cases which were negative before and after the injection. The reaction was

still positive in 97 cases when examined at the end of five weeks, although a more or less reduction in the strength of the reaction was noticed in 34 of these cases.

Michaelis treated 110 cases and observed 3 relapses. According to him the serum reaction may become negative within a period of from two to ten weeks after the injection. In a few instances the reactions became stronger than before the injection while the clinical symptoms were fast disappearing under the influence of "606." This last phenomenon has also been observed by Munk and Fraenkel and Grouven.

Herxheimer treated 789 cases and had 33 relapses within a period of five months of observations. Many of his cases went out of sight before a negative reaction was obtained. In a limited number of cases which remained under his observation for a sufficient length of time the reaction became negative in 75 per cent. of cases within 50 days after the injection. Bering reports that the reaction became negative in 40 cases after the lapse of five weeks or longer, while it remained positive in 26 cases.

Treupel, Halberstädter, Ledermann, Schlesinger, Bruhns, and Hoffmann experienced very slow reduction or persistence of the reaction in most of their patients. On the other hand, Kromayer, Gennerich,

Linser, Cramer, and others saw the reaction disappear in, at least, 50 per cent. of the cases within four to five weeks.

In the work above quoted the arsenobenzol was used either in a neutral or a slightly alkaline suspension and administered intramuscularly by one set and subcutaneously by the other set of investigators. In the beginning most of the earlier cases had received only 0.3 gram as a dose (instead of 0.6 gram as recommended later).

An intravenous administration of "606" had been advocated by Schreiber, who compared the efficacy of the arsenobenzol by giving it intramuscularly in one series and intravenously in another series of cases. Schreiber administered "606" intramuscularly to 152 cases and observed 18 relapses, while in 565 cases treated by the intravenous injection there was only one case of recidive. In his earlier report Schreiber mentions that the reaction disappeared in 50 per cent. of cases after the injection (intramuscular as well as intravenous?), but inferring from his last report he now seems to succeed in making the reaction disappear in every case by the intravenous injection, because he orders another intravenous injection whenever the reaction remains positive after the first administration. Géronne treated 220 cases with intravenous administration of "606" and

observed 14 recidives. Of 77 cases of all stages of syphilis the reaction became negative in 37 and remained so for at least 8 weeks, while in the remaining 40 it became negative for a time and later again positive. In 9 out of 13 recidives the reaction quickly disappeared upon a second injection, while the rest retained the positive reaction after the second dose.

In going over the entire literature on the Ehrlich-Hata "606" I find that the statements in regard to the Wassermann reaction are extremely brief and vague, and it was with much difficulty that I could gather the data just reviewed. The chief reason for the incomplete serological analysis of their cases is unquestionably due to the enormous labor and material demanded by the original Wassermann method. It is by no means easy to carry out a systematic quantitative serological examination on a very large number of cases by this method. Even when this was done the results would not permit one to gain an insight into the quantitative relation of the reaction to the clinical course of the disease under the treatment with "606," because the results obtained with the original method do not indicate differences among positive reactions as to whether the complete fixation is caused by exactly one antibody unit or by several or any other number above one.

In order to follow the effect of "606" upon the

serum reaction in a strictly quantitative manner I have undertaken, with Dr. Bronfenbrenner, a series of examinations of cases treated with the arsenobenzol. The cases[1] included in my series belonged to Drs. Cohen, Fordyce, Fox, Fuller, Gottheil, Henderson, Kakels, Lapowsky, Luckett, Pedersen, Pollitzer, and Simonds. The cases of Dr. Fuller and Dr. Gottheil were injected by me.

The total number of cases available for a complete serological analysis is 102. More than half of this number have been under observation for a period over three months, while the latest cases were injected about four weeks ago. The amounts of the arsenobenzol were 0.5 to 0.6 for men, 0.4–0.5 for women and 0.015–0.025 for children. The modes of injection were variable with different investigators, but the majority injected a slightly alkaline suspension or semi-solution intramuscularly or subcutaneously. Occasionally intravenous injections were made, especially in later cases. Many cases have been injected into the lumbar sacral region of the erector spinæ muscle as recommended by Meltzer. From my experience I consider the intravenous injection of an alkaline solution as the best, and the subcutaneous administration the worst. The intramuscular mode

[1] For their courtesy in permitting me to use their cases for the present study I express my thanks to these gentlemen.

of injection into the glutei, though decidedly less effective than the intravenous one, gives a good result. Whether Meltzer's method of intramuscular injection is equally effective as the intravenous cannot be told yet, but if this proves to be the case his method may be adopted.

The quantitative determination of the serum reaction in each case was carried out with my method in the manner already described under the titration of syphilitic antibody. (See page 69.) The blood was examined before the injection and then 1 day, 3 days, 1 week, 2 weeks, 3 weeks, 4 weeks, 6 weeks, 8 weeks, etc., after the injection.

Table 22 shows the serological conditions of these cases before and some time after the injection of the arsenobenzol. This table furnishes us with many interesting facts in regard to the syphilis reaction.

Examining first the varieties of the reactions in these 102 strongly positive specimens one will notice that in primary, secondary, tertiary and hereditary syphilis the average specimens contained more than one antibody unit, more frequently 2, 3, and 4 units. Among the specimens derived from secondary syphilis one with 10 units was encountered. On the other hand, the majority of specimens from latent syphilis contained 1 or 2 units. In cerebrospinal syphilis and tabes the antibody content was also com-

paratively low. Taking the average for different stages of syphilis in groups one finds that of the secondary to be the highest, followed by those of the hereditary, tertiary, primary, and latent syphilis. It may be recalled here that any specimen containing more than one antibody unit is capable of giving a complete inhibition of hæmolysis, commonly known as a strong positive reaction.

Let us next study the serological conditions which have been created in the same series of cases after the injection of "606." There we find a striking contrast to the conditions which existed before injection. There are two new columns, one for entering the number of specimens as negative and the other for the specimens which no longer contain one unit of antibody, and both are well filled up with different figures. In the following columns one notices that beyond the column for 4 units all are blank up to the last, signifying, of course, that after the treatment none of the cases contained more than 4 units. In reality the positive specimens after " 606 " usually contained 1 or 2 units and seldom 3 or 4. Speaking more in detail, 30 cases lost the reaction, 24 cases reduced to less than one antibody unit, while the remaining 48 (47.5 per cent.) still contained more than one unit and gave strong positive reactions. When speaking vaguely these 48 cases may be taken as an evidence that the

TABLE 22.

	Number of cases.	Before the injection of "606." Number of syphilitic antibody units in 0.02 c.c. 1	2	3	4	5	6	7	8	9	10	Average units.	After the injection of "606." Number of syphilitic antibody units in 0.02 c.c. —	<1	1	2	3	4	5	6	7	8	9	10	Average units.	Compared with the original (before injection).	Percentage of negative cases after the injection.
Primary syphilis....	12	2	4	3	2	1	..	..	..	..	..	2.66	5	3	3	1	..	..	..	..	..	..	..	..	0.54	1/5	40
Secondary syphilis..	38	2	11	12	5	3	2	1	1	..	1	3.50	14	7	8	4	2	3	..	..	..	..	..	..	0.98	1/3.5	37
Tertiary syphilis....	31	6	6	8	3	5	3	..	..	..	..	3.18	11	5	8	6	1	..	..	..	..	..	..	..	0.88	1/3.6	35
Latent syphilis.....	6	3	2	..	..	1	..	..	..	..	..	2.00	2	3	..	1	..	..	..	..	..	..	..	..	0.40	1/4	33
Hereditary syphilis..	7	1	1	3	1	..	..	1	..	..	..	3.28	1	1	2	3	..	..	..	..	..	..	..	..	1.20	1/2.7	14
Cerebrospinal syphilis.....	6	2	2	2	..	..	..	..	..	..	..	2.00	..	1	2	3	..	..	..	..	..	..	..	..	1.35	1/1.5	0
Tabes.....	2	..	2	..	..	..	..	..	..	..	..	2.00	1	..	1	..	..	..	..	..	..	..	..	..	0.50	1/4	50
Total.....	102	16	28	28	11	10	5	2	1	0	1	2.66	34[1]	20[2]	24	18	3	3	0	0	0	0	0	0	0.83	1/3.2	33.7

These 102 cases are commonly designated as strongly positive reactions, but note that a strongly positive reaction can be caused by variable number of the antibody units from 1 to 10 in this series.

These 48 cases are commonly known as strongly positive reaction, but see how variable they can be when analyzed by a quantitative method.
=47.5%.†

[1] Negative reaction. 33.7%.
[2] Weakly positive reactions. 19.8%.

arsenobenzol had no influence upon them, but the affair changes entirely when we examine the data from the quantitative side. These cases while still retaining the strong reactions are decidedly reduced in antibody content from what they originally possessed, as will be seen in the table. For the sake of comparison I have calculated out the average antibody units for each group of cases and also the ratios between the averages for the original and those after the treatment. The average for primary cases is seen to be reduced to 1/5, that for secondary to 1/3.5, that for tertiary to 1/3.6, that for latent to 1/4, that for hereditary to 1/2.7, that for cerebrospinal to 1/1.5 and that for tabes to 1/4 of the original antibody contents. This shows clearly that the arsenobenzol had the effect of reducing the antibody content in general.

Now considering the frequency with which positive reactions became negative after the treatment we find that in 40 per cent. of the primary cases, in 37 per cent. of secondary, in 35 per cent. of tertiary, in 33 per cent. of latent, in 14 per cent. of hereditary and in 50 per cent. of incipient tabes the reaction was lost, while all cases of cerebrospinal syphilis became somewhat weaker but remained still positive. The average of the negative reactions corresponds to 33.7 per cent. of the total 102 cases.

The percentage of weak positive cases is 19.8 of the total, but this group of cases is progressively losing the strength of the reaction and is likely to fall in due course of time into the category of the negative group.

The Relation Between the Clinical and Serological Findings.—In order to study what relation exists be-

TABLE 23.—*Latent cases not included.*

	Symptoms cleared up	Slow improvement	No improvement	Relapses
Primary syphilis.....	12[1]	..	..	..
Secondary syphilis	30[2]	7	2	10
Tertiary syphilis.....	19[3]	10	3	1
Hereditary syphilis.....	5[4]	2	..	..
Cerebrospinal syphilis..	..	..	6	..
Tabes.....	..	1[6]	1	..
	66[5]	20[7]	12	11

[1] 5 became negative. [2] 14 became negative. [3] 11 became negative. [4] 1 became negative. [5] 31 became negative. [6] Became negative. [7] 1 became negative.

tween the clinical data and the serological findings a brief summary of the clinical observations is presented above. For the details of these cases I refer to the publications of Fordyce, Fox, Gottheil, Henderson, Kakels, Luckett, Pedersen, and Pollitzer.

In 66 cases which responded favorably to the arsenobenzol and lost the clinical symptoms within a few weeks the serum reaction became negative or reduced in strength. The effect of "606" upon the

clinical symptoms is far more prompt than upon the reaction. In a large number of cases symptoms commence to clear up within a week, not infrequently, however, even within 24 hours after the injection. The progress of healing is usually quick, clearing up within a few weeks. On the other hand, the reaction becomes gradually weaker, requiring a considerably

TABLE 24.—*Showing the length of time required for positive reactions to become negative after* "606."

	1 week	2 weeks	3 weeks	4 weeks	5 weeks	6 weeks	7 weeks	8 weeks	Total
Primary syphilis	..	1	1	2	..	1	..	..	5
Secondary syphilis	..	..	3	5	3	2	1	..	14
Tertiary syphilis	..	2	3	4	2	..	..	..	11
Latent syphilis	..	..	2	..	..	..	..	..	2
Hereditary syphilis	..	..	..	..	..	1	..	..	1
Cerebrospinal syphilis	..	..	..	..	..	..	..	..	0
Tabes	..	..	1	..	..	..	..	..	1
	..	3	10	11	5	4	1	..	34

longer time before turning into a negative. In promptly cured cases the reaction may disappear within two weeks, although in some instances it may take four or five weeks. In this group only 31 cases became negative, while in the remaining 35 cases the reaction is still weakly or strongly positive.

In Table 24, I present the data in regard to the time of disappearance of the reaction in cases of different stages of syphilis after the injection of "606."

In 20 cases where clinical improvement was very slow the reaction was also extremely slow in diminution and in some cases it became stationary. In 2 cases of tertiary syphilis the clinical symptoms showed but little improvement, while the reaction became slowly but progressively weaker within two months.

Six cases of cerebrospinal syphilis (Henderson) showed no improvement clinically, but the reactions were more or less weakened within 5 weeks.

In 2 cases of incipient tabes (Pedersen) the clinical and serological conditions improved in one and not in the other.

Ten relapses were observed in 102 cases. Most of these were cases of malignant or tertiary syphilis. The recurrence of the disease could always be detected by the return of the reactions, which were diminishing until the relapse. Six relapses were reinjected with good results, while one had a second relapse.

Among 102 cases there were 3 cases which showed no effect upon the reaction as well as upon the symptoms.

In 4 instances the reactions became somewhat stronger during a few days following the injection, but their strengths were gradually reduced later.

More recently, Craig conducted a very comprehensive series of study on the immediate effect of salvarsan treatment on the complement-fixation test

(Noguchi system). The results obtained by Craig are especially valuable because the patients (soldiers) have been and are still being kept under constant observation, thus affording him every facility to make the test at whatever time chosen. Under such favorable circumstances Craig has been examining 700 soldiers at a period, and reported in September, 1911, an analysis of the results on 225 cases which had been observed for at least eight weeks since the administration of salvarsan, and most of them for a longer period.

Of the 225 cases reported, 164, or 72.8 per cent., became negative, and 61, or 27.1 per cent., have remained positive. Of the 164 cases which became negative, 24, or 14.6 per cent., have relapsed; 43 have remained negative for 2 months; 41 for 2½ months; 20 for 3 months; 7 for 4½ months; 11 for 5½ months; 7 for 6 months, and 6 for 7 months.

In relation to the stage of disease Craig found that the reaction disappears more readily in primary syphilis (25 out of 31 cases = 80.6%) than in secondary (100 out of 135 cases = 74%), tertiary (12 out of 22 cases = 54.9%), and latent period (27 out of 37 cases = 72.9%). The number of relapses was also smaller in primary (12%) than in secondary (15%), tertiary (16.6%), and latent cases (14%).

The rapidity of disappearance of the reaction

varied according to the stages of the disease. The tertiary cases became negative more rapidly than others, 9 of the 12 becoming negative within 2 weeks. In the secondary cases the reaction disappeared most frequently during the second, third and fourth weeks, while the longest period was 8 weeks. In the primary cases, 13 of the 25 became negative within 2 weeks, and the rest within 5 weeks. In latent cases the majority became negative during the second, third, fourth and fifth weeks, and no case became negative after 6 weeks.

The relation of the intensity of the reaction to the disappearance of the reaction was also analyzed. Of the 119 cases with more than one antibody unit (complete inhibition of hæmolysis) 66.3 per cent. became negative, of which number 16.4 per cent. relapsed. Of 71 cases with less than one and more than one-half antibody unit (inhibition at least 50%) 80.2 per cent. became negative, of which 12.2 per cent. relapsed. Of 35 cases with less than one-half antibody unit (inhibition less than 50%) 80 per cent. became negative and 14.2 per cent. relapsed. Nearly half of the cases giving a weak reaction (less than 50% inhibition) were patients in the late secondary or tertiary stages of the disease in which the infection was still active, although they had been treated vigorously with mercury. The one-fifth of the primary cases gave

also a weak reaction and 71 per cent. of this group became negative.

Among others Craig paid special attention to the relation of the method of administration of salvarsan to the disappearance of the complement-fixation reaction. The methods used in the cases reported were as follows: Injection of the neutral suspension; intramuscular injection of the alkaline solution; intravenous injection, and combined intramuscular and intravenous injections.

		Became negative	Remained positive	Relapse
		Per cent.	Per cent.	Per cent.
1. Neutral suspension	9	77.7	22.2	71.4
2. Alk. sol. intramuscular	150	78.6	21.3	6.7
3. Intravenous	30	53.3	46.6	37.5
4. Combined intramusc. and intravenous	36	63.8	36.1	21.7

While the disappearance of the reaction was more rapid in the cases treated with the intravenous than with the intramuscular injection, yet the percentage of the relapses was strikingly higher in the former.

The effect of a previous mercurial treatment was also considered. It was found that the reaction disappears more rapidly in the mercurialized than in untreated cases, and the chances of relapse are less, although relapses have occurred in patients previously well treated with mercury. In the 225 cases reported,

110 patients had received no treatment previous to the use of salvarsan. Of these 82, or 74.5 per cent., became negative; 28, or 25.4 per cent., remained positive, and 10, or 12.2 per cent., relapsed. Of 75 cases previously mercurialized, 63, or 84 per cent., became negative; 12, or 16 per cent., remained positive, and 7, or 9.3 per cent., relapsed.

Regarding the time of relapse in 24 cases reported, Craig obtained the following data: Two in 4, four in 5, three in 6, four in 7, one in 8, one in 9, one in 10, two in 11, two in 12, one in 14, one in 16, one in 22, and one in 23 weeks, after the reaction became negative. A great many of these relapsing cases had a strong fixation reaction before the treatment with salvarsan.

The careful analysis of Craig has doubtless brought the serum reaction and the therapeutic as well as prognostic problems in syphilis to a much closer and clearer relation than has hitherto been done by others. Craig and Nichols are inclined to consider that the absence of clinical and serological manifestations persisting for a period of over one year after the treatment with salvarsan indicates a cure of the disease. In this connection the writer, as also mentioned by Nichols, would suggest the use of the cutaneous reaction with the luetin as another means of detecting the latent focus of the infection in this

class of patients. According to the writer's experience the luetin reaction reveals the latent syphilis in many cases where the serum reaction or clinical symptoms are absent. The results of the luetin test on the cases treated with salvarsan and mercury and where no more clinical or serological signs of syphilis were manifest for one year or longer show that some of them still give a distinct cutaneous reaction, while others do not respond to the luetin. It seems that the latter group of patients may belong to the cured cases of syphilis and the former still harbors the infection in latency.

XIII.

SPECIFIC COMPLEMENT-FIXATION IN SYPHILIS.

Two principal facts, namely, the existence of so-called " antigen " in non-syphilitic tissues and the occurrence of the Wassermann reaction in non-syphilitic diseases (yaws, leprosy, malaria, etc.), disprove indirectly that the Wassermann reaction is caused by the true syphilitic antibodies and antigen (Treponema pallidum). No one has as yet conclusively separated the Wassermann reaction from the specific antibody-antigen fixation. The obstacle in settling this point was the lack of pure culture of Treponema pallidum. The pure culture of the pallidum furnishes us with a material in which we can obtain the pallidum substance free from any tissue lipoids which may produce the Wassermann reaction. With a pure pallidum extract as antigen we can find out whether a given syphilitic serum contains the specific antibody or not.

After successful cultivation of Treponema pallidum in 1910-1911, the writer immunized a number of animals (rabbits, sheep) with the pure pallidum extract for several months and then tested their serums for the complement-fixation. These were tested simultaneously with both the pallidum extract

and the pure lipoids. It was found that these immune serums bind complement with the pallidum extract, but not with the lipoids. On the other hand, the serums from rabbits with active experimental syphilitic orchitis bind complement with the lipoids, but not with the pallidum extract. The above findings show that the immune serums contain the specific antibodies for the pallidum but not for the lipoids, and that in the serums of syphilitic rabbits (active stage) there is an abundance of the lipotropic substance (probably an enzyme) capable of rendering complement inactive (so-called fixation) in the presence of certain lipoids, but too little specific antibodies to bind complement with the pallidum antigen. This completely demonstrates the difference between the Wassermann and the true antibody antigen reaction in syphilis.

The above results obtained in an experimental syphilis in animals hold good also for human syphilis, for the writer found that the serums derived from primary and secondary cases of syphilis almost never give a positive reaction with the pallidum antigen, and, if there is any, it is usually weakly positive. The same serums, as is well known, usually give a strong fixation with the lipoidal "antigen" (Wassermann reaction). While there is a striking absence of the specific antibodies (negative phase) during the active

stage (primary and secondary) of syphilis, we encounter among the serums of patients suffering from the chronic course of syphilis (tertiary, latent, tardive congenital) those which contain varying quantities of the specific antibodies (positive phase) to be detected with the pallidum antigen. In this latter class of patients the Wassermann reaction may be positive in some and negative in others. It is noticed that the serums from patients, whose Wassermann had disappeared under an energetic treatment, give more frequently a positive fixation with the pallidum antigen, possibly due to a more vigorous formation of the specific antibodies. Speaking in general, the amount of the specific antibodies in human syphilis is, however, remarkably small and it is rather infrequent to obtain a complete exhibition of hæmolysis even when the serum is used in maximum quantity. On the other hand, the immune serums (rabbit, sheep) give a beautiful complete fixation with the pallidum extract.

The significance of a positive reaction with the pallidum antigen awaits the future development for its solution, yet it is probable that a positive reaction (the presence of the specific antibodies) is a favorable sign for the patient. It is desirable, indeed, to establish a definite relationship between the reaction and prognosis. In view of a possible interest for the

serologists and clinicians the writer presents below a brief technic for making the fixation test with the pallidum extract.

The pallidum antigen. Pure cultures of several different strains of Treponema pallidum growing for different lengths of time (7, 14, 21, 28, 35, 42 days) in a special medium (consult the writer's publications for the details) are ground in a mill until the pallidum is nearly disintegrated. The thick emulsion is then diluted with 0.9% salt solution. It is first tested for its anticomplementary property in the usual way of titration. The amount of complement (guinea-pig's fresh serum) to be used in the titration is 0.04 c.c. (or 0.1 c.c. of 40% dilution). If the pallidum extract inhibits the action of the complement in the dose of 0.2 c.c., for example, one employs 0.1 c.c. or half of the inhibiting titre for the fixation test. The antigen may be preserved on ice with the addition of 0.4% phenol. The writer does not use an emulsion which has been standing over one week. It is best to test its reliability by means of an immune serum (rabbit's or sheep's).

The patient's serum (antibody). The serum of the patient is collected in the usual way (venepuncture, etc.). Before making the test it should be heated to 56° C. for 30 minutes in a water-bath. This precaution is absolutely necessary because of the pro-

tein nature of the pallidum antigen (see pages 98–101). For the test 0.1–0.2 c.c. of the inactivated serum is used.

The complement, amboceptor, and corpuscle suspension. Same as given in procedures described on pages 62 and 63.

The technic for the fixation test. Same as indicated in the tables on pages 62 and 63. Special attention is called not to use the fresh unheated patient's serum in this test, as one is liable to do so while following the steps indicated in these procedures. As already stated above, 0.1–0.2 c.c. of the inactivated serum is to be used, but not one drop of fresh serum. Here we are using an antigen of protein nature, while there (the lipotropic or Wassermann reaction) pure lipoids are employed, and hence this distinction.

COMPLEX COMPLEMENT-FIXATION PHENOMENON.

The clear distinction between the Wassermann and the specific fixation reaction in syphilis is brought out only through the use of pure lipoids on one hand and a pure pallidum extract on the other. This is no doubt a valuable distinction, inasmuch as the former indicates the activity of the infecting organism (Treponema pallidum) and the latter the immunity reaction on the part of the suffering host. But when

the complement-fixation test is made by means of an antigen containing both the active lipoids and the pallidum antigen, the result is capable of being interpreted in two entirely diagonal senses. It may have been a sign of the activity of the pallidum or that of the host against the pallidum, or a mixture of the two phenomena. The original antigen of Wassermann, Neisser and Bruck is liable to bring about this mixed phenomena, because it contains both the lipoids and the pallidum. As a matter of fact, the rôle of the pallidum in the Wassermann reaction is very insignificant in the majority of instances, for the reason, that whenever the reaction is very strong (as in the primary or secondary syphilis) it is usually caused by the lipotropic substances alone and not by the specific antibodies. It may become of some importance only in the chronic cases. Yet, if one interprets both phenomena in the same sense, he is misinformed. This confusion does not occur frequently, but it should be avoided by separating the two reactions by pure lipoids and pallidum antigen, respectively. The antigenic principle of the pallidum is insoluble in alcohol and such an extract no longer fixes complement either with an immune serum or with human serum containing *the specific antibodies.* From this fact it follows that an alcoholic extract of a fœtal liver with pallidum contains no more specific antigen

and does not differ from an extract derived from a normal liver. Thus, the Wassermann reaction, as is understood today, is nothing but a lipotropic fixation, as practically every serologist is now employing an alcoholic extract or a purified mass of lipoids.

Recently W. H. Hoffmann reported that by using pure cultures of his so-called pallidum as antigen, he was able to obtain the results parallel to those obtained by the use of a syphilitic liver extract. The spirochæta which he isolated belongs beyond any dispute to Treponema microdentium (Noguchi) and differs from the pallidum in producing a putrefactive odor and growing in a serum agar (horse serum and agar) without fresh tissue. Now it is very difficult to understand how his culture happened to contain so much active lipoids without which the reaction could not have taken place in the majority of syphilitic serums. That his culture is not identical with the pallidum can be easily shown by the fact, that even the thickest emulsion of the pallidum derived from the syphilitic lesions of rabbits' testicles or from the pure cultures (Noguchi) does not cause complement-fixation with most of the active cases of primary or secondary syphilis, and that even in latent or tertiary syphilis the fixation is not so uniform.

Before leaving this chapter the writer wishes to emphasize that in the later chronic stages of syphilis

there may be a certain amount of specific antibodies and the lipotropic substances, both of which can be detected by an aqueous extract of a tissue rich in pallidum and lipoids, but not in the acute period of the disease. In the latter the fixation is caused almost exclusively by the lipotropic substances, and the pallidum plays but a small rôle in the antigen; the specific antibodies during that period of the disease seem to be lacking or present in a negligible quantity. It is of advantage to carry out the fixation test on syphilitic serums for the lipotropic substances (Wassermann reaction) and the specific antibodies separately, because each has its own significance for the condition of the patient.

XIV.

THE LUETIN REACTION.

ACTIVE or passive immunity, the state of allergy, and numerous other phenomena, which have been so commonly observed and profitably studied in certain infectious diseases since the successful pure cultivation of their respective causative agents, are rather imperfectly understood in syphilis. Soon after obtaining pure cultures of *Treponema pallidum,* I commenced to study these questions experimentally. While the results of my experiments on the effects of repeated injections of living and killed pallida on experimental syphilis in animals will be presented later, I wish to make a brief report here on one of the phases of study that seems to me to be of interest not only to those who are engaged in experimental work but also to clinicians at large; namely, on a cutaneous reaction in experimental and human syphilis.

Stimulated by von Pirquet's discovery of a specific cutaneous reaction for tuberculosis, several investigators (Meirowsky, Wolff-Eisner, Tedeschi, Nobl, Ciuffo, Nicolas, Favre and Gauthier, Neisser and Bruck, Jadassohn, and Fontana) attempted to obtain a specific reaction for syphilis by applying extracts of syphilitic tissues, prepared from syphilitic

fetal liver or chancre, to the skin of syphilitic patients. Their results were, on the whole and in spite of some encouraging effects, contradictory. Neisser and Bruck, however, found that a reaction similar to that produced with syphilitic extract can be obtained also with a concentrated extract of normal liver. This peculiarity of the skin of syphilitics is ascribed by Neisser to what he calls the state of "Umstimmung" in the later stages of syphilis. Neisser, nevertheless, expresses the hope that the reaction may possibly be improved by employing an extract of the pallidum free from tissue constituents. This had not been accomplished before. Pure cultures of *Treponema pallidum* obviously offer many advantages, since in them we possess not only pallida of different ages, but also their metabolism products, which doubtless are important factors in establishing an allergic state in syphilitic subjects.

THE PREPARATION OF CULTURES FOR THE CUTANEOUS REACTION.

Pure cultures of several strains of the pallidum are allowed to grow for periods of six, twelve, twenty-four, and fifty days at 37° C. under anaërobic conditions. One set is cultivated in ascitic fluid containing a piece of sterile placenta, and the other in ascitic fluid agar also containing placenta. The lower por-

tion of each solid culture in which a dense growth has occurred is cut out and the tissue removed. The agar columns which contain innumerable spirochætæ are then carefully ground in a sterile mortar. The resulting thick paste is gradually diluted by adding, little by little, the fluid culture which also contained an enormous mass of the pure organisms. The dilution is continued until the emulsion becomes perfectly liquid. The preparation is next heated to 60° C. for thirty minutes in a water-bath, and then 0.5 per cent. tricresol is added. When examined under the dark field microscope, numerous dead pallida per field may be seen. Cultures made from this suspension remain sterile, and with them no infection can be produced in the testicles of rabbits. The suspension is kept in a refrigerator when not in use. I propose to speak of this preparation under the name of *luetin.*

In order to ascertain whether the reaction produced with this suspension might not be due to the introduction of the carbolized culture medium alone, it is necessary to prepare a similar emulsion with uninoculated media to be used for control purposes.

METHOD OF APPLICATION.

For rabbits, the hair on the lower side of the back is shaved off and one or two injections of the luetin and one injection of the control suspension are made

in different spots. The injections are made intradermically with a very fine needle, the amount injected being in each case 0.07 of a cubic centimeter. For human subjects, the skin of the upper arm is selected as the site for the intradermic injection of the luetin and the control suspension. In the earlier experiments, different spots on the same upper arm were used for both, but now one arm is used for luetin and the other for the control. The amount injected in each instance is 0.07 of a cubic centimeter, and the skin is always sterilized with alcoholic sublimate solution before the injection.

THE CUTANEOUS REACTION IN RABBITS.

Before the skin test was applied to human subjects, several series of experiments were performed on rabbits. The tests may be divided into five groups according to the treatment previous to the cutaneous tests. The first group comprised four rabbits which received within five months twelve intravenous injections of emulsions prepared from syphilitic orchitis or rabbits rich in pallida, the last injection being given two months before the date of application of the skin reaction. Ten different strains of pallidum were represented in this series. The second group was composed of four rabbits which had been injected with similar emulsions, the differ-

ence being that the pallidum had been killed by heating the emulsions to 60° C. for thirty minutes before injection. The third group included twelve rabbits which were showing, four to six weeks after inoculation, syphilitic orchitis experimentally produced with several different pallidum strains. The fourth group consisted of four rabbits in which experimental syphilitic orchitis had been cured about four months previously by the intravenous administration of salvarsan. The fifth group consisted of eight normal male rabbits. The intradermic injections of the luetin and control emulsions were made on the same day to all the rabbits.

RESULTS OF THE TESTS.

In the control group, a very slight erythematous condition appeared at the injection sites twenty-four hours after inoculation, which disappeared within forty-eight hours, the skin resuming its normal appearance. The first and second groups of treated rabbits gave different reactions. The sites of injection of the control emulsion became normal within forty-eight hours, while the sites of injection of the luetin became distinctly red and indurated after forty-eight hours. The point of redness gradually spread and became raised to the size of a pea. This condition persisted for four to six days, when the re-

action commenced to recede. The redness and induration disappeared in most animals within ten days. In one instance, a round sterile pustule developed on the fifth day on the site of each of the two inoculations of the luetin (Plate I). These pustules resembled variolous pustules in general appearance and healed with crust formation. The third group gave only slight reactions, which possibly were somewhat greater than in the control rabbits. But, as a whole, they were not, except in a few instances, distinct enough to be considered positive. The fourth group behaved like the control. No constitutional effects were observed even among the animals with positive cutaneous reactions.

THE CUTANEOUS REACTION IN MAN.

Through the courtesy and collaboration of Dr. Martin Cohen (Harlem Hospital, Randall's Island Asylum, New York Ophthalmic and Aural Institute), Dr. Henderson (State Hospital, Ward's Island, New York), Dr. Lapowski (Good Samaritan Dispensary), Dr. McDonald (Kings County Hospital), Dr. Orleman-Robinson (North-Western Clinic, New York Polyclinic), Dr. Pollitzer (German Hospital), Dr. Rosanoff (Kings Park State Hospital), Dr. Satenstein (City Hospital, Blackwell's Island, New York), Dr. Schmitter (Captain United

PLATE I.

An actively immunized rabbit (No. 4), inoculated on June 14, 1911. The drawing was made on the sixth day after inoculation. Both pustules are produced by the luetin. The control site disappeared.

States Army, at Fort Slocum), Dr. Schradieck (Kings County Hospital), Dr. Charles Schwartz (California), Dr. Smith (Long Island State Hospital), Dr. Strong (Manhattan Eye, Ear, and Throat Hospital), Dr. Swinburn (Good Samaritan Dispensary), Dr. Winfield (Kings County Hospital), Dr. Wiseman (Kings Park State Hospital), and the Hospital of the Rockefeller Institute for Medical Research, I was enabled to apply the skin reaction to a number of human cases.

The total number of cases studied was 642; of these 315 were of syphilitic nature, 77 of parasyphilitic nature, while 250 represented various controls.

The emulsions were always injected intradermically, that is, in the skin as superficially as possible. When the injection is successfully carried out, the epidermic layer is raised up sharply from the cutis, the pale swelling thus produced going down in from ten to fifteen minutes.

DESCRIPTION OF THE REACTIONS.

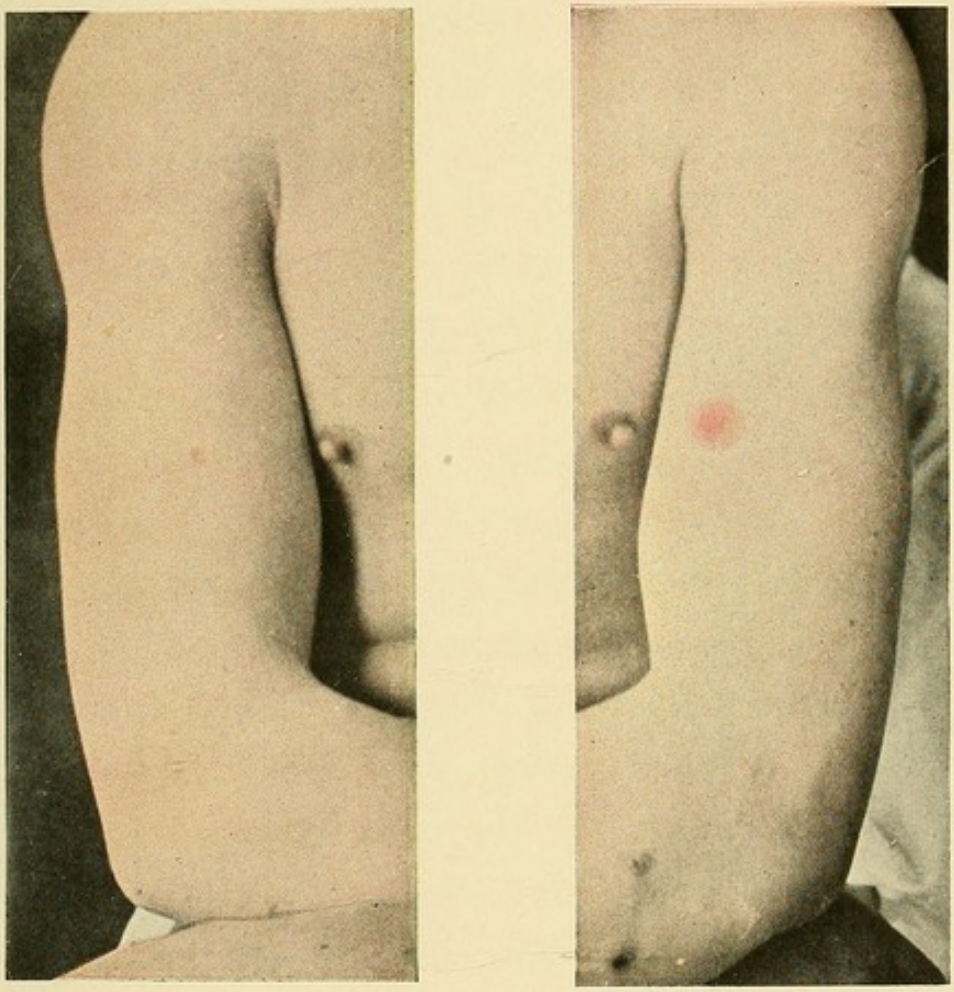
Normal or Negative Reactions.—After applying the emulsions, both luetin and control, to about fifty non-syphilitic individuals, I was able to determine the variations and limitations of the reactions that follow intradermic administration in the skin of non-luetic individuals. In the majority of non-luetic persons

there appears, after twenty-four hours, a very small erythematous area at and around the point of injection. No pain or itching sensation is experienced. This reaction gradually recedes within forty-eight hours and leaves no induration. In certain individuals, the reaction may reach a stage of small papule formation (about 4 x 4 mm.) after twenty-four to forty-eight hours, after which and within seventy-two hours it commences to subside. No induration is left behind, although occasionally slight yellowish pigmentation may result from mild ecchymosis.

Positive Reactions.—According to the manner and intensity with which the skin of syphilitics responds to the introduction of the luetin, one may distinguish the following varieties of effects:

(*A*) *Papular Form* (Plate II).—A large, raised, reddish, indurated papule, usually seven to ten millimeters in diameter, makes its appearance in twenty-four to forty-eight hours. The papule may be surrounded by a diffused zone of redness and show marked telangiectasis. The dimensions and the degree of induration slowly increase during the following four or five days, after which the inflammatory processes begin to recede. The color of the papule gradually becomes dark bluish red. The induration disappears within two weeks, except in certain instances in which a trace of the reaction may persist for a longer period. This latter effect is

PLATE II.



Right. Left.

Male, aged 23 years. Chancre four months ago, followed by rupio-papular eruptions, which have cleared up with some scars in certain localities. Treatment: three intravenous injections of salvarsan up to the time of making the luetin test. Wassermann reaction weakly positive. The left arm shows the luetin reaction on its fifth day; the right is the control.

usually met with among cases of secondary syphilis under regular mercurial treatment in which there are no manifest lesions at the time of making the skin test. Congenitally syphilitic children under the age of one year also show this reaction.

(*B*) *Pustular Form.*—The beginning and course of this reaction resemble the papular form until about the fourth or fifth day, when the inflammatory processes still increase in intensity. The surface of the indurated, round papule becomes mildly edematous, and multiple miliary vesicles occasionally form (Plate III). At the same time, a beginning central softening of the papule can be seen. Within the next twenty-four hours, the papule changes into a vesicle filled at first with a semi-opaque serum that later becomes definitely purulent (Plates III, IV, V). Soon after this, the pustule ruptures spontaneously or after slight friction or pressure. The margin of the broken pustule remains indurated, while the defect caused by the escape of the pustular content becomes quickly covered by a crust that falls off within a few days. A small induration sometimes remains for a few weeks or even months, leaving a small keloid after healing. There is a wide range of variation in the degree of intensity of the reaction described in different cases, as some show rather small pustules, while in others the pustule is much larger. This reaction was found almost constantly in cases

of tertiary and tardive hereditary syphilis, as well as in cases of secondary syphilis which had been treated with salvarsan.

(*C*) *Torpid Form.*—In rare instances, the injection sites fade away to almost invisible points within three or four days, so that they may be passed over as negative reactions. But sometimes these spots suddenly light up again after ten days or even longer and progress to small pustular formation. The course of this pustule is similar to that described for the preceding form.

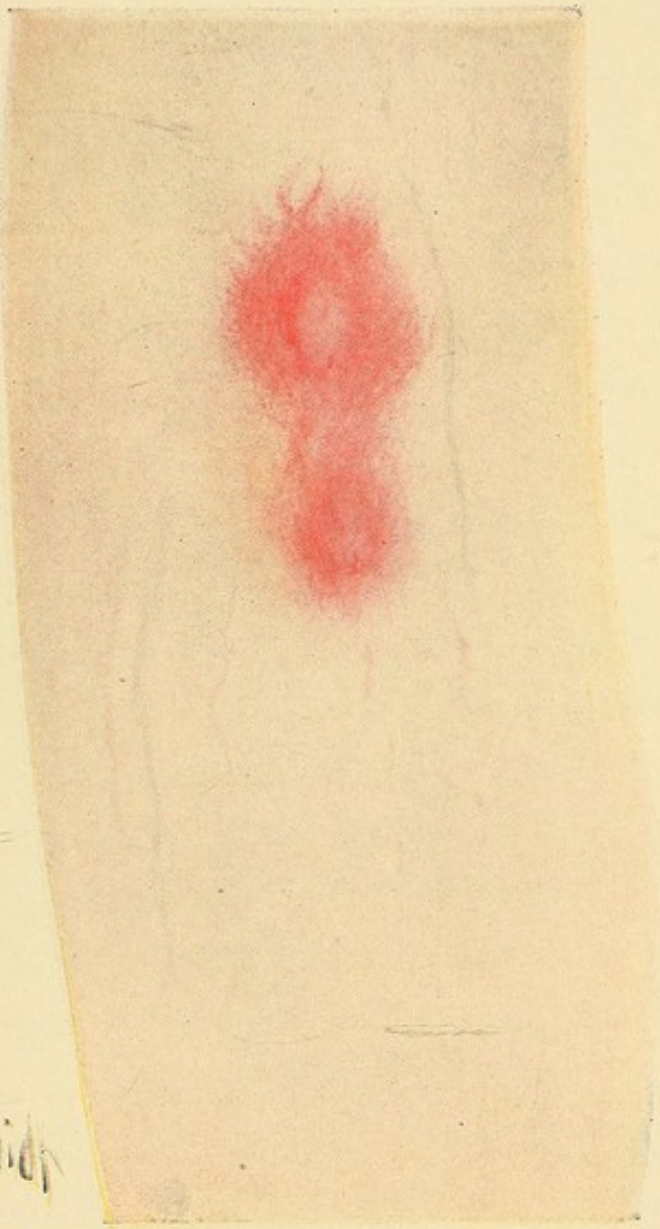
This type of reaction has been observed in a few cases of primary, secondary and congenital syphilis; quite frequently among the cases suffering from syphilitic affections of central nervous system.

Neither in syphilitics nor in parasyphilitics did a marked constitutional effect follow the intradermic inoculation of the luetin. In most positive cases, a slight rise in temperature took place, lasting for one day. In several tertiary and tardive hereditary cases, however, general malaise, loss of appetite, and diarrhœa were noted.

THE PECULIARITY OF THE SKIN OF SYPHILITICS.

The skin of certain individuals suffering from tertiary syphilis is noted for its susceptibility to traumatic irritations. This tendency has been much dis-

PLATE III.



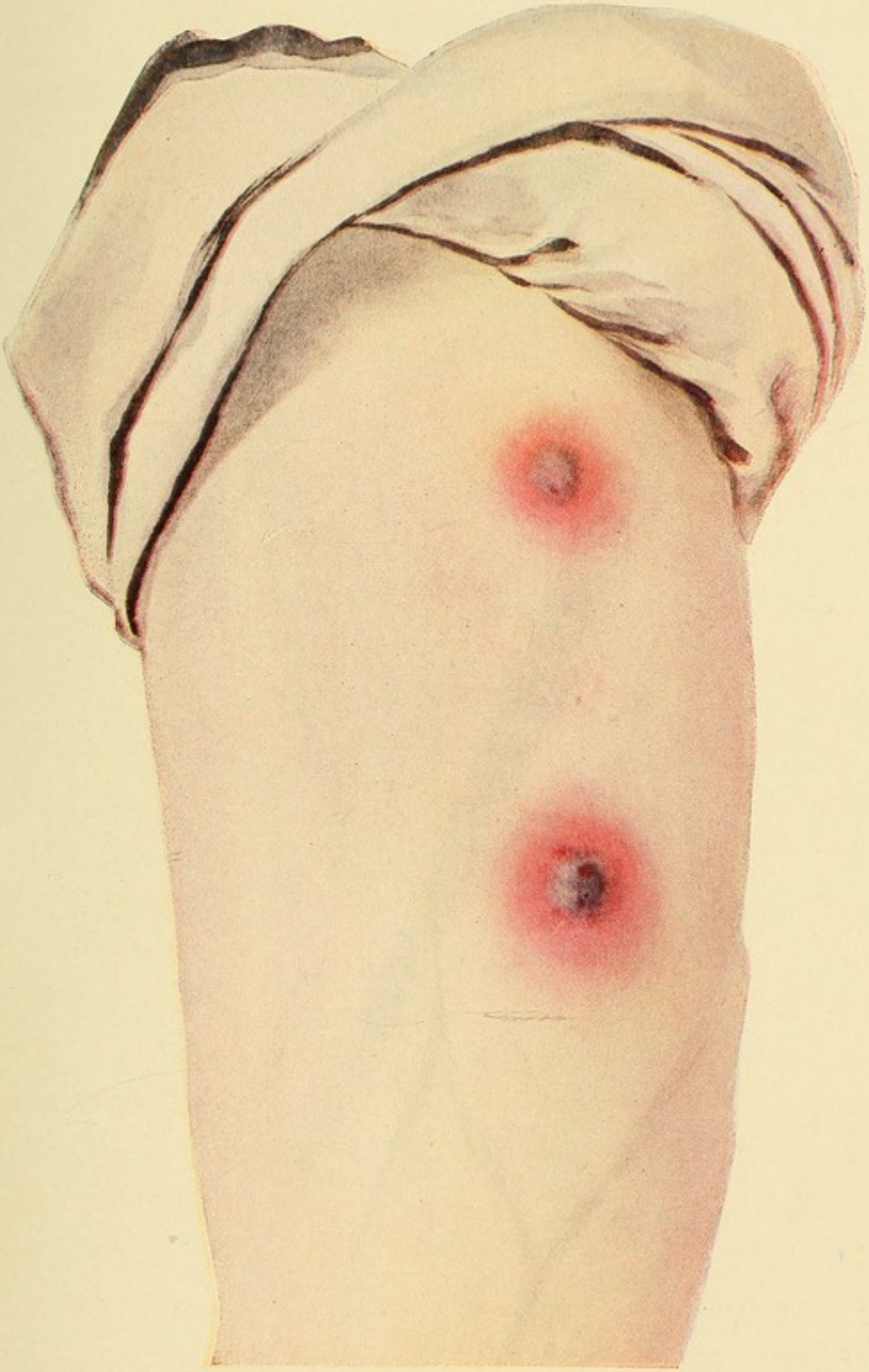
Female, aged 16 years. Hereditary syphilis, and interstitial keratitis of six months' standing. Salvarsan injected five months ago without good results. Wassermann reaction positive. Inoculated on June 17, 1911. The drawing was made on the fifth day. Both sites of the luetin injection show a tendency to pustulation. Marked telangiectasis.

cussed by dermatologists. To account for this phenomenon, Finger advanced the theory of superinfection, which presupposes that a trauma creates a spot of weakened resistance in the skin and that the syphilitic virus wanders thither from a hidden focus in the interior to set up the lesion. On the other hand, Neisser maintains that it is not the spirochæta that produces a syphilitic lesion after a slight trauma, because he failed to prove the presence of any spirochæta or infectious agent in the lesions; but he believes that it is due to a pathological condition of the skin itself, which he calls "Umstimmung." Among 315 cases of syphilis, I observed fifteen cases (one secondary, twelve tertiary, and two hereditary) in which the sites of the control emulsion reacted quite intensely. But these reactions were usually less intense than those produced by the luetin in the same persons. Furthermore, in these cases the induration remained much longer at the sites of luetin injection than at the control sites. In view of these results and of the additional fact that the majority of cases giving the positive skin reactions did not react to the control emulsion, I am of the belief that the reactions set up by the intradermic inoculation of luetin are not due to the abnormal irritative condition of the skin alone, but more to a specific allergic condition. It is, of course, possible that both conditions may be

coëxistent in the same patient, although the occurrence of "Umstimmung" appears, from my experience, to be far less frequent than that of allergy. In carrying out the cutaneous reaction for syphilis (as for any other infectious disease), it is highly important to provide adequate control observations to determine whether the state of "Umstimmung" exists only in syphilis, or whether it may not also occur in other diseases.

THE RESULTS OF THE CUTANEOUS REACTION IN MAN.

In all, 642 cases, comprising 315 syphilitics, 77 parasyphilitics, and 250 controls, have been studied. The results obtained in syphilitics are summarized in Table 25. The table shows that in cases of primary and secondary syphilis, which have had either insufficient treatment or none at all, no skin reaction occurred, except in a few instances. The reaction in the positive cases was always of the indurated papular variety. In one primary case, in which the skin test was applied before regular mercurial treatment was begun, a torpid reaction followed the administration of mercury. On the other hand, most of the secondary cases which had been mercurialized before the administration of salvarsan, and which remained without symptoms for some months after the salvarsan injections, gave striking and unmistakable reactions.



Male, aged 29 years. Chancre seven months ago, followed by secondaries. Six intramuscular injections of salvarsan, the last about three months ago. Developed exudative chorioiditis six weeks ago. The right eye shows typical exudative chorioiditis; the left eye is free from it. Wassermann reaction negative. Inoculated on June 23, 1911. The drawing was made on the sixth day. Between the two large luetin pustules there is a faint trace of the injection of the control material.

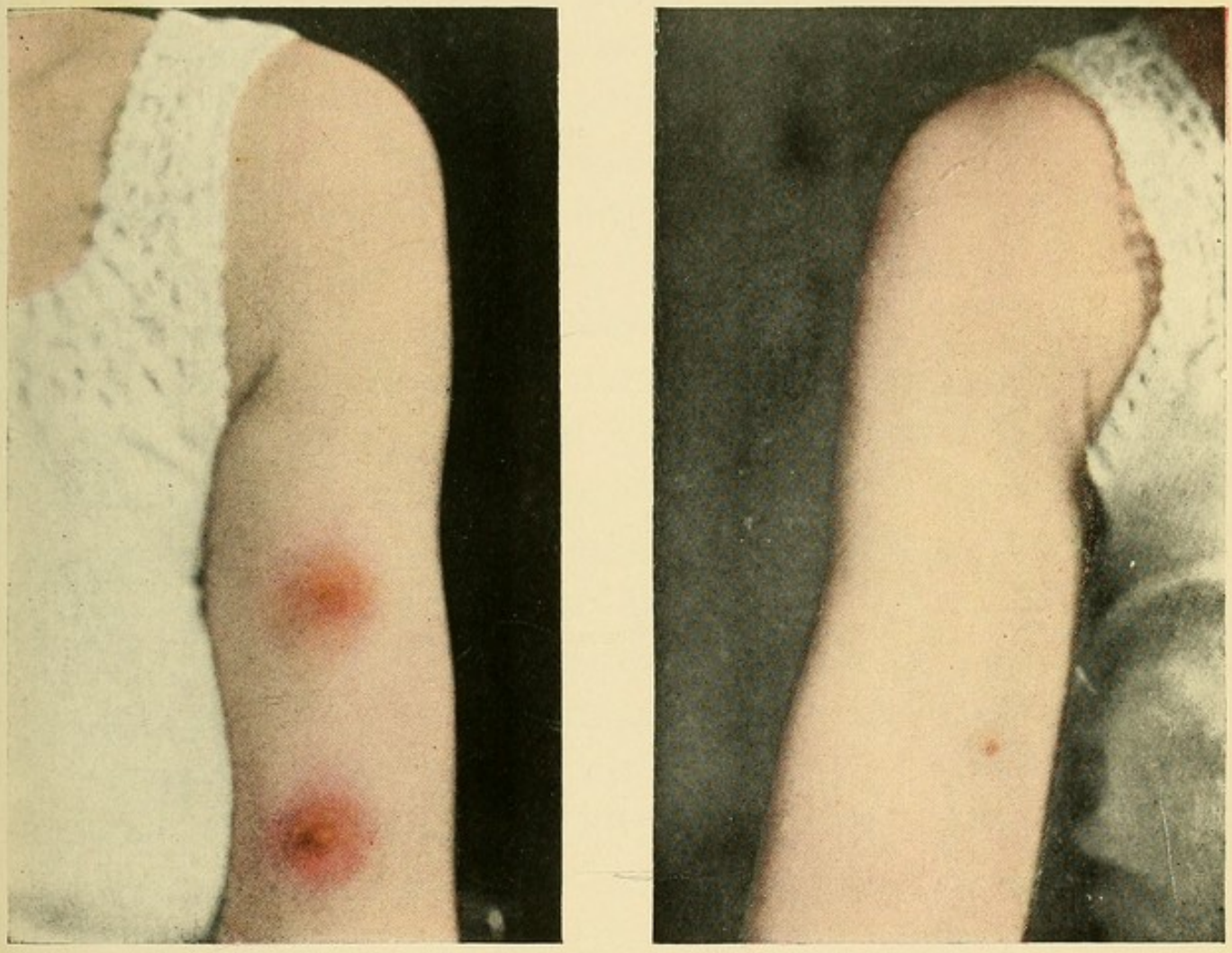
TABLE 25.—*Luetin Reaction in Various Syphilitic Conditions and in Controls.*

	Primary Syphilis		Secondary Syphilis				Tertiary Syphilis				Congenital Syphilis				Cerebro-spinal Syphilis		Latent Syphilis		Controls	
	Symptoms Present		Symptoms Present		Symptoms Absent		Symptoms Present		Symptoms Absent		Under 1 Year		Late Cases		Symptoms Present				Non-Syphilitic Cases	
Luetin reaction	+	−	+	−	+	−	+	−	+	−	+	−	+	−	+	−	+	−	+	−
No antisyphilitic treatment.....	..	13	..	..	..	..	..	..	..	..	..	..	..	..	..	..	24	6	..	250
Slight mercurial treatment.....	1	12	2	25	..	..	12	..	..	..	5	18	..	..	..	..	..	..	..	..
Regular mercurial treatment.....	..	..	..	..	14	3	31	..	29	1	1	3	15	1	5	5	..	..	..	..
Salvarsan and mercurial treatment .	..	..	1	..	42	12	..	..	22	3	..	..	9	..	..	..	..	..	..	..
	1	25	3	25	56	15	43	0	51	4	6	21	24	1	5	5	24	6	0	250
	26		99				98				52				10		30		250	
	315																			

Two distinct groups that give a negative or doubtful reaction occur among the salvarsan cases. One consists of cases showing a reappearance of the Wassermann reaction, but no other symptoms, and usually gives doubtful cutaneous reactions. The other, which, however, comprised only fifteen cases treated with salvarsan and mercury that remained without any clinical symptoms or Wassermann reaction for more than a year, gave no cutaneous reaction.

To this group also belong two interesting cases that have been under my observation since September, 1910. One was treated for gumma of the liver by an intramuscular injection of salvarsan by Dr. Kakels at the Lebanon Hospital. The large gumma promptly disappeared, and the patient has remained without symptoms for two years. The Wassermann reaction in this patient disappeared slowly but completely in about ten weeks. The blood, tested every two months, has remained negative. The skin test with luetin, made in August, 1911, and January, 1912, was negative. The other case is one of malignant syphilis, refractory to mercurial treatment. Three intramuscular injections of salvarsan were given in September and November, 1910, and in January, 1911. The Wassermann reaction disappeared soon after the healing of the extensive and

PLATE V.



Left. Right.

Female, aged 51 years. Became infected twenty years ago, and was treated moderately by Lassar in Berlin. Present symptoms: exostosis and stenosis of lacrimal canal. Wassermann reaction weakly positive. Luetin test on July 11th. The left arm shows two well marked pustules at the sites of the luetin injection, while the right arm shows a faintly visible trace on the control site. The photograph was taken on the sixth day. (Dr. S. Pollitzer kindly took this photograph for me.)

destructive lesions, and still remains negative. A luetin test made in August, 1911, and February, 1912, was negative. Both patients are now in excellent health. I have introduced these cases to illustrate the point that the allergic state of the skin in syphilis seems not to persist beyond a certain time after the probable complete eradication of the pallidum from the body. This point has been confirmed experimentally by rabbits treated with salvarsan.

The results in tertiary and late hereditary syphilis present a striking contrast to those observed in the earlier stages of the disease. The skin reacts intensely to luetin in these cases. The intensity of the reaction in these cases is probably increased by the state of "Umstimmung," but the constancy with which it appears suffices to render it a valuable clinical diagnostic aid. It is in this stage that syphilis manifests itself in its most diverse and often most obscure forms. A gumma or other tertiary lesion on the visible parts of the body offers but little diagnostic difficulty; but it is not always easy to ascertain the luetic nature of lesions of the internal or specific organs. In tertiary cases, moreover, the Wassermann reaction is frequently absent, especially after antiluetic treatment. Thus it is important to find that the skin reaction is more constant than the Wassermann reaction in tertiary syphilis. Two causes for a negative

Wassermann reaction in the tertiary stage may be distinguished. The first, which may apply also to latent syphilis, consists of the restraining power of the body upon the propagation of the pallidum together with the neutralization of its injurious products through the formation of antibodies. The second cause, which also operates in some primary and secondary cases, arises from the inability of the body to respond to the pallidum stimulus by the formation of the substances on which the Wassermann reaction depends.

The results of the luetin reaction in syphilis of the central nervous system appear less constant than is the Wassermann reaction, as long as the treatment remains ineffective, but, judged from my later observations, the luetin reaction develops in almost every case which had been treated energetically. In these well-treated cases the Wassermann reaction in the blood usually disappears. The cases of latent syphilis reported here consist chiefly of parents of the hereditary syphilitic cases reported in Table 25. Most of them became infected many years before and have remained without symptoms. Many of the mothers have, however, suffered miscarriages previous to or after the birth of their syphilitic children.

The controls include 50 non-syphilitic children between the ages of two and eighteen years, and 200

adults suffering from various diseases of non-syphilitic nature. These include tuberculosis, leprosy, pneumonia, typhoid fever, psoriasis, malaria, alcoholic psychosis, dementia præcox, gonorrhea, chancroid, brain tumor, eczema, epithelioma, carcinoma, etc. In none was a positive luetin reaction obtained.

The results thus far obtained in parasyphilitic cases are unsatisfactory and call for further study with more active preparations of the luetin. Seventy-two cases of general paralysis and five of tabes were studied. Of the seventy-two cases of general paralysis, forty-five reacted positively. In a few instances pustules were formed, but twenty-seven gave no reaction. Of five cases of tabes, three reacted positively. Among thirty-five controls of this series, consisting of fifteen cases of dementia præcox, six of alcoholic psychosis, and fourteen of other forms of psychoses, four reacted positively, and these were cases of dementia præcox. These patients were adults, and two of them gave positive Wassermann reactions. I incline, therefore, to the opinion that they had suffered either from congenital or acquired syphilis.

A large series of dermatological cases were studied by Orleman-Robinson, whose results are quoted below:

TABLE. 26.

	Number of Cases		Symptoms Present		Symptoms Absent		Total	
			Luetin	Wassermann	Luetin	Wassermann	L	W
Primary syphilis....	4	Positive reaction	0	3	....	....	+ 0	3
		Negative reaction	4	1	....	....	− 4	1
Secondary syphilis..	35	Positive reaction	20*	25‡	....	....	+20	25
		Negative reaction	15†	10	....	....	−15	10
Tertiary syphilis....	17	Positive reaction	13	8	4	2	+17	10
		Negative reaction	0	5	0	2	− 0	7
Latent syphilis	5	Positive reaction	2	1	3	0	+ 5	1
		Negative reaction	0	1	0	3	− 0	4
Congenital syphilis..	2	Positive reaction	1	1	1	1	+ 2	2
		Negative reaction	0	0	0	0	− 0	0

* Under regular treatment. † No or slight treatment.
‡ The majority only slightly treated.

TABLE 27.

CONTROL CASES

	Number of Cases	Luetin Reaction Positive	Luetin Reaction Negative
Acne vulgaris	9	1*	8
Alopecia areata	3	..	3
Bromide eruption	1	..	1
Carcinoma	6	..	6
Darier's disease	1	..	1
Eczema (various forms)	15	..	15
Erythema multiforme	4	..	4
Erythema toxicum	3	..	3
Herpes zoster	5	..	5
Ichthyosis	2	..	2
Keloid	2	..	2
Lupus erythematosus	6	..	6
Molluscum contagiosum	1	..	1

* A woman of 40 years of age with a questionable history, admits two miscarriages and is a chronic alcoholic subject. The Wassermann reaction could not be performed, as she objected, and would have been of no avail on account of her constant usage of alcohol. Syphilis cannot be excluded from this case.

TABLE 27, Control Cases—Continued

	Number of Cases	Luetin Reaction Positive	Luetin Reaction Negative
Pityriasis rosea	2	..	2
Psoriasis	14	..	14
Sarcoma (Kaposi)	1	..	1
Scabies	10	..	10
Sycosis	3	..	3
Tinea versicolor	2	..	2
Trichophytosis	4	..	4
Tuberculosis pulmonalis	12	..	12
Xanthoma	2	..	2
	108	1	107

Nobl and Fluss examined 100 dermatological cases at Wiener allgemeine Poliklinik, and made the following preliminary report:

Luetin reaction	Primary stage	Secondary stage	Gummatous stage	Late latency	Parasyphilis	Hereditary syphilis	Controls
Marked	2	21	1	9	2	1	3*
Weak	1	15	..	3	..	1	3*
None	4	26	..	4	..	1	3*
Total	7	62	1	16	2	3	9

* 4 out of the 8 control cases gave positive Wassermann, one case not tested.

These authors regret not having had larger numbers of tertiary and latent cases in which the luetin reaction is expected to come out more constantly positive. They state also that from those control cases which responded to the luetin test a possibility of existing luetic infection is hard to rule out, and there were, indeed, 4 cases giving positive Wassermann reaction among the total 8 (1 case not tested for the serum reaction) examined. It will be seen that the luetin

reaction was negative in three out of the four Wassermann negative cases.

Martin Cohen applied the luetin test to ophthalmological cases, and obtained the following results:

TABLE 28.

Name of disease	Number of cases	Clinical manifestations +	Clinical manifestations −	Recently treated	Not recently treated	Wassermann +	Wassermann −	Cutaneous reaction +	Cutaneous reaction −
1. Interstitial keratitis	20	12	8	12	8	12	8	11	9
2. Kerato-iritis	3		3	1	2	2	1	2	1
3. Keratitis marg. profunda	1		1		1		1	1	
4. Keratitis neuro-paralytica	1		1		1		1		1
5. Keratitis disciformis	1		1		1	1			1
6. Acute iritis	4	3	1	2	2	2	2	4	
7. Irido-cyclitis (acute)	3	1	2	2	1	1	2	2	1
8. Irido-choroiditis	1	1			1	1		1	
9. Choroiditis exud. (acute)	1		1		1		1	1	
10. Iritis serosa	1		1		1		1		1
11. Scleritis	1		1		1		1		1
12. Optic neuritis	3	2	1	1	2		3	3	
13. Opt. atrophy (prim. 3, sec. 2)	5	1	4	1	4	5		4	1
14. Chorio-retinitis	1	1		1			1	1*	
15. Retinitis proliferans	2		2		2		2		2*
16. Detachm. of retina	1		1		1		1		1*
17. Detachm. of retina (traumatic)	1		1		1		1		1
18. Retinitis prolif. (traumatic)	1		1		1		1		1
19. Macular choroiditis	1		1		1		1		1
20. Abducens paralysis	2	2		2		1	1	2	
21. Ophthalmopl. externa	1		1		1		1	1	
22. Thrombosis, cent. art. inf. br.	1		1		1		1		1
23. Anisocoria	1		1		1	1		1	
24. Stenosis lachr. canal.	1	1		1		1		1	
25. Puls. exophthalmos (idiop.)	1		1		1	1		1	
26. Orbital tumor	1		1	1			1		1
	60	24	36	24	36	28	32	36	24

* T. B. C. test + + = positive, − = negative.

A { I. Cutan. test +, clin. evid. +, Wasserm. +, 12 cases
  { II. Cutan. test −, clin. evid. −, Wasserm. −, 16 cases
28 cases

B { I. Cutan. test +, clin. evid. −, Wasserm. −, 3 cases*
  { II. Cutan. test −, clin. evid. +, Wasserm. +, 11 cases†
14 cases

C { I. Cutan. test +, clin. evid. +, Wasserm. −, 2 cases
  { II. Cutan. test +, clin. evid. −, Wasserm. +, 6 cases
  { III. Cutan. test −, clin. evid. −, Wasserm. +, 7 cases‡
  { IV. Cutan. test −, clin. evid. +, Wasserm. −, 3 cases‖
18 cases

60 cases

* These 3 cases may belong to latent syphilis in which no clinical or serological manifestations are present.

† These 11 cases belong to untreated or only slightly treated early syphilis.

‡ These 7 cases may belong to precose latent stage where the clinical symptoms had disappeared, but the luetin reaction has not yet developed.

‖ These 3 cases belong to an anomalous type of patients in whom the Wassermann develops very slowly or may altogether remain missing. The luetin reaction has not developed yet.

The following cases are cited here from his observations as they illustrate the practical value of the luetin reaction in this class of patients.

1. *Orbital Tumor.*—A married woman, 31 years of age, exhibited unilateral exophthalmos, orbital periostitis, ocular paralysis and keratitis lagophthalmos. Antiluetic treatment had resulted in no improvement. The Wassermann was negative. The luetin test was negative. Pathological examination of the specimen following the Kronlein operation for orbital tumor showed it to be a fibro-endothelioma.

2. *Case of Pulsating Exophthalmos, Bilateral.*—A married man, 43 years of age, whose wife had had three miscarriages, exhibited eleven months ago a protrusion of the right eyeball; five weeks later the left eye also began to protrude. There were also paralysis of both external recti and anæsthesia of both corneæ. Pupillary reactions normal. Visual fields normal. Vision markedly diminished, more on the right side than on the left. Veins of both upper lids congested, also the veins of both ocular conjunctivæ. Ophthalmoscopic examination showed dilatation and tortuosity of the retinal veins on the left side, but the right fundus was normal. A distinct bruit was heard over the left eyeball and left temple. Wassermann and cutaneous reactions both positive.

Four months before the patient was first seen he had begun to complain of roaring and buzzing noises in the head and of severe frontal headaches; but there were no other symptoms. No serious previous illness or trauma. The patient denied syphilis.

After treatment with inunctions and grey powder for two months the exophthalmos in the right eye disappeared entirely and improved somewhat in the left eye; the paralysis of the external recti and the corneal anæsthesia disappeared on both sides; the venous engorgement in the upper lids disappeared on the right side and diminished on the left, but the congestion of both ocular conjunctivæ persisted. Vision improved from 20-200 to 20-40 in the right eye, and from 20-50 to 20-30 in the left eye. The symptoms, viz., the buzzing and roaring, disappeared entirely and the general condition improved markedly. The Wassermann and luetin tests are still both positive.

3. *Abducens Paralysis.*—A patient, 40 years of age, acquired syphilis three years ago, and has been energetically treated with injections of salicylate of mercury since then. Diplopia developed three months ago. Wassermann negative. Cutaneous reaction positive. Eye condition has improved greatly since salvarsan was administered and mercury readministered.

4. *Acute Iridocyclitis, Unilateral.*—A man, 29 years of age, had a chancre seven months ago, followed by secondary manifestations. Treated with six intramuscular injections of salvarsan, each 0.3 gm. Despite the treatment eye symptoms developed two months ago. Wassermann repeatedly negative, luetin reaction strongly positive.

On several occasions during the first part of 1912, I had the opportunity of demonstrating the luetin reaction before different medical societies. On these occasions the patients were placed at my disposal at whatever place the meetings took place. The observations on the results of the tests were absolutely objective, being made by all those who happened to be present at the time of demonstrations. I thought it of interest to the readers to see how these demonstrations turned out. Below will be presented the results obtained at Chicago and St. Louis.

I. Chicago Medical Society Series.

Case 1.—N. M., American woman, aged 29, clinic patient of Drs. Baum and Corbus. Present condition: Early secondary lues. Treatment: Mercury rubbings. Wassermann reaction not taken. Luetin mild positive, Mar. 14, 1912.

Case 2.—F. B., white man, aged 44, clinic patient of Drs. Baum and Corbus. Present condition: Latent secondaries. Chancre in October, 1910. Treatment: Mercury rubbings and internal. Wassermann positive. Luetin papular distinct (positive), Mar. 14, 1912.

Case 3.—J. D., American man, aged 34, clinic patient of Drs. Baum and Corbus. Present condition: Latent secondaries. Infected two years ago. Treatment: Mercury rubbings. Salvarsan injected in oil suspension 0.6 gm. Wassermann positive. Luetin mild positive, Mar. 14, 1912.

Case 4.—S. B., American man, aged 26, clinic patient of Drs. Baum and Corbus. Present condition: Recurrent secondaries. Treatment: Mercury rubbings intermittent. Wassermann positive. Luetin positive, Mar. 14, 1912.

Case 5.—W. H. W., American man, aged 23, clinic patient of Drs. Baum and Corbus. Present condition: Marked secondaries. Treatment: Salvarsan in oil suspension, February, 1912. Mercury intermittent. Wassermann not made. Luetin positive, Mar. 14, 1912.

Case 6.—L. J., colored man, aged 23, clinic patient of Drs. Baum and Corbus. Present condition: Secondaries. Eighteen months since treatment. Treatment: Intravenous injection of salvarsan eight months ago. Mercury rubbings. Wassermann positive. Luetin suppuration on both arms. No difference between control and luetin (Umstimmung?), Mar. 14, 1912.

Case 7.—C. K., German man, aged 22, clinic patient of Drs. Baum and Corbus. Present condition: Secondary period. No symptoms. Chancre four years ago. Treatment: Mercury rubbings. Salvarsan—intravenous injection May 20, 1911; June 7, 1911; October, 1911; November, 1911. Wassermann not taken. Luetin papular reaction distinct positive, Mar. 14, 1912.

Case 8.—H. K., American man, aged 46, clinic patient of Drs. Baum and Corbus. Present condition: Cerebral gumma. Treatment: Mercury intermittent. Wassermann positive. Luetin large full indurated papule. Typical positive reaction, Mar. 14, 1912.

Case 9.—J. S., colored man, aged 34, clinic patient of Drs. Baum and Corbus. Present condition: Probable tertiary. No history. Treatment: Internal about one year. Wassermann positive. Luetin positive with Umstimmung, Mar. 14, 1912.

Case 10.—A. M., American woman, aged 21, clinic patient of Dr. Stein. Present condition: Congenital lues. Treatment: None at any time. Wassermann negative. Luetin positive, Mar. 14, 1912.

Case 11.—C. H., American man, aged 16, clinic patient of Drs. Baum and Corbus. Present condition: Congenital lues. Treatment: Mercury intermittent. Wassermann positive. Luetin positive. Slight Umstimmung, Mar. 14, 1912.

Case 12.—W. J. H., American man, aged 42, clinic patient of Dr. Grinker. Present condition: Paresis. Probably infected twenty years ago. Treatment: Neglected. Salvarsan injected intravenously by Dr. Corbus Dec. 1, 1911, and Feb. 5, 1912. Vigorous mercury rubbings between salvarsan injections. Wassermann positive, Nov. 28, 1911. Luetin positive, Mar. 14, 1912.

Case 13.—Control case. S. C., colored man, aged 37, clinic patient of Drs. Baum and Corbus. Present condition: No history of initial lesion. No secondaries. Believed to have been infected twenty years ago. Treatment: Mercury intermittent. Wassermann negative. Luetin negative, Mar. 14, 1912.

Case 14.—C. D., American man, aged 26, private patient of Dr. Corbus, treated after the biologic method. Present condition: Probably cured. Tonsillar chancre, November, 1910. Treatment: Salvarsan injected intramuscularly, Nov. 7, 1910, and Dec. 15, 1910. Wassermann positive, Nov. 28, 1910; negative, Jan. 23, 1911; negative, May 9, 1911; negative, March 12, 1912. Luetin negative, Mar. 14, 1912.

Case 15.—F. S., American man, aged 22, private patient of Dr. Corbus, treated after the biologic method. Present condition: Early secondaries. Last symptoms, Sept. 4, 1911. Treatment: injected salvarsan in oil suspension, Sept. 4, 1911; intravenously, Feb. 6, 1912. Vigorous mercury rubbings between salvarsan injections. Wassermann negative, Jan. 16, 1912. Luetin positive, Mar. 14, 1912.

Case 16.—C. L., American man, aged 38, private patient of Dr. Corbus, treated after the biologic method. Present condition incipient tabes. Infected eleven years ago. Treatment: Salvarsan injected intramuscularly, Jan. 9, 1911, and March 5, 1911; intravenously, Oct. 6, 1911, and Jan. 13, 1912. Vigorous mercury rubbings between injections. Wassermann positive, Nov. 28, 1910; positive, Feb. 23, 1911; negative, July 7, 1911; negative, Oct. 6, 1911; negative, Jan. 9, 1912. Luetin negative, Mar. 14, 1912.

Case 17.—M. A., American man, aged 36, private patient of Dr. Corbus, treated after the biologic method. Present condition: Secondaries.

Last appearance of palmar syphilis, seven months ago. Treatment: Injected salvarsan intramuscularly, Jan. 28, 1911; intravenously, Mar. 18, 1911; intramuscularly, August, 1911. Vigorous mercury rubbings between salvarsan injections. Wassermann negative, Aug. 22, 1911; negative, Jan. 16, 1912. Luetin positive, Mar. 14, 1912.

Case 18.—P. S., American man, aged 22, private patient of Dr. Corbus, treated after the biologic method. Present condition: Cured. Primary lesion, Jan. 21, 1909. Treatment: Vigorous mercury rubbings. Cure obtained before salvarsan was administered. Injected salvarsan intramuscularly, Jan. 17, 1911. Wassermann negative, Dec. 10, 1910; Feb. 15, 1911; April 15, 1911; Aug. 1, 1911, and Dec. 15, 1911. Luetin negative, Mar. 14, 1912.

Case 19.—O. J. G., American man, aged 31, private patient of Dr. Corbus, treated after the biologic method. Present condition: Latent secondaries. Chancre, September, 1905. Last symptoms, Oct. 20, 1910. Treatment: Neglected at first. Injected salvarsan intramuscularly, Oct. 20, 1910, and Dec. 11, 1910; intravenously, Sept. 2, 1911, and March 9, 1912. Vigorous mercury rubbings between salvarsan injections. Wassermann positive, Nov. 11, 1910; negative, Jan. 1, 1910; positive, March 8, 1912. Luetin positive, Mar. 14, 1912.

Case 20.—A. G., American man, aged 20, private patient of Dr. Corbus, treated after the biologic method. Present condition: Secondaries. Infected Jan. 1, 1911. Last symptoms May 6, 1911. Treatment: Internal. Salvarsan injected in oil suspension, 0.6 gm., May 6, 1911; intravenously, 0.4 gm., Feb. 24, 1911. Vigorous mercury rubbings between injections of salvarsan. Wassermann positive, April 20, 1911, and March 4, 1912. Luetin positive, Mar. 14, 1912.

II. St. Louis Medical Society Series.

	Luetin	*Wassermann*
St. Louis Hospital.		
1. Conner, infection 6 months, one month ago rupial eruption, almost well, Hg med..	Negative	Three weeks ago positive
2. Willard, 2 months ago, initial lesion, 3 weeks ago, secondary, 3 weeks ago, 0.6 gm. salvarsan	Positive	Positive

	Luetin	*Wassermann*
3. Hoffman, three penis lesions, probably chancroidal.	Negative	Negative
4. Morelock, initial lesion 6 weeks ago.	Negative	Positive
5. Smith, mac. pap. erup. appearing 3 weeks ago, initial lesion 42 days ago.	Negative	Positive
6. Dunroy, 12 years ago initial lesion, sores on lower lip, lingua geogr.	Positive	Positive
7. Wagner, trauma of nose simulating saddle nose. No history of lues.	Negative	Negative
8. Murphy, 6 years ago initial lesion, 3 months ago ulcerative lesions on legs, 3 weeks ago salvarsan intramusc. ...	Positive	Negative
9. Wilson, 9 years old infection, saddle nose, etc.	Positive	Negative
10. Pender (control), gonor. arthritis.	Negative	Negative
11. Brown (control), gonor. acuta.	Negative	Negative
Alexian Bros. Hospital Cases.		
12. McLaughlin, diagnosis ?	Negative	Negative
13. Carstaphan, general paresis...	Negative	Positive blood and c. s. fld.
14. Shaffner, C. sp. lues.	Positive	Positive
15. Mack, definite history lues. ..	Positive	Positive
16. Baby, Dr. Lipman's case, 6 weeks old, congenital syphilis (case has yielded to Hg medication).	Negative	Blood of mother negative

	Luetin	*Wassermann*
17 Pearson (Dr. Schuchat), primary lesion, 3 weeks old, classical Hunterian chancre, spirochæta in dark field....	Negative	Positive
18. Lewis, suspicious sore on penis, no spirochæta found in dark field.	Negative	Negative
St. Louis City Hospital Medical Cases:		
19. Stebbins, liver syphilis, tertiary	Positive (Umstimmung)	Positive
20. Franklin, gall-bladder ?	Negative	Negative
21. Burke, surgical (control)...	Negative	Negative
22. Brown, diabetes bronze, liver cirrhosis	Negative	Negative
23. Broadwell, tertiary syphilis (Dr. Englebach)	Positive	Negative
24. Barrows (Dr. Richeter), aneurism aortæ	Positive (Umstimmung)	Negative
25. McLaren, aneurism aortæ....	Positive (Umstimmung)	Positive
26. Carmody (control).....	Negative	Negative
27. Coff (control).....	Negative	Negative
28. Broskow (control)	Negative	Negative
29. DeWorth (Dr. Meisenbach), 5 years' treatment, 3 Wassermanns by 3 different men negative. This test applied 2 years after treatment stopped	Negative	Negative
30. Carman, latent, 3 years after infection, sores in mouth, salvarsan administered. Test to be repeated	Positive	Positive
31. Crohn (Dr. Suggett), tertiary lesion nose	Negative	Positive

	Luetin	*Wassermann*
32. Dr. R. S. B., old well-treated case, blood tested repeatedly, always negative.....	Negative	Negative
33. G. T. (Dr. Harris), incipient tabes	Negative	Positive
34. Brankston, syphilis 4 years, very little treatment, sore throat, enlarged glands, etc.	Positive	Positive
35. Walsh (Frisco Hosp.), man unconscious, aphasia, etc. Test applied, but death ensued in 24 hours, no P. M...	?	Positive
36. Rice, old case, well treated..	Negative	Negative
37. Rowe, cong. case, supposed reinfection, and reported as such. (Drs. Sugget & Graves).	Negative	Negative
38. Wolfert, 5 years' infection, very little treatment, liver up to 3d rib, 3 Wassermanns in 6 weeks negative.....	Positive (Umstimmung)	Positive, after KI for 10 days.
39. Arnold, well-treated case for 6 years, 3 Wassermanns in last 2 years, negative.....	Negative	Negative
40. Mrs. Norris (Dr. Graves), c. sp. lues (osteomalacia or neurasthenia), 3 blood tests positive. Husband's blood negative.....	Positive (Umstimmung)	Positive
41. Kelly, mac. pap. syph. severe type 1 year ago, constitutional symptoms pronounced, fever, etc., Salvarsan at that time followed by Hg. No symptoms now.....	Positive	Positive
42. Mennie (Dr. Chilton), case 5 years old, palmar syphilis last year over hands like a gauntlet. Salvarsan alone cleaned it up, resistant to Hg		

	Luetin	*Wassermann*
altogether. Three intravenous injections in past year..	Positive	Negative
43. Steyns (Dr. Dorsett), supposed syphilis, stricture rectum, no history.....	Negative	Negative
44. Ernst, optic nerve atrophy, luetic case one and a half years old, salvarsan intramusc. 1 year ago into hip. One week ago another salvarsan intravenous injected with Hg injections now being taken.	Negative	Positive

The above series of cases, though limited in number and varieties, confirm practically all essential points brought out by different investigators that the luetin is specific for syphilis, and occurs most constantly and intensely during the period of tertiary syphilis. In primary or secondary stages the luetin reaction is usually absent or very mild, while it may become more intense after the energetic treatment. In congenitally syphilitic infants it is less marked than after many years' duration, when the reaction becomes more pronounced and constant.

The recent investigations of Julian Wolfsohn on the luetin reaction made at the Johns Hopkins Hospital, in the medical division under Professor L. F. Barker, are particularly interesting and valuable, as the varieties of diseases studied by him were chiefly

internal where syphilis may play important parts in etiology and a specific diagnostic test may find its practical usefulness. The following table shows the results of his study:

TABLE 29.

Secondary Syphilis.

Diagnosis	Treatment	Luetin reaction	Wassermann	Remarks
Secondary syphilis (maculopapular)	"606" 24 hrs. before luetin test given	+	+	Temp. 99.8°
Secondary syphilis	"606" given 48 hrs. before luetin test	+	+	–
		2	2	

Tertiary Syphilis.

Diagnosis	Previous treatment	Luetin reaction	Wassermann reaction Blood	Wassermann reaction C. S. F.	Remarks
Syphilitic cirrhosis of liver. Pulmonary tuberculosis	1896–1899 long intervals	–	+	Not done	–
Syphilitic periostitis	3 months. Chancre, secondaries	+	+	Not done	Large axillary glands
Syphilitic periostitis	None (no hist.)	+	+	Not done	–
Syphilitic periostitis. *Gummata*	None (no hist.)	+	+	Not done	–
Hemiplegia. Arteriosclerosis	"606" 1 yr. previously. No hist.	+	–		–
Luetic periostitis. Polyarthritis	None (no hist.) Miscarriage.	+	+	Not done	Tender arm
		5 positive 1 negative	5 positive 1 negative		

Latent Syphilis.

Diagnosis	Previous antisyphilitic treatment	Luetin reaction	Wassermann reaction Blood	Wassermann reaction C. S. F.	Remarks
Acute lobar pneumonia	2 months(chancre, 1909)	+	−	Not done	−
Typhoid fever (?)	1–2 days secondaries, 1900	+	−		Very tender axillary glands 2 wks.
Pulmonary tuberculosis	1 yr. constantly (chancre, 1911)	+	−	Not done	−
Subacute appendicitis	None (no hist.)	+	−	Not done	−
Aortic insufficiency	None (no hist.)	+	−	Not done	−
Pregnancy	None (macerated fœtus)	+	+	Not done	−
Brain tumor. Hysteria	6 mos. (chancre, 1895)	+	−		−
Latent syphilis. "Basilar meningitis"	"606" 1911 (chancre, 1873)	+	−	Not done	−
Hysteria?	None (no hist.)	+	−	Not done	−
Rheumatic fever. Syphilis (Wassermann)	None (no hist.)	+	−	Not done	Nodules were very tender
Chronic nephritis	None (no hist.)	+	−	Not done	−
Splenic anæmia	None (chancre, 1904) (cauterized)	+	−		Tachycardia to 100. Abdominal pain over enlarged spleen
Posterior urethritis. Tuberculosis. Syphilis (Wass.)	None (no hist.)	+	+	Not done	−
Catarrhal jaundice. Syphilis (Wass.)	None (no hist.)	+	+	Not done	−
Hysteria. Syphilis (Wass.)	1 year at intervals	+	+	Not done	Bone pains and nausea 12 hrs. after injection Temp. 99.8°

Latent Syphilis.—Continued.

Diagnosis	Previous antisyphilitic treatment	Luetin reaction	Wassermann reaction Blood	Wassermann reaction C.S.F.	Remarks
Acute bronchitis. Syphilis (Wassermann)	None (no hist.)	+	+	Not done	−
Pulmonary tuberculosis. Syphilis?	None (no hist.)	+	−	Not done	−
	(Patient has old iritis)	+	−		−
Carcinoma of head of pancreas	None. Chancre, 1872	+	−	Not done	−
Paroxysmal tachycardia. Syphilis (Wass.)	None (no hist.)	+	+	Not done	−
Pregnancy. Syphilis (Wass.)	None (macerated fœtus)	+	+	Not done	−
Pregnancy. Syphilis (Wass.) in child	None (macerated fœtus)	+	−	Not done	−
Hemiplegia	No hist. No treatment	+	−	Not done	−
Carcinoma of jaw	Treatment 1 mo. each year, for 10 yrs. (chancre 1902)	+	+	Not done	−
		23 positive 0 negative	8 positive 15 negative		

Parasyphilis.

Diagnosis	Previous antisyphilitic treatment	Luetin reaction	Wassermann reaction Blood	Wassermann reaction C.S.F.	Remarks
Cerebrospinal syphilis. Beginning dementia paralytica	*3 days.* Chancre, 1899. Iritis, 1899	+	+		Tachycardia to 110.
Myocardial insufficiency. Aortic insufficiency. Syphilis (Wass.)	3 weeks. Chancre, 1887	−	+	Not done	−
Transverse myelitis	3–4 months. Chancre, 1902.	+	−	Not done	−
	Secondaries	+	−		Not done
Myocardial insufficiency. Aortic insufficiency	None. Secondaries, 1911	+	−	Not done	−
Aneurism aortic arch	None. Chancre, 1908	+	−	Not done	−
Myocardial and aortic insufficiency	None (no hist.)	+	−	Not done	−
Myocardial insufficiency	None (no hist.)	+		Not done	−
Myocardial insufficiency	None (no hist.)	+	−		−
Aortic insufficiency	1 year. Chancre, 1899. Secondaries, 1899	+	−	Not done	−
Dementia paralytica, C. S. Lues	Short while? Chancre	+	−		−
Aneurism of aortic arch. Myocardial insufficiency. Syphilis (Wass.)	None	+	+	Not done	−
Aneurism of abdominal aorta. Syphilis (Wass.)	3 mos. (1890) (primary and secondaries)	+	+	Not done	−

Parasyphilis.—Continued.

Diagnosis	Previous antisyphilitic treatment	Luetin reaction	Wassermann reaction Blood	Wassermann reaction C. S. F.	Remarks
Tabes dorsalis. Acromegaly. Syphilis (Wass.)	1 mo. 1897, 3 doses of "606" 1911–1912. Primaries and secondaries	+	+1911 +1912 −1912		−
Arteriosclerosis. Aortic insufficiency. Syphilis (Wass.)	3–4 weeks, 1900. Primaries and secondaries	+	+	Not done	−
Myocardial insufficiency. Aortic insufficiency. Syphilis (Wass.)	1 week (1889). Chancre	+	+	Not done	−
Myelitis	None	+	−	Not done	−
Tabes dorsalis. Chancre. Nephritis	3 months (1887). Chancre	+	−		−
Aneurism of aortic arch	1 year, 1892. Chancre	+	+	Not done	−
Tabes dorsalis	None (no hist.)	+	−		Fever to 103°, pain in abdomen, vomiting and nausea beginning 30 hours after and lasting 4 days.
		18 positive 1 negative	10 positive 1 negative	1 C. S. F. positive	

The foregoing series was accompanied by a series of non-syphilitic cases. Of the seventy controls in which the patients were suffering from diseases other

than syphilis, *e.g.*, soft chancre, mitral insufficiency, myocardial insufficiency, cancer of the tonsil, acute rheumatic fever, pregnancy with still-born infant, senile palsy, bronchitis, brain tumor, diabetes mellitus, pleurisy with effusion, pericarditis, hypophysis tumor, pernicious anæmia, epilepsy, peliosus rheumatica, sarcoma of the ileum, myelogenous leukæmia, carcinoma ventriculi, thyreoid cyst, pulmonary tuberculosis, chronic nephritis, rickets, chronic constipation, gastric ulcer, uræmia, typhoid fever, and infectious arthritis, etc., when no history of syphilitic infection could be obtained and where the Wassermann reaction was negative in each case, no positive luetin or control reactions were obtained. In two cases, small non-indurated pustules developed within 3 days after the injection, but these easily could be distinguished from the positive reactions. No constitutional symptoms were complained of or noted in these cases.

The analysis and discussion of the above cases by Wolfsohn are quoted below, as they bring out many interesting and instructive points regarding the luetin reaction in its relation to clinical manifestations and the Wassermann reaction.

Secondary Syphilis.—Two cases of secondary syphilis, both in the maculo-papular stage, were inoculated. In each case the Wassermann reaction was positive and each patient had been given 0.4 gram

salvarsan intravenously 24 to 48 hours before the test was given. Both tests were positive. In the first case the salvarsan had been administered only 24 hours before, but the reaction to the luetin, although delayed till the fifth day, was definitely positive. No constitutional symptoms or reaction over the site of injection of the control emulsion ("Umstimmung") were noted.

Tertiary Syphilis.—This series includes six cases, in which the Wassermann reaction was positive in five. The sixth patient had had 0.6 gram of salvarsan one year before admission and his test proved negative both for blood-serum and cerebrospinal fluid at this time. The Wassermann was positive in 1911, however. The luetin reaction in this case was positive. In the first case of this series the luetin reaction was negative though the Wassermann was positive. This case was not followed longer than 10 days.

The reaction in four cases of luetic periostitis was of the violent variety and showed early pustule formation and rather marked reaction on the control side ("Umstimmung"). Two of these complained of tender and painful arms and one developed enlargement of the axillary glands. All these manifestations disappeared in the following 48 hours.

It is interesting to note that, in one case, two weeks after subsidence of the local manifestations

there was a flare-up at the site of the injection of luetin. A pustule formed and rapidly disappeared, leaving no other signs than slight desquamation and pigmentation.

The rapidity with which the reaction becomes manifest, the ease with which it is interpreted, together with the almost constant development of it, in this stage of the disease, makes it a most valuable aid in diagnosis. It not only checks up the Wassermann reaction, but it may be indeed supplementary to it, especially in the treated cases, in which the Wassermann reaction not infrequently may be negative.

Parasyphilis.—If one accepts the newer conception of parasyphilis he will include not only tabes and general paresis, *but* those cases which show vascular changes of luetic origin, *e.g.*, cases of syphilitic mesaortitis and aortic aneurisms. Therefore, included in this series are nineteen cases, seven of which are of central nervous system affection, and twelve of cardiovascular disturbance.

A careful analysis of these cases shows the great value of the luetin test. Of the former cases all seven gave positive tests, while the Wassermann test was negative in six.[1] One of these, a tabetic, had a

[1] Of course one must keep in mind the limited number of cases that the luetin test has been tried on; the result, however, even in this small series has been striking.

positive Wassermann reaction one year previously and had had in the interim three doses of salvarsan, but the cerebrospinal fluid still gave a positive Wassermann test. The luetin reaction in this case was violent, the reaction over the site of control injection ("Umstimmung") being especially noticeable, as it was also in five of these cases.

Another tabetic, who showed no other signs than diminished knee-kicks and sluggish pupils, developed remarkable constitutional symptoms, beginning 30 hours after inoculation and lasting four days. These symptoms consisted of fever as high as 103°, pain in the abdomen resembling crises, with nausea and vomiting. The reaction was violent and "Umstimmung" was present. The Wassermann reaction was negative, both for blood-serum and cerebrospinal fluid in this case. This patient had never received treatment previous to this time.

Of the twelve parasyphilitics showing cardiovascular lesions, eleven gave positive luetin reactions and one reacted negatively. Only seven showed positive Wassermann reactions. The one case giving a negative luetin test had a positive Wassermann reaction. But six of this series giving negative Wassermann reactions gave positive luetin tests. It is in this group of cases in which great care must be exercised, as one might readily consider the test negative if it were not watched for some time. Six of these twelve cases

showed reactions of the torpid form, no sign of the reaction appearing till the ninth day, and in one case of abdominal aneurism, which gave a positive Wassermann test, there was no manifestation until the twenty-eighth day. The luetin reaction will prove of great value in this type of case, if properly followed, because the Wassermann tests are relatively inconstant. "Umstimmung" is infrequent here as compared with cases of parasyphilis of the central nervous system. No other cases showing constitutional symptoms were noted.

Latent Syphilis.—This stage of syphilis shows a wonderful constancy of results with this test. In the 23 cases of latent syphilis tested all gave positive reactions. The Wassermann reaction in this series was positive only in ten cases. In three of these cases the Wassermann reaction on the cerebrospinal fluid was also negative.

Some of the cases reported in this group denied having contracted syphilis, but after the luetin test was found positive, in several instances the patients confessed having had a primary lesion or secondary manifestations. The test was applied in four cases of pregnancy, three of which were completed by the birth of macerated fœtuses and the fourth by the birth at term of a still-born infant. All four patients denied infection. The three former patients reacted "violently" to the luetin and showed "Umstim-

mung." The Wassermann reaction was positive and an anatomical diagnosis of syphilis in the infant was made in each case. The fourth case gave a negative luetin reaction, the Wassermann reaction was negative, and no signs of syphilis could be discovered in the dead infant. No constitutional disturbances were noted in these cases.

Of the remaining nineteen cases in this series, nine showed "Umstimmung." One patient suffering from carcinoma of the head of the pancreas, who had a chancre in 1865, showed a delayed luetin test, but gave a negative Wassermann reaction.

Constitutional Symptoms.—Constitutional symptoms consisting of tender axillary glands, tender arms, tachycardia, abdominal pains, bone pains, and nausea were present in four of the cases, but these symptoms were usually of only 24 to 48 hours' duration and caused no alarming discomfort to the patient. One case showed a second hemorrhagic pustule two weeks after the first manifestation had subsided.

Thus latent syphilis, so difficult to diagnose clinically and in which the Wassermann reaction is not of assistance in over 40 to 70 per cent. of the cases, shows a positive luetin reaction in all the cases tried. It seems that the luetin reaction will prove of even greater value in the diagnosis of this group than in the tertiary stage in which the Wassermann reaction is more constantly present. The effects of treatment

on the results of the luetin test in latent syphilis have not been significant.

"*Umstimmung.*"—In reviewing the whole series of one hundred and fifty cases, another interesting fact was noted—that in many cases of tertiary and of latent syphilis the site of the control injection showed almost as marked a reaction as developed about the point where the luetin was injected. This, as was pointed out by Neisser and Bruck, and which seems to be confirmed by Noguchi and this series of tests, appears to be due to the susceptibility to trauma of the skin of syphilitics late in the disease ("Umstimmung"), for not one of the seventy control patients reacted on the side in which the control emulsion was injected.

The cases exhibiting the most marked "control" reactions ("Umstimmung") were those suffering from syphilis in its later stages. The inconstancy of this phenomenon in all probability precludes its being of an allergic nature, which latter Noguchi has so well shown the principle of the luetin reaction to be.

Wolfsohn drew the following conclusions:

1. The luetin reaction is specific for syphilis.

2. The reaction is found of greatest value in the latent and tertiary stages of the disease.

3. In some treated cases of secondary syphilis the reaction is positive.

4. In parasyphilitics with the cardiovascular

manifestations of the disease the reaction may be delayed for from nine to thirty days.

5. The luetin reaction is helpful in the diagnosis of latent syphilis in pregnancy.

6. The state of " Umstimmung " is well brought out in the tertiary and latent forms of syphilis.

In pediatry the luetin reaction seems to find its useful application. Thus Alan Brown, working under Professor L. Emmet Holt, at the Babies' Hospital, New York, obtained a positive reaction in 30 (90 per cent.) out of the 33 children suffering from congenital syphilis, while the remaining three cases gave doubtful reactions. In 73 non-syphilitic children there was no positive reaction. In 15 positive cases the reaction was of pustular form and the other 15 showed the inflammatory nodules. When arranged according to the age the reactions were found as follows:

	Positive reaction	Doubtful reaction
1 to 3 months	12	3
3 to 6 months	8	
6 to 12 months	6	
1 to 4 years	4	
	30	3

It was also found that the more energetic the treatment the more distinct was the luetin reaction. The three infants who gave the indecisive reactions had not been under the antisyphilitic treatment, while

the other 30 positive cases were being treated either with mercury or salvarsan or both in combination for some time.

The varieties of control cases studied by Brown are shown in the following list. The Wassermann[1] as well as luetin reaction was uniformly negative in these cases.

TABLE 30.

NON-SYPHILITIC CASES FROM THE BABIES' HOSPITAL.

No. cases	Disease	
1	Scleroderma	The Wassermann and luetin reactions all negative.
2	Spastic diplegia	
4	Marasmus	
2	Cretinism	
13	Bronchopneumonia	
2	Mongolian idiocy	
2	Eczema	
1	Bronchitis	
1	Retropharyngeal abscess	
7	Lobar pneumonia	
16	Infant feeding	
3	Tetanus	
3	Gastro-enteritis	
1	Pemphigus neonatorum	
1	Scarlet fever	
3	Empyema	
1	Tuberculous meningitis	
1	Adenitis	
1	Still's disease	
2	Rachitis	
1	Nævus	
1	Cleft palate	
2	Hernia	
2	Congenital heart	
73		

[1] The Wassermann tests (Noguchi system) were performed by Dr. Bronfenbrenner at the Rockefeller Institute. The tests were made absolutely objectively.

The results of study by Brown thus establish the specificity of the luetin reaction for syphilis in pediatric cases.

THE CONSEQUENCE OF THE REPEATED LUETIN TESTS.

When a patient who gives a positive luetin reaction is tested again after an interval of time not shorter than one month from the previous test, the reaction appears very much in the same manner as the previous one, but if the tests are repeated a number of times at shorter intervals, the reactions seem to appear somewhat quicker than the earlier ones. Apparently there is an abbreviation of the incubation period after repeated inoculations of the luetin. The duration of the reaction also becomes shorter. A normal rate of reaction velocity seems to re-establish once more, if the patient is allowed to go without the test for a few months. It has also been found by Cohen that when the injection of the luetin is made within one week after a positive reaction was obtained the second inoculation may produce only a transient, mild reaction within 24 hours and quickly fades away. This is probably due to the negative phase of allergy following the positive reaction. (Plate VI.)

Female, aged 15 years. A typical case of tardiac congenital syphilis with bilateral insterstitial keratitis, Hutchinson teeth, saddle nose, etc. Has been under mercurial treatment. This case has shown a most pronounced pustular reaction when tested on several previous occasions, but the present test, which was made within one week since the last, shows only a mild reaction.

EFFECT OF TREATMENT UPON THE LUETIN REACTION.

From what has been presented in the foregoing it is quite evident that the luetin reaction remains but little affected by the usual intermittent mercurial treatment in a large number of cases. As aforesaid the allergic condition may be brought out by the usual mercurial or any other anti-syphilitic treatment in those cases where it has not appeared yet. According to my observations, salvarsan, either singly or combined with mercury, appears to exert the greatest influence, not only in inducing the development of the allergy, but also in removing it after it has developed. The explanation for this remarkable feature of salvarsan lies, no doubt, in its powerful spirochætocidal property, by virtue of which it destroys a large number of the pallidum, thus inducing the allergic condition in earlier stages of syphilis and then, if successful, annihilating all pallida, thus removing the source of this condition. The latter is a cure, in other words.

Although there can be no dispute about an accomplished cure with the mercurial treatment in certain percentages of cases under favorable conditions, yet the successes are rather uncertain. Still too early for deciding a cure or a mere latency in the cases treated with salvarsan, yet I am strongly in-

clined to believe that there are certain cases which are definitely cured. The absence of the clinical and serological signs of syphilis over a period of one year is certainly an encouraging aspect, but, considering the possibility of these signs being absent in some latent cases, one has a right to hesitate in pronouncing these cases as cured. It is in this connection that the luetin reaction may become a great aid in settling this important question. As already stated, the luetin reaction alone cannot decide the point, but combined with other means of diagnosis it is bound to throw some light into this problem.

I have now certain data which may aid to clear up the relation between the luetin reaction, clinical symptoms and Wassermann reaction, in regard to prognosis of syphilis. In one series of cases the patients were treated with both mercury and salvarsan, and in due time the clinical and the serological symptoms had cleared up and remained so for a certain length of time. The luetin reaction was tried on each of them and the results are as follows:

CASES PARTIALLY TREATED WHERE THE CLINICAL SYMPTOMS ARE ABSENT AND THE WASSERMANN MOSTLY NEGATIVE.

Cases of Captain Schmitter.

1.—A. G., male, aged 33. Chancre, 1906. Keratitis, 1907, and recurrence in 1910 and 1911. Treatment: Injected 0.3 gm. salvarsan, Feb. 14, 1911; intravenously, Mar. 18, 1911; intramusc., Mar. 18, 1911; intravenously, July 29, 1911. Wassermann: Positive, Nov. 12, 1910; negative (?) Feb. 23, 1911, and April 21, 1911;

positive, April 26, 1911; negative, May 2, 1911, May 10, 1911, May 17, 1911, June 1, 1911; positive, June 14, 1911; negative (?), July 13, July 20, 1911; negative, July 27, 1911. Hg and KI treatment from Oct., 1910, to Feb., 1911. Luetin positive, Sept. 12, 1911.

2.—W. B. J., male, aged 24. Chancre, Dec., 1910. Mucous patches on tonsils and soft palate, Mar. 16, 1911. Treatment: Injected salvarsan intravenously Mar. 16, 1911; intramuscularly, Mar. 16, 1911. Wassermann: Positive, Mar. 20, 1911, and April 12, 1911; negative, May 22, 1911, and Aug. 29, 1911. Luetin positive, Sept. 3, 1911.

3.—A. B. F., male, aged 23. Non-specific (control). Luetin negative Sept. 1, 1911.

4.—D. J. C., male, aged 33. Chancre, Nov., 1910. Secondaries Jan. 16, 1911. Treatment: Injected salvarsan intramusc. and intravenously, Feb 27, 1911; intravenously, Aug. 18, 1911. Hg. and KI treatment to present time. Wassermann: Positive Feb. 1, 1911; ± Feb. 23, 1911; negative, Mar. 11, 1911, and Mar. 22, 1911; negative June 19, 1911. Luetin positive Sept. 6, 1911.

5.—E. C., male, aged 33. Chancre, Apr., 1904. Secondaries Aug., 1904. Hg. for 3 months. Treatment: Injected salvarsan intramuscularly and intravenously, Feb. 2, 1911. Wassermann: Positive, April 13, 1910, and Nov. 30, 1910; negative (?), Feb. 23, 1911, and Mar. 15, 1911; negative, Mar. 22, 1911, and June 28, 1911. Luetin positive, Sept. 8, 1911.

6.—O. C., male, aged 28. Chancre, Mar., 1911. Secondaries, June 5, 1911. Treatment: Injected salvarsan intravenously, June 5, 1911; intramusc., June 8, 1911. Wassermann: Positive (?), May 17, 1911; negative, May 22, 1911; positive, June 1, 1911, and June 16, 1911; negative, June 21, 1911, and June 28, 1911; positive, July 6, 1911; negative, July 20, 1911, and July 27, 1911. Luetin doubtful, Sept. 5, 1911.

7.—G. C. C., male, aged 23. Chancre, Jan 14, 1911. Secondaries Feb. 20, 1911. Treatment: Injected salvarsan intramusc. and intravenously, Feb. 24, 1911, Hg. and KI from July 12, 1911, to the present. Salvarsan intravenously Aug. 13, 1911. Wassermann: Negative, Feb. 1, 1911; negative (?), Feb. 17 and Mar. 11, 1911; negative, Mar. 22, 1911, Mar. 29, 1911, April 5, 1911, April 12, 1911; doubtful June 1 and 7, 1911; positive, July 6, 1911. Luetin positive Sept. 3, 1911.

8.—S. F., male, aged 28. Chancre, June, 1910. Secondaries, Oct. 28, 1910. Treatment: Injected salvarsan intramuscularly and intra-

venously, Feb. 13, 1911. Wassermann: Negative Oct. 28, 1910; positive Feb. 12, 1911; negative, Feb. 23, 1911, Mar. 22, 1911, and July 15, 1911. Luetin positive, Sept. 11, 1911.

9.—T. A. K., male, aged 25. Chancre, Jan., 1911. Secondaries, Feb. 26, 1911. Treatment: Injected salvarsan intramusc. and intravenously, Feb. 26, 1911; intravenously, Aug. 19, 1911. Hg. and KI from July 28, 1911, to present. Luetin positive, Sept. 5, 1911.

10.—J. H. McB., male, aged 29. Chancre, Feb. 1, 1911. Secondaries April 13, 1911. Treatment: Injected salvarsan intravenously, April 11, 1911; intramuscularly, April 13, 1911. Wassermann: Positive, April 13, 1911, April 21, 1911, and April 26, 1911; negative, May 17, 1911, and June 7, 1911. Luetin positive, Sept. 7, 1911.

12.—J. J. M., male, aged 28. Chancre, Apr., 1911. Secondaries, Aug. 17, 1911. Treatment: Injected salvarsan intravenously, Aug. 18, 1911. Wassermann: Negative Aug. 23 and Aug. 26, 1911. Luetin positive, Sept 6, 1911.

13.—J. G. M., male, aged 30. Macular rash over body in 1900. Treatment; Injected salvarsan intravenously May 17, 1911; intramusc. May 10, 1911. Wassermann: Positive May 2, 1911; negative (?) May 17, 1911; negative May 22 and June 1, 1911; positive June 7, 1911, and June 14, 1911; negative June 21, 1911. Luetin positive, Sept. 3, 1911.

14.—W. M., male, aged 28. Chancre, 1910. Secondaries, April 10, 1911. Treatment: Injected salvarsan intravenously, April 10, 1911; intramusc. Apr. 13, 1911; intravenously, Aug. 20, 1911. Hg and KI to the present time. Wassermann: Negative, Mar. 27, 1911; positive (?), April 3, 1911; positive, April 12, 1911; negative, April 21, 1911; negative (?), April 26, 1911; positive, May 2, 1911; O May 10, 1911; positive (?), May 17, 1911; negative, June 1, 1911; positive, June 7, 1911; positive, June 14, 1911. Luetin positive, Sept. 7, 1911.

15.—F. S., male, aged 25. Chancre, Dec., 1910. Secondaries, Feb., 1911. Treatment: Injected salvarsan intramusc. and intravenously, Feb. 13, 1911; intramusc., May 20, 1911. Hg and KI from May 27 to Aug. 1, 1911. Wassermann: Positive, Feb. 10 and Feb. 23, 1911; positive (?), Mar. 11, 1911; negative, Mar. 22, 1911; positive, May 12, 1911; negative, Aug. 23, 1911. Luetin positive, Sept. 6, 1911.

16.—R. W., male, aged 26. Chancre, Oct., 1909. Secondaries, Aug. 21, 1911. Treatment: Injected salvarsan intravenously, Aug. 21, 1911. Hg and KI from Aug. 23, 1911, to date. Wassermann: Negative Aug. 26, 1911. Luetin positive Sept. 6, 1911.

17.—J. H. S., male, aged 29. Chancre, Jan., 1909. Secondaries, July 22, 1911. Treatment not given. Wassermann: Negative July 27, 1911; positive (?), Aug. 5, 1911; negative, Aug. 23 and Aug. 29, 1911. Luetin negative, Sept. 6, 1911.

18.—H. L. A., male, aged 22. Congenital. Treatment: Injected salvarsan intravenously, June 5, 1911; intramusc., June 8, 1911. Wassermann: Positive, June 1 and June 21, 1911; negative, June 29, 1911; positive, July 6, 1911; negative, July 13, July 20 and July 27, 1911. Luetin positive, Sept. 11, 1911.

19.—P. F. B., male, aged 26. Chancre, Feb. 19, 1910. Secondaries, May 16, 1911. Treatment: Injected salvarsan intramusc. and intravenously, Feb. 17, 1911; intravenously Aug. 18, 1911. Hg and KI from July 20, 1911, to present time. Wassermann: Positive, Feb. 17, Feb. 23, Mar. 11, 1911; negative, Mar. 22 and July 6, 1911. Luetin doubtful, Sept. 5, 1911.

20.—G. A. D., male, aged 30. Chancre, May 12, 1911. Secondaries, July 1, 1911. Treatment: Injected salvarsan intravenously, July 1, 1911; intramusc., July 4, 1911. Hg and KI from July 27, 1911, to the present. Wassermann: doubtful, July 6, 1911; positive (?), July 13, 1911; positive (?), July 20, 1911; doubtful, July 27, 1911. Luetin doubtful, Sept. 6, 1911.

21.—C. N. S., male, aged 26. Chancre, Mar. 10, 1911. Secondaries, Apr. 2, 1911. Treatment: Injected salvarsan intravenously, Aug. 19, 1911; intravenously and intramuscularly, April 6, 1911. Hg and KI from July 27, 1911, to present. Wassermann: Positive, April 10, 1911; positive April 21, 1911; positive, April 26, 1911; positive, May 2, 1911; doubtful, May 10, 1911; negative, May 17, May 22, and June 1, 1911; doubtful, July 20, 1911; negative, July 27, 1911. Luetin negative, Sept. 6, 1911.

The above series of cases illustrate very clearly that the absence of the clinical and serological signs of syphilis indicates merely that they were mostly in the latency of the disease and could be detected by the positive luetin reactions.

In another series of cases (Dr. Corbus) the patients were treated similarly, but decidedly more vigorously and effectively. The patients remained

symptomless and their Wassermann reactions negative for varying lengths of time when the luetin reaction was applied.

CASES THOROUGHLY TREATED WHERE THE CLINICAL SYMPTOMS AND THE WASSERMANN ARE ABSENT.

Private cases of Dr. Corbus.

1.—C. K. A., male, aged 43, early secondaries when he came under observation. Now believed cured. Treatment: Injected intramusc. 0.5 gm. salvarsan Nov. 4, 1910, and Jan. 17, 1911; intravenously, July 24, 1911. Vigorous Hg rubbings between injections. Wassermann negative, Jan. 17, 1911, March 6, 1911, June 8, 1911, July 25, 1911, and Dec. 1, 1911. Luetin negative, Mar. 14, 1912. Complained slight gastric disturbance.

2.—W. E. M., male, aged 28, latent lues. Treatment: Salvarsan injected abroad; intramusc., June 21, 1911, Aug. 15, 1911; intravenously, Oct. 27, 1911, Dec. 18, 1911. Wassermann: Positive, June 9, 1911; negative, Sept. 12, 1911; negative (?), Dec. 19, 1911; negative, Mar. 8, 1912. Luetin negative, Mar. 14, 1912.

3.—M. H., male, aged 22, latent. Treatment: Injected salvarsan intravenously, July 24, 1911, and Sept. 8, 1911. Wassermann negative, Sept. 12, 1911. Luetin negative, Mar. 14, 1912.

4.—G. C. F., male, aged 27, early secondaries when he came under observation. No symptoms now. Treatment: Injected salvarsan intramuscularly Mar. 9, 1911, and April 20, 1911; intravenously Oct. 27, 1911. Vigorous Hg rubbings between injections. Wassermann negative, Sept. 8, 1911. Luetin positive, Mar. 14, 1912.

5.—B. B., female, aged 20, early secondaries when she came under observation. No symptoms now. Treatment: Injected salvarsan intramusc., Oct. 18, 1910, and Nov. 30, 1911. Wassermann: Positive, Oct. 18, 1910, and Nov. 11, 1910; negative, Dec. 1, 1910; slightly positive, Mar. 8, 1912. Luetin positive, Mar. 14, 1912.

6.—C. E. H., male, aged 26, latent. Treatment: Injected salvarsan intramusc., Dec. 9, 1910; intravenously, April 20, 1911. Wassermann: Negative, Mar. 16, 1911, April 20, 1911, June 14, 1911, Dec. 1, 1911. Luetin negative, Mar. 14, 1912.

7.—M. E., male, aged 34. Now believed cured. Treatment: Injected salvarsan intravenously Nov. 18, 1910; intramusc. Nov 21, 1910; intravenously Aug. 11, 1911, Nov. 24, 1911, and Mar. 1, 1912. Wassermann: Positive, Nov. 11, 1910, Nov. 28, 1910, Dec. 15,

1910, and Mar. 8, 1911; negative, Sept. 18, 1911, Oct. 27, 1911, Nov. 28, 1911, and Mar. 2, 1912. Luetin negative, Mar. 14, 1912.

8.—W. S., male, aged 29, latent. Treatment: Injected salvarsan intramusc. Jan. 12, 1911; intravenously, Mar. 22, 1911, and Aug. 21, 1911. Vigorous Hg rubbings between injections. Wassermann: Negative Mar. 2, 1911; slightly positive Aug. 1, 1911; negative Aug. 9, 1911, and Oct. 24, 1911. Luetin negative, Mar. 14, 1912.

9.—A. E. B., male, aged 34. Apparent mercury cure. Treatment with vigorous Hg rubbings and injections regularly. Wassermann: Positive May 1, 1911; negative May 11, 1911 (Dr. Waugh); negative May 13, 1911, June 10, 1911, and Jan. 1, 1912. Luetin negative Mar. 14, 1912.

10.—F. R., male, aged 33, late secondaries when he came under observation. Latent at present. Treatment: Injected salvarsan intramusc. Nov. 17, 1910, and Jan. 12, 1911; intravenously, Dec. 1, 1911. Vigorous Hg rubbings between injections. Wassermann: Positive Jan. 11, 1911, and Mar. 18, 1911; negative Sept. 27, 1911, and Nov. 28, 1911. Luetin positive, Mar. 14, 1912.

11.—E. H. J., male, aged 28, luetic periostitis when he came under observation. Latent at present. Treatment: Injected salvarsan intravenously May 14, 1911; intramusc. May 20, 1911; intravenously Nov. 11, 1911. Vigorous Hg rubbings between injections and KI. Wassermann: positive, April 24, 1911, negative, Oct. 21, 1911, and Feb. 23, 1912. Luetin negative, Mar. 14, 1912.

12.—L. A. R., male, aged 36, believed cured. Treatment: Hg rubbings and injections, chronic intermittent form. Wassermann: Negative, Mar. 20, 1912. Luetin negative, Mar. 14, 1912.

13.—G. S., male, aged 20, primary lesion when he first came under observation. Wassermann always negative. Treatment: Injected salvarsan intravenously April 29, 1911; intramusc. May 4, 1911; intravenously July 1, 1911, and July 24, 1911. Hg rubbings for two months. Wassermann negative June 10, 1911, and Oct. 31, 1911. Luetin negative, Mar. 14, 1912.

14.—J. C. S., male, aged 40. Believed cured after biological method. Treatment: Injected salvarsan intramusc. Nov. 24, 1910, and ? date; intravenously May 7, 1912. Wassermann: Negative Nov. 11, 1910, May 9, 1911, Sept. 27, 1911, (?) Nov. 7, 1911, and April 9, 1912. Luetin, indolent reaction, marked after 21 days, Mar. 14, 1912. Wassermann negative at this time.

15.—H. C. S., male, aged 25, latent syphilis. Treatment: Injected salvarsan intramusc. 6 gm., May 19, 1911, and Aug. 28, 1911;

intravenously Nov. 10, 1911, and Mar. 24, 1912. Hg rubbings between injections. Wassermann: Positive May 8, 1911; slightly positive, Aug. 30, 1911; slightly positive, Oct. 20, 1911; negative, Feb. 6, 1912. Luetin negative, Mar. 14, 1912.

16.—L. S. K., male, aged ?, secondary lues when he came under observation. Latent at present. Treatment: Injected salvarsan Sept. 11, 1911; intravenously, Oct. 30, 1911, Dec. 23, 1911, and Mar. 4, 1912. Hg rubbings between injections. Wassermann: Positive, Sept. 12, 1911, and Oct. 31, 1911; negative, Dec. 24, 1911. Luetin negative, Mar. 14, 1912.

17.—F. McN, male, aged 32, now believed cured. Treatment: Injected intramusc. salvarsan, Nov. 17, 1910, and Jan. 12, 1911; intravenously Oct. 30, 1911. Wassermann: Positive, Jan. 8, 1911, negative (?), April 22, 1911, negative (?), Sept. 27, 1911, negative (?), Oct. 31, 1911. Luetin negative, Mar. 14, 1912.

18.—W. D., male, aged 21, secondaries when he came under observation. Latent now. Treatment: Injected salvarsan intramusc., Mar. 13, 1911, and May 8, 1911; intravenously July 7, 1911. Hg rubbings between injections. Wassermann positive, July 7, 1911. Luetin positive, Mar. 14, 1912.

19.—J. K., male, aged 28, latent now. Treatment: Injected salvarsan intramusc. Feb. 16, 1911; intravenously July 24, 1911, and Nov. 3, 1911. Hg rubbings between injections and Hg internally. Wassermann: Positive Jan. 23, 1911, and May 1, 1911; negative Aug. 25, 1911, and Nov. 7, 1911. Luetin negative, Mar. 14, 1912.

20.—W. H. S., male, aged 22. Early secondaries when he came under observation. Latent now. Treatment: Injected salvarsan intramusc., April 24, 1911, and Sept. 7, 1911; intravenously Jan. 19, 1912. Vigorous mercury rubbings between injections. Wassermann: Negative Sept. 8, 1911, and Jan. 23, 1912. Luetin negative, Mar. 14, 1912.

The above series of cases, though necessarily limited in number, are very important from the prognostic standpoint of view, as they are exactly the cases where the clinicians desire to ascertain whether the absence of the clinical and serological signs of syphilis is an indication of latency or a cure. That some of the cases of this group of patients belong

to the latent stage of the disease is well shown by the positive outcome of the luetin reaction, yet it remains for the future to decide, by continued observations for years to come, whether or not the other cases where the luetin reaction as well as the clinical and serological symptoms are now missing had really been cured by the energetic treatment.

While reading the proof, an excellent article of Kämmerer has appeared in the *Münchener medizinische Wochenschrift*. This investigator, working at the medical clinic of Professor von Müller, at Munich, Germany, has tried out the luetin submitted to him by the writer on a number of cases suffering from various diseases, and obtained the results, which are in the main confirmatory of those obtained by other investigators. While the percentage of positive reaction in syphilis is much lower than that found by others, Kämmerer found the reaction to be specific for syphilis. This is a highly important factor, as the value of the luetin test depends upon its specificity.

Through a personal communication I am informed of the results obtained by Goldenberg and Kaliski, who applied the luetin to a very large number of cases at the Mount Sinai Hospital, New York. Their observations confirm those of previous workers.

Fordyce, Pusey, and others have also obtained similar results on dermatological cases.

It is hoped that by preparing a more active luetin it may eventually be possible to substitute the intrademic application by a cutaneous procedure, in order to render the test simple enough to enable more physicians to employ it. At present the mode of application of the luetin test is by no means ideal and requires much care and preparation to perform it properly.

XV.

THE BUTYRIC ACID TEST.

WHILE studying the relation of proteids, lipoids and salts to the Wassermann reaction, I observed that the syphilitic antibody* is contained in or precipitated with globulin, and particularly the euglobulin fraction of the blood-serum or cerebrospinal fluid. I incidentally ascertained that the globulin fraction of these fluids is increased in syphilis, and that there exists a parallel between the titre of the syphilitic antibody and the amount of the globulin fractions, to which rule I observed certain exceptions, in which this parallelism was absent. There would therefore appear to be no necessary connection between the syphilitic antibody and the increase of globulin, although the two conditions are likely to be associated. While the appearance of the antibody and the increase of the globulin are often found associated, I have observed that the increase in the globulin is recognizable earlier than the presence of the antibody; and in the early stages of primary syphilis, when the presence of the antibody may not be detectable, the globulin content is seen already to be

* The term antibody in this instance refers to the active lipotropic substances causing the Wassermann reaction, but not the specific antibody.

increased. Again, in cases of latent syphilis the antibody so far as it is demonstrable is more or less inconstant and may thus escape detection altogether, whereas it is exceptional not to find the globulin increased. These facts apply also to the cerebrospinal fluid. In specimens of cerebrospinal fluid coming from cases of secondary or tertiary syphilis in which there is no special involvement of the central nervous system, the syphilitic antibody is extremely difficult to detect, and this is true even though this fluid contains an increase in its protein fraction. In cases of parasyphilitic affections, where the central nervous system is primarily involved, the detection of the antibody is often readily accomplished. In general paralysis, the antibody is detectable in the cerebrospinal fluid in about 90 per cent. of the cases. In locomotor ataxia or cerebral or spinal syphilis, the detection of the antibody in the cerebrospinal fluid is successful in about 60 per cent. of the cases. The increase of protein in the cerebrospinal fluid of these cases is greater than the appearance of the antibody, and my experience leads me to conclude that the abnormally high protein content is a more constant occurrence in the cerebrospinal fluid in syphilitic and parasyphilitic cases than is the presence of a detectable antibody.

For the detection of the increase of globulin in the blood or cerebrospinal fluid numerous methods

have been devised by different investigators. For the estimation of the globulin of the blood, the methods proposed are the usual chemical procedures, the application of which to clinical laboratories has not been successfully accomplished. The detection of the increased globulin in the cerebrospinal fluid has been accomplished by simpler quantitative methods, such as the half saturation with ammonium sulphate, as devised by Nonne and Apelt, which is applicable to clinical laboratories. On the whole, this method, while useful, is somewhat difficult of application and fails to give a proper differentiation when the increase in the globulin is only slight. My own method consists in the employment of butyric acid as precipitant for the globulin, but the manner of application differs somewhat according as it is applied to the blood-serum or the cerebrospinal fluid. This method of detecting an increase in the globulin content is applicable *especially to the cerebrospinal fluid,* and is so simple as to be within the reach of the simplest laboratory.

Method for Cerebrospinal Fluid.—Two parts of the cerebrospinal fluid to be examined are mixed with 5 parts of a 10 per cent. butyric acid solution in physiological salt solution, and are heated over a flame and boiled for a brief period. One part of a normal solution of NaOH is then added quickly to the heated mixture, and the whole boiled once

more for a few seconds. The actual quantities of these three agents that I prefer are 0.1 or 0.2 c.c. of the spinal fluid, 0.5 c.c. of the butyric acid solution, and 0.1 c.c. of the normal sodium hydroxide. It is necessary to take the precaution to employ for this test only cerebrospinal fluid entirely free from blood.

The presence of an increased content of protein in the cerebrospinal fluid is indicated by the appearance of a granular or floccular precipitate, which gradually settles to the bottom of the tube, beneath a clear, supernatant fluid. The velocity and intensity of the reaction vary according to the quantity of the protein contained in a given specimen. The greater the amount of the protein, the more quickly and distinctly the reaction appears. The granular precipitate appears within a few minutes in a specimen containing a considerable increase in protein, while one hour may be required to obtain a distinct reaction in specimens weaker in protein. In obtaining the reaction, the time period should not be greater than two hours.

This reaction I have found to appear regularly in the cerebrospinal fluid of the patients with syphilitic and parasyphilitic affections, and also in all cases of inflammation of the meninges caused by such micro-organisms as *Diplococcus intracellularis,* pneumococcus, influenza bacillus, tubercle bacillus, etc.

These acute inflammatory infections are of course readily differentiated from the syphilitic affections.

According to the recent investigations of Flexner and his coworkers, Lewis and Clark, the cerebrospinal fluid of man as well as monkeys with acute poliomyelitis contains an abnormally large amount of proteins and gives a positive reaction to the butyric acid test. It was found that the increase of the proteins is one of the earliest symptoms of this disease and reaches the maximum just before the paralytic symptoms develop. Flexner employed the test in determining the result of inoculation of his filtrable virus into monkeys. He also discovered a certain number of abortive cases of poliomyelitis in man by means of the butyric acid test and cytodiagnosis, thereby of course eliminating all other diseases giving the same reaction and lymphocytosis by careful clinical data and other differential diagnostic means.

Normal cerebrospinal fluid gives with the butyric acid test a slight opalescence and sometimes a marked turbidity, but the granular precipitate does not occur at all or occurs only after several hours or even after twenty-four hours.

Method for Blood-serum.—One part of clear serum free from hæmoglobin is mixed with 9 parts of a *half-saturated* solution of ammonium sulphate, the precipitated globulin centrifugalized by a power-

ful machine, and the compact globulin fraction separated by decantation from the supernatant fluid. The deposit may now be *weighed* to obtain an idea of its quantity. It is then redissolved in 10 parts of 0.9 per cent. salt solution, and is ready for the test. The test is made by mixing one part of the solution with an equal part of 10 per cent. butyric acid solution, when a prompt, dense, milky turbidity appears in the mixture, if the serum tested was derived from cases of syphilis, while it remains clear or shows only a slight opalescence without precipitation after several hours' standing, if it was derived from persons not suffering with syphilis.

In carrying out this test I have been in the custom of using 0.5 c.c. of serum and 4.5 c.c. of ammonium sulphate solution, and of performing the centrifugalization for 30 minutes in a machine which runs at the rate of 5000 revolutions per minute. After decanting the fluid, the deposit is redissolved in 5 c.c. of 0.9 per cent. salt solution. Of this solution, 0.5 c.c. is mixed with an equal quantity of the butyric acid solution. It is advisable to carry out the examination of the several specimens of the fluid at the same time, and especially to include a normal serum, giving a negative reaction, to act as a control for the series.

It should be mentioned that the weights of the

globulin deposits are comparable with one another only when they are packed equally by a definite degree of centrifugalization. Under similar conditions the use of weighing to determine the increase in the globulin is an advantage and is recommended, but where the conditions are not identical, such weighings may give an erroneous indication.

BUTYRIC ACID REACTION OF CEREBROSPINAL FLUID IN SYPHILIS AND PARASYPHILITIC DISEASES.

The results which I have obtained with the butyric acid reaction, along with Dr. Moore of the Manhattan State Hospital on Ward's Island, will serve to illustrate the value of the butyric acid test in psychiatry. For the purpose of the test the cerebrospinal fluid from cases of general paralysis, tabes dorsalis, dementia præcox, epilepsy, alcoholic psychosis, senile dementia, and certain other forms of insanity was employed. In order to arrive at an accurate result, the fluids tested by means of the butyric acid were also subjected to the Wassermann test and to the usual cytodiagnosis observation. In order to make the series complete, the cerebrospinal fluid from several cases of syphilis free from involvement of the central nervous system was also examined.

In the secondary and tertiary stages of syphilis,

without direct involvement of the nervous system, the cerebrospinal fluid yielded a reaction of feeble intensity to the butyric acid test. These fluids gave neither

TABLE 31.—*Results in cases in which the diagnosis was reasonably certain.*

Cases	No. of cases	Butyric acid reaction			Wassermann reaction			Cell count		
		+	−	±	+	−	±	+	−	±
Syphilis:										
Secondary stage... (without nervous symptoms)	3	3	0	0	0	3	0	0	3	0
Tertiary stage..... (without nervous symptoms)	1	1	0	0	0	1	0	0	1	0
Cerebral syphilis..	3	3	0	0	1	1	1	3	0	0
Spinal syphilis....	3	3	0	0	2	1	0	3	0	0
Hereditary syphilis	10	9	0	1	8	2	0			
Parasyphilis:										
General paralysis:										
Cerebral.....	43	37	4	2	32	6	5	39	2	2
Tabetic.....	17	17	0	0	12	3	2	16	1	0
Tabes.....	11	11	0	0	6	4	1	11	0	0
	91	84	4	3	61	21	9			
Psychoses:										
Arteriosclerotic ...	3	1	2	0	1	2	0	1	2	0
Traumatic.....	2	0	2	0	0	2	0	0	2	0
Senile.....	1	0	1	0	0	1	0	0	1	0
Epileptic.....	6	0	6	0	0	5	1	0	6	0
Alcoholic.....	7	0	6	1	3	3	1	0	6	1
Manic depressive.	2	0	2	0	1	1	0	0	2	0
Dementia præcox .	11	1	10	0	1	8	2	1	10	0
Imbecility.....	2	0	2	0	0	2	0	0	2	0
	34	2	31	1	6	24	4	2	31	1

a positive cytodiagnosis nor the Wassermann reaction. The cerebrospinal fluid of a group of cases of heredi-

tary syphilis gave a positive butyric acid reaction in about 90 per cent. and a positive Wassermann reaction in about 80 per cent. of those examined. On the other hand the cerebrospinal fluid obtained from cases of cerebral and spinal syphilis yielded the butyric acid reaction in all cases and at the same time gave a positive cytodiagnosis. As against these results is to be placed the result with the

TABLE 32.—*Analysis of the reactions with regard to syphilis.*

Cases	No. of cases	Butyric acid reaction			Wassermann reaction			Cell count		
		+	−	±	+	−	±	+	−	±
General paralysis and tabes:										
Syphilis +	36	34	1	1	26	8	2	36	0	0
Syphilis −	16	13	3	1	10	3	3	11	3	2
Other diseases:										
Syphilis +	1	1	0	0	1	0	0	1	0	0
Syphilis −	12	1	11	0	3	8	1	1	11	0

Wassermann reaction, which was positive in 50 per cent. of the cases examined. The cerebrospinal fluid obtained from cases of general paralysis gave positive butyric acid reaction in 90 per cent., positive cytodiagnosis in 91 per cent., and positive Wassermann reaction in 73 per cent. of those examined. The cerebrospinal fluid from cases of tabes dorsalis gave positive butyric acid reaction and cytodiagnosis in all, or 100 per cent., and positive Wassermann reactions in 53 per cent. of those examined.

Finally, the cerebrospinal fluid obtained from patients suffering with various forms of psychosis in whom a syphilitic history was excludable, or at least not obtained, gave positive butyric acid reactions and cytodiagnosis in 2.8 per cent. and positive Wassermann reactions in 13 per cent. of those examined.

From the above statement it becomes at once evident that the butyric acid reaction runs parallel with the cytodiagnosis in cases of parasyphilitic disease, and is especially reliable as an indicator of that condition, with the cytodiagnosis. Moreover, the results of the examination of the cerebrospinal fluid of cases of secondary and tertiary syphilis, in which there are no special lesions of the central nervous system, indicate through the feeble reaction obtained that a protein increase in the fluid is not necessarily associated with an increase and change in the number and quality of the cells contained in the fluid. In other words, the butyric acid reaction not only detects the changes in the fluid associated with parasyphilitic disease and with direct syphilitic lesions of the central nervous system, but it also indicates the existence of a general syphilitic state of infection, which cannot be detected by the means of cytodiagnosis.

The butyric acid reaction, as stated, is about parallel in results with cytodiagnosis, but is not parallel with the results of the Wassermann reaction.

In cases with established syphilitic history, the butyric acid reaction gives a higher percentage of positive result than the Wassermann reaction. It is therefore somewhat confusing to find that in nonsyphilitic forms of psychosis, the percentage of positive result of the Wassermann reaction exceeds that of the butyric acid test or cytodiagnosis. This discrepancy has not been cleared up, and calls for further study. Whether or not it has to do with the existence of an independent constituent similar to syphilitic "antibody" in the cerebrospinal fluid in these cases needs determination.

It is obvious that the butyric acid test is a useful addition to our diagnostic methods in the detection of parasyphilitic diseases of the central nervous system, and of cerebrospinal syphilis. It is, of course, desirable to confirm as often as possible the indications of the reactions by post-mortem examinations. Of the series which we examined, 17 cases have come to autopsy. Of these, 15 had given positive butyric acid tests, 14 having been diagnosed as cases of general paralysis, and one as a case of cerebral syphilis. Two had given negative tests. The autopsy findings were in complete agreement with the indications of the test.

In a series of investigations recently conducted at the Kings Park State Hospital, New York, Rosanoff,

TABLE 33.—*General paralysis.*

Variety of test		Serum	Cerebrospinal fluid			No. of cases for each group	Frequency of association of different reactions analyzed
		W.-N.	W.-N.	Butyric acid	Cells		
Number and percentage of positive and negative reactions obtained in corresponding tests.	+	27 = 62%	32 = 72.8%	43 = 97.7%	41 = 93.2%	44	Syphilis ascertained in..... 16 cases Syphilis negative in ..... 9 cases Syphilis unascertainable in. 19 cases 44 cases
	±	7 = 16.1%	6 = 13.6%	0	1 = 2.3%		
	−	10 = 22%	6 = 13.6%	1 = 2.3%	2 = 4.5%		
	+ and ±	78%	86.4%	97.7%	95.5%		
Grouping of cases according to the frequency and mode of combination of the four different reactions for which they were examined.		+	+	+	+	24	Four reactions all positive:— 31 = 70%
		±	+	+	+	1	
		+	±	+	+	2	
		±	±	+	+	4	
		−	+	+	+	4	Only three reactions positive:— 7 = 16.4%
		+	+	+	±	1	
		±	±	+	+	1	
		+	−	+	−	1	
		−	+	+	−?	1	Only two reactions positive:— 6 = 13.6%
		−	+	−?	+	1	
		−	−	+	+	4	
						44	Cases with more than three reactions positive:— 38 = 86.4% Cases with more than two reactions positive:— 44 = 100%

Wiseman, and the writer confirmed and extended the observations of Moore and the writer referred to above. In all 413 cases have been examined from the standpoints of the Wassermann reaction, butyric acid test, and cytodiagnosis. Of this total number 252 cases were available for the four tests simultaneously (the Wassermann reaction in serum and in cerebrospinal fluid, butyric acid test, and cytodiagnosis), while in the remaining 161 cases the examination of the spinal fluid was either incomplete or not undertaken. The Wassermann reaction was done by the writer's system [1] and is designated in the tables as W.-N. In Table 33 the results obtained with general paralysis are presented. It is interesting to notice that the increase of protein and of lymphocytes in cerebrospinal fluid of these cases is distinctly more constant than the presence of the Wassermann reaction. This last reaction was more frequently met with in the spinal fluid than in the serum. Noteworthy is it also that the four reactions are present in 70 per cent. of the cases examined and that all gave positive reactions to at least two different tests. This simultaneous presence of positive reactions to more than two different tests is quite characteristic of parasyphilitic conditions, for it is very seldom that other forms of psychoses give plural positive re-

[1] See Chapter VII, page 50.

actions without a definite syphilitic infection. In Tables 33, 34, 35, 36, 37, I present the results

TABLE 34.

		Serum	Cerebrospinal fluid			No. of cases in each group	Remarks
		W.-N.	W.-N.	B.	Cells		
Dementia præcox 71 cases		—	—	—	—	45	Syphilis ascertained in 5 cases all reacting positively to the fixation and butyric acid tests. The fixation reaction was present either singly in serum or cerebrospinal fluid or in both. In remaining positive cases syphilis was unascertainable and cannot be excluded. None showed pleocytosis.
		±	—	—	—	4	
		+	—	—	—	9	
		—	+	—	—	2	
		—	±	—	—	3	
		±	—	±	—	2	
		±	±	—	—	1	
		+	—	±	—	4	
		+	+	—	—	1	
	—	50 = 70%	64 = 88.8%	65 = 91.5%	71 = 100%	71	
	±	7 = 10%	4 = 6.6%	6 = 8.5%	0		
	+	14 = 20%	3 = 4.6%	0	0		
Epilepsy 51 cases		—	—	—	—	36	Syphilis unascertainable in this group of cases, but cannot be excluded from the cases giving positive reactions for the fixation and butyric acid tests. None showed pleocytosis.
		±	—	—	—	2	
		—	±	—	—	1	
		+	—	—	—	8	
		—	—	+	—	1	
		±	—	+	—	1	
		+	+	—	—	2	
	—	38 = 74%	48 = 94%	49 = 96%	51 = 100%	51	
	±	3 = 6%	1 = 2%	0	0		
	+	10 = 20%	2 = 4%	2 = 4%	0		

obtained with other forms of insanity. There are a number of cases giving solitary positive Wassermann

reaction, but scarcely any that gave positive cytodiagnosis. Again, we find that the butyric acid test was

TABLE 35.

		Serum	Cerebrospinal fluid			No. of cases in each group	Remarks
		W.-N.	W.-N.	B.	Cells		
Senile dementia . 9 cases		—	—	—	—	7	Syphilis probable in cases giving positive reactions for the fixation and butyric acid tests, but difficult to establish with certainty. None showed pleocytosis.
		±	—	—	—	1	
		—	+	+	—	1	
	—	8 = 88.9%	8 = 88.9%	8 = 88.9%	9 = 100%	9	
	±	1 = 11.1%	0	0	0		
	+	0	1 = 11.1%	1 = 11.1%	0		
Manic depressive insanity, 6 cases		—	—	—	—	3	Syphilis unascertainable, but possible in positive cases. None showed pleocytosis.
		±	—	—	—	2	
		+	+	—	—	1	
	—	3	5	6	6	6	
	±	2	0	0	0		
	+	1	1	0	0		
Alcoholic psychosis, 4 cases		±	—	—	—	1	Syphilis ascertained in all cases giving positive reactions for the fixation or butyric acid tests. None showed pleocytosis.
		±	—	±	—	1	
		+	—	+	—	1	
		—	+	±	—	1	
	—	1	3	1	4	4	
	±	2	0	2	0		
	+	1	1	1	0		

positive in some cases with syphilitic histories and the Wassermann reaction in serum was also positive in these cases.

Samuel Stern employed the butyric acid test in a large series of psychiatric conditions and obtained the following results: General paresis, 57; 52 positive and 4 negative. Tabes dorsalis, 3; 3 positive. One

TABLE 36.

		Serum	Cerebrospinal fluid			No. of cases in each group	Remarks
		W.-N.	W.-N.	B.	Cells		
Polyneuritic psychosis, 7 cases	—	—	—	—	—	6	Syphilis unascertainable in the case reacting positively to the fixation test in serum. The fixation test in spinal fluid, butyric acid test and pleocytosis negative in all.
	+	+	—	—	—	1	
	—	6	7	7	7	7	
	+	1	0	0	0		
Involution melancholia, 7 cases	—	—	—	—	—	6	Syphilis unascertained in the positive case. All reacted negatively to the fixation test in spinal fluid, butyric acid test and cytodiagnosis.
	+	+	—	—	—	1	
	—	6	7	7	7	7	
	+	1	0	0	0		
Paranoic condition, 4 cases	—	—	—	—	—	3	Syphilis unascertainable.
	+	+	—	—	—	1	
	—	3	4	4	4	4	
	+	1	0	0	0		
Imbecility ..... 4 cases	—	—	—	—	—	2	Syphilis unascertainable.
	+	+	—	—	—	2	
	—	2	4	4	4	4	
	+	2	0	0	0		

cerebrospinal syphilis positive. Forty-eight non-syphilitic were studied as controls. The controls include the following forms of psychosis: Dementia præcox, manic depressive, melancholia, epilepsy,

senility; toxic nephritic, alcoholic psychosis, Korsakoff's, postparalytic, imbecility, idio-imbecility, and puerperal. Of these, only two profound uremics and one postparalytic dementia were positive. Eight cadavers; all positive.

TABLE 37.

	Serum	Cerebrospinal fluid			No. of cases in each group	Remarks
	W.-N.	W.-N.	B.	Cells		
Infantile cerebral palsy, 4 cases	—	—	—	—	4	Syphilis unascertained. All reacted negatively.
Arteriosclerotic dementia, 7 cases	—	—	—	—	7	Syphilis unascertained. All reacted negatively.
Brain tumor ..... 1 case	—	—	—	—	1	Syphilis unascertained. All reacted negatively.
Traumatic psychosis, 1 case	—	—	—	—	1	Syphilis unascertained. All reacted negatively.
Unclassified .... 32 cases	—	—	—	—	18	Syphilis ascertained in 5 cases reacting positively either to the fixation or to the butyric acid test or to both. In other positive cases it was unascertainable and unexcludable. None showed pleocytosis.
	±	—	—	—	4	
	+	—	—	—	3	
	—	—	±	—	2	
	—	—	+	—	2	
	+	—	+	—	1	
	±	+	—	—	1	
	±	—	±	—	1	

McCampbell and Rowland made a comparative study of the Wassermann reaction, butyric acid test, Ross-Jones test, and cytodiagnosis on 46 cases of general paralysis, 5 cases of dementia præcox, 2 cases of paranoia, 1 case of melancholia, 2 cases of manic

depressive insanity, 3 cases of secondary lues and 2 cases of tertiary lues, including 2 normal individuals.

Their results are largely confirmatory of ours except that with the Wassermann reaction a much higher percentage of positive reactions was obtained by them with the blood sera from parasyphilitic cases. They found exactly the same as others in regard to the cerebrospinal fluid, namely, the percentage of positive reactions in the paretics was 85.7 per cent. for the Wassermann reaction and 95.6 per cent. for the butyric acid test and cytodiagnosis. The Ross-Jones test was slightly lower in percentage than the butyric acid test. The results obtained with the cerebrospinal fluids from those ten non-parasyphilitic psychiatric cases were the same, being uniformly negative to every test employed. In the cerebrospinal fluid of five syphilitics above mentioned the reaction was positive in all three secondary cases for the butyric acid and Ross-Jones tests, but negative for the Wassermann reaction and cytodiagnosis, and in the two tertiary cases one positive and one doubtful for the butyric acid and one positive and one negative for the Ross-Jones tests, while the Wassermann test and cytodiagnosis were totally negative. The sera of these syphilitic cases all gave positive Wassermann reaction as would be

expected. Finally no positive reaction was obtained with the cerebrospinal fluid or serum of the two normal persons.

BUTYRIC ACID REACTION IN GENERAL DISEASES.

That the butyric acid reaction will serve a useful purpose in the diagnosis of nervous and mental diseases has not only been indicated by my own studies in conjunction with Dr. Moore, but by several reports from other sources, in which the reaction has been applied. It is, however, necessary that the limit of the test should be precisely defined, which can be done by subjecting the cerebrospinal fluid from a large number of general diseases to the action of the test. It will require such a wide study to determine whether or not the reaction is either specific or special for syphilitic disease in a manner to render it useful for diagnosis. It can, of course, be predicted that in all cases in which there is increase in protein, and particularly in the globulin fraction of the cerebrospinal fluid, the reaction will be given. Now there are other diseases which produce this increase of protein in the cerebrospinal fluid, and they would naturally yield the reaction. The chief if not the sole diseases other than syphilis in some of its stages, associated with this exudative inflammatory condition, are the acute infections of the cerebrospinal meninges. Thus in all acute and subacute inflammations of the meninges

a positive reaction is obtained. Luckily, there is no difficulty whatever likely to be experienced in the separation of this class of cases, as has already been mentioned (see page 157). The only example of inflammation which might be confused with a syphilitic affection is tubercular meningitis, because, in this affection, the fluid is clear and contains an excessive number of mononuclear cells. But this affection is distinguishable readily not only by the clinical history, but also by the presence of the tubercle bacilli.

Should, however, cases arise in which there remains some doubt, this can be eliminated readily by invoking the aid of the Wassermann reaction, in one of its forms. The cerebrospinal fluid in typhoid fever and pneumonia, independent of the acute inflammations of the meninges which sometimes attend these diseases, does not yield the butyric acid reaction.

The butyric acid reaction will, I believe, suffice to distinguish normal from pathological cerebrospinal fluid, and especially that form of pathological fluid which is altered through an increase in its protein constituent. It may therefore prove applicable to some of the ill-defined inflammatory conditions of the meninges—such, for example, as the so-called serous meningitis, in which condition the micro-organisms and inflammatory cells are not, as a rule, demonstrable. If the excessive serous exudation differs

from the normal cerebrospinal fluid in the manner which is characteristic of inflammatory exudates, the butyric acid reaction would be obtainable. It also suggests itself that the reaction would be with profit

TABLE 38.—*The butyric acid reaction in general diseases.*

Cases	No. of cases	Butyric acid reaction			Wassermann reaction		
		+	−	±	+	−	±
Diseases of the meninges:							
Epidemic cerebrospinal meningitis.	14	14	0	0	0	14	0
Pneumococcal meningitis.....	6	6	0	0	0	6	0
Influenzal meningitis.....	1	1	0	0	0	1	0
Tubercular meningitis.....	30	30	0	0	0	30	0
Hydrocephalus externus.....	2	2	0	0	1	1	0
	53	53	0	0	1	52	0
Diseases without meningeal involvement:							
Typhoid fever.....	1	0	1	0	0	1	0
Pneumonia.....	4	0	4	0	0	4	0
Pulmonary tuberculosis.....	1	0	1	0	0	1	0
Enterocolitis.....	2	0	2	0	0	2	0
Rachitis.....	1	0	1	0	0	1	0
Uræmia.....	2	0	2	0	0	2	0
Septicæmia.....	1	0	1	0	0	1	0
Miscellaneous without nervous involvement.....	12	0	11	1	0	10	2
	24	0	23	1	0	22	2

invoked in certain cases of tubercular meningitis in which tubercle bacilli are not readily demonstrable. A positive reaction with butyric acid will, of course, be given by the cerebrospinal fluid provided there is tubercular inflammation, and the same fluid will be

negative to the Wassermann test. Hence the two tests, together with the clinical history, may lead to a provisional diagnosis at a time when the tubercle bacilli have not yet been discovered and animal inoculations have not yet had time to declare the nature of the disease.

BLOOD-SERUM.

I have subjected about 300 specimens of blood-serum, taken from cases of syphilis, from normal persons, and from persons suffering with other diseases than syphilis, to the globulin estimation by means of the butyric acid precipitation and by direct weighing. According to my observations, the globulin content of normal blood-serum varies from 0.120 to 0.150 gram per 0.5 c.c. of the serum, weighed in the moist condition. The weight of the dry globulin is about one-eighth to one-ninth of that of the moist specimens. The blood-serum which contains normal globulin content, prepared in the manner described (see page 225), does not give a positive butyric acid reaction.

In cases of untreated and manifest secondary and tertiary syphilis, the globulin content of the serum, weighed in the moist condition, varies from 0.200 to 0.350 gram per 0.5 c.c. In the primary stages of syphilis the increase in globulin is less great, but is still sufficiently pronounced to give the butyric acid

reaction. In cases of latent syphilis, the globulin content rarely exceeds 0.200 gram and may be somewhat less, but is also sufficiently increased to give the reactions. On the other hand, cases of syphilis which have been well treated and have not exhibited symptoms for many years, showed no increase in the globulin content over that of normal individuals.

I have therefore studied cases of syphilis in progress of treatment, and have found that, as the treatment progresses and the symptoms disappear, the reaction becomes less and less pronounced, and that the globulin tends correspondingly to approach closer and closer the normal quantity. However, the butyric acid reaction does not entirely disappear from the serum for many months after treatment has been carried on and the obvious symptoms have entirely disappeared. As a rule, the butyric acid reaction disappears later than the Wassermann reaction, and the intensity of the butyric acid reaction does not always run parallel with that of the Wassermann reaction.

I have, of course, studied the blood-serum derived from persons suffering from diseases of a general nature, in whom syphilis could be excluded. It is important to record that, in a small number of cases of carcinoma and tuberculosis, the butyric acid reaction was obtained, while the Wassermann reactions were negative. Similarly, two cases of Hodgkin's

disease which I examined gave strong butyric acid reactions, but no Wassermann reaction. It has been pointed out by Gay and Fitzgerald that in some acute infectious diseases, such as pneumonia and scarlet fever, there may occur an increase in the globulin content leading to a positive butyric acid reaction. With these facts in mind, it is not difficult to define the limit of application of the butyric acid reaction to blood-serum. It may therefore be stated that the reaction is not specific, and when it is present it does not necessarily indicate a syphilitic infection. But, on the other hand, it can be employed to establish or confirm a deduction based upon the clinical history and the results of the Wassermann reaction and thus become indirectly of diagnostic value. On the other hand, *a negative result is valuable as excluding a syphilitic infection.* In this respect the reaction has advantages over the Wassermann reaction, in which a negative result is not always reliable as indicating absence of syphilitic infection.

GLOSSARY.

Agglutination.

Clumping of bacteria or blood-corpuscles by specific agglutinins. For corpuscles the term hæmagglutination is often used.

Agglutinins.

A single or repeated injection of bacteria or foreign blood corpuscles into an animal is followed by the development of a new property in the serum of that animal. This serum, when deprived of its own complement either by inactivation or by dilution, is capable of clumping in test tube the bacteria or blood corpuscles employed for immunization. This phenomenon is called agglutination and is ascribed to the reaction product designated agglutinin. Its nature is not known except that it is found in the protein fraction of serum and resists the temperature of 56° C. Agglutinins may be found in some normal sera in varying quantity. Agglutinins being antibodies are specific, and can be absorbed by bacteria or blood-corpuscles.

Alexin.

First introduced by Hans Buchner, adopted by Bordet; is now synonymous with complement of Ehrlich and cytase of Metchnikoff. See Complement. Buchner's idea of alexin is not identical with that of Bordet, and the term was used to designate bacteriolysins and hæmolysins, but not complement of Ehrlich or alexin of Bordet. The term alexin to-day is used in Bordet's sense but not in Buchner's.

Amboceptor.

Introduced by Ehrlich; is synonymous with Fixateur of Metchnikoff, Substance sensibilisatrice of Bordet, Preparator of Max Gruber, and Copula of P. Th. Müller. Amboceptor is one of the two active principles necessary to cause Hæmolysis, Bacteriolysis, or any other cytolysis caused by serum, the other active principle being complement. Amboceptor retains its activity after the serum is heated to from 55° to 56° C. for 30 minutes, while complement is destroyed at that temperature. Amboceptor, as well as complement, is present in the coagulable protein fraction of serum. Amboceptor may be present in any normal serum, and can be produced in the serum of an animal by injecting repeatedly the cells for which it has no amboceptor. The amboceptor normally present is called natural amboceptor and that which is produced by means of repeated injections of foreign cells is called immune amboceptor. The amboceptor capable of causing hæmolysis (in presence of complement, of course) is called hæmolytic amboceptor, while that which is capable of dissolving bacteria is called bacteriolytic amboceptor. A few writers use the simple terms of hæmolysin or bacteriolysin instead of hæmolytic or bacteriolytic amboceptor. Amboceptors are capable of producing anti-amboceptors when injected into a susceptible animal.

Antibodies.

A general term applied to a group of reaction products arising from single or repeated administrations of antigens to a suitable animal. Immune body is a synonym of antibody. Among antibodies we may enumerate hæmolytic amboceptors, bacteriolytic amboceptors, other cytolytic amboceptors, precipitins, agglutinins, antitoxins, antivenins, antiricin, antiabrin, etc. Antibodies possess specific affinity for the antigens which are used for their production. Certain antibodies such as agglutinins, amboceptors, antitoxins, or antihæmolysins may be normally present in certain sera in small amount. A group of antibodies is capable of producing antibodies when injected into another animal, thus forming anti-antibodies.

Anticomplementary action.

Substances possessing the power of reducing or removing totally the action of complements are said to be anticomplementary. Most acids, alkalies, and certain salts have anticomplementary action. In certain sera there are often certain principles possessing anticomplementary properties. Human serum gradually acquires this action on standing. Repeated injections of fresh serum into an animal of another species is followed by the appearance of anticomplements (Ehrlich and Morgenroth), while Gay considers it as an example of complement-fixation by specific precipitate.

Antigens.

A general term applied to a group of substances capable of producing specific antibodies administered once or repeatedly, usually by injection, to a suitable animal. For example, bacteria, blood-corpuscles, and certain somatic cells are antigens because they produce specific antibodies called amboceptors and agglutinins. Blood-serum, milk or bacterial extracts are also antigens, because they produce antibodies called precipitins, each being specific for the substance employed for its production. On the other hand, most inorganic or organic substances with definite chemical structure are not antigens, because their introduction is not followed by the formation of antagonistic substances (antibodies) in the body. Repeated administrations of various alkaloids render the organism gradually more resistant to their effect, but do not produce antibodies, hence these alkaloids are not antigens. Diphtheria toxin, tetanus toxin, ricin, abrin, snake venoms, are antigens and their injections are followed by specific antitoxins, as is well known.

Bacteriolysins.

Active principles in blood-serum capable of dissolving bacteria, consist of specific bacteriolytic amboceptors and complement. Analogous to hæmolysins and cytolysins in general.

Bacteriolysis.

Dissolution of bacteria by immune or normal sera. It is caused by specific bacteriolytic amboceptors and complement. Analogous to hæmolysis.

Bacteriotropins.

Introduced by Neufeld; are active principles of certain immune sera inducing phagocytosis. Their action is on the bacteria but not on the phagocytes. They are thermostable.

Complement.

Introduced by Ehrlich; is synonymous with Metchnikoff's cytase and Bordet's alexin. By the term complement one understands one of the two active principles concerned in Hæmolysis, Bacteriolysis, and other instances of serum cytolysis. The other principle is called amboceptor, which is incapable of causing dissolution of cells without the first, hence the term complement is applied to it. Complement is normally present in all sera freshly drawn from the body, but disappears gradually on standing or is completely destroyed at from 55° to 56° C. in about thirty minutes. Complement of one species is not identical in its action with that of other species.

Complement deflection.

Synonymous with complement deviation.

Complement deviation.

Synonymous with deflection; originates from a German term Ablenkung, introduced by Neisser. Complement deviation is identical with Komplementablenkung of the Germans, and fixation of alexin of the French. By the deviation of complement one understands that complement is fixed by the antigen-antibody combination and is made unavailable for a second set of antigen-antibody combination to complete a reaction in which complement is essential. This second set may be a hæmolytic or a bacteriolytic system. See illustrations on pages 22 and 23.

Complement fixation.

Synonymous with complement deviation.

Complementoids.

Modified complements in which the zymotoxic group is destroyed without losing their binding property with amboceptors. Complementoids are formed at 56° C.

Complementophilic group.

Atom-complex of amboceptor on which complement anchors. This complex remains inactive until the cytophilic group (another atom-complex) of the amboceptor joins with the receptor of the cell.

Copula.

Synonymous with amboceptor.

Cytase.

Introduced by Metchnikoff; is synonymous with alexin of Bordet and complement of Ehrlich. See Complement.

Cytolysins.

Active substances in blood-serum consisting of specific cytolytic amboceptors and complement.

Cytolysis.

Dissolution of cells by specific amboceptors and complement. In case of blood-corpuscles the term hæmolysis is used and for bacteria the term bacteriolysis is used.

Cytophilic group.

Atom-complex of amboceptor with which the receptor of a cell combines. Thus an amboceptor possesses two atom-complexes, one for the complement and the other for the receptor of the cell.

Endotoxin.

Toxic constituents of bacterial cells.

Fixateur.

Metchnikoff's term for Amboceptor of Ehrlich and Substance sensibilisatrice of Bordet. See Amboceptor.

Hæmolysins.

Any substance capable of causing hæmolysis may be called an hæmolysin, but its use is restricted to the biological products of unknown chemical constitution, especially the blood-serum, or often the amboceptor of the serum.

Hæmolysis.

Dissolution of blood-corpuscles by various forces, setting the hæmoglobin free into the medium in which the corpuscles are suspended. Distilled water, freezing and thawing, temperature of about 55° C. for 30 minutes, etc., are physical agents which cause hæmolysis. Acids, alkalies, and certain salts can cause hæmolysis in proper concentrations. Of these chemicals may be mentioned most organic acids, mineral acids, all alkalies, bile salts, bichloride of mercury, soaps. Of biological origin may be mentioned certain glycosides such as saponin, solanin, etc., certain bacterial cultures such as those of staphylococcus, vibrios, megatherium, tetanus bacillus, etc.; certain animal venoms such as those of snakes, bees, spiders, etc. The hæmolytic process caused by these different agents is different according to the nature of the hæmolytic forces, but they attack the corpuscles more or less directly. Hæmolysis by serum is, however, somewhat different from that caused by the various forces just mentioned. Thus, hæmolysis by fresh alien serum is caused by two distinct groups of substances, both contained in blood-serum. One is called complement and the other amboceptor. The one is inactive without the other. Serum hæmolysis forms the basis of many interesting phenomena, the serum diagnosis of syphilis being one of these.

Hæmolytic amboceptors.

See under Amboceptors.

Haptins.

Introduced by Ehrlich; synonymous with antibodies, except in somewhat broader sense.

Haptophore group.

The atom-complex of complement which has the power of anchoring on the complementophilic group of amboceptor, thus uniting complement with the cell through the intermediation of amboceptor.

Immune bodies.

Synonymous with antibodies.

Inactivation.

Fresh serum containing both amboceptor and complement, becomes inactive when heated to from 55° to 56° C. for about 30 minutes because of the destruction of complement. This process is called inactivation, and the heated serum is called inactivated serum. Amboceptor is not affected materially by the process.

Inter-body.

Ehrlich used the term Zwischenkörper before he introduced the term Amboceptor, and its English version is Inter-body (Bolduan) or Intermediary body (Flexner and Noguchi).

Intermediary body.

Synonymous with Inter-body; an English translation of Ehrlich's Zwischenkörper. Identical with amboceptor.

Iso-agglutinin.

Blood-serum of an animal usually does not contain agglutinins for the blood-corpuscles of another animal of the same species, but in some instances agglutination may occur and is due to the substances called iso-agglutinins.

Iso-hæmolysin.

Blood-serum of one animal usually does not hæmolyse the blood-corpuscles of another animal of the same species, but in some instances hæmolysis may occur. This phenomenon is known as isohæmolysis and is caused by the presence of iso-hæmolysin. In man this is observed quite frequently in the serum of patients suffering from malignant tumors.

Komplementablenkung.

Synonymous with complement deviation.

Komplementbindung.

Synonymous with complement deviation.

Komplementverankelung.

Synonymous with complement deviation.

Komplementoidverstopfung.

Prevention of complement fixation on account of interference on the part of complementoid. In case of hæmolysis, this causes inhibition of hæmolysis.

Opsonins.

Introduced by A. E. Wright; are active substances of normal as well as immune sera causing phagocytosis. Normal opsonins are rendered inactive at 56° C. and seem to depend upon the coöperation of complement. Immune opsonins are thermostable.

Pleocytosis.

Introduced by Nonne and identical with lymphocytosis in the cerebrospinal fluid in syphilitic and parasyphilitic diseases of the central nervous system.

Precipitates.

By the term precipitate in immunity work is meant the flocculence or clumps formed by mixing specific antigen and antibody, such as serum precipitates, bacterial extract precipitates, etc.

Precipitation.

In immunity work one understands by precipitation a clumping phenomenon of protein or protein-like substances by specific precipitins.

Precipitin.

In the blood-serum of an animal which received repeated injections of a solution of proteid matter there is found a substance capable of precipitating that proteid when mixed in a test tube. This precipitating principle is called precipitin, and its action is specific; that is, a precipitin for human serum precipitates the latter, but no other serum. Precipitins can be produced in animals for different proteins, such as egg albumin, serum, milk, bacterial proteins, etc. It is resistant to the temperature of 56° C. like most immunization products and remains active for a very long time when desiccated.

Precipitinogen.

A general term occasionally used for the substances capable of producing precipitins by means of immunization, or repeated injections into animals.

Preparator.

Synonymous with Amboceptor.

Protectin.

A term introduced by Noguchi to designate a substance (or substances) developing in all blood-sera on standing *in vitro*, and characterized by its or their effects in protecting blood-corpuscles against hæmolytic serum. This protective substance (or substances) is taken up by the corpuscles through long contact, this property being increased in sera of

certain animals after heating to 60° C. or a little higher. It is similar to the complementoid of Ehrlich and Morgenroth, differing only in its absorbability by non-sensitized cells and extractability by fat solvents such as ether, acetone, and alcohol.

Reactivation.

The addition of complement to an inactivated serum restores its lytic activity, and the process is called reactivation.

Receptors.

Constituents of the cell uniting with amboceptors or any other antibodies or toxins. The presence or absence of receptors determines whether the cell is susceptible to a given amboceptor or toxin, or not.

Sensibilisation.

Synonymous with sensitization and is caused by allowing amboceptor to act on cells.

Sensitization.

When a cell is acted upon by specific amboceptor it becomes sensitive to the dissolving action of complement. This process of rendering a cell sensitive is called sensitization. In French it is sensibilisation.

Sensitizer.

Synonymous with Amboceptor of Ehrlich and Bordet's Substance sensibilisatrice.

Sensitizing substance.

Synonymous with Amboceptor.

Stimulin.

Introduced by Metchnikoff; is an active principle of serum favoring phagocytosis. Metchnikoff thought it due to the stimulation of phagocytes, but it is probably identical with the opsonins of Wright.

Substance sensibilisatrice.

Introduced by Bordet; is synonymous with Ehrlich's Amboceptor, Metchnikoff's Fixateur, Gruber's Preparator, or P. Th. Müller's Copula. Bordet often uses the term "sensibilisatrice." See Amboceptor.

Thermolabile.

Complement loses its activity at about 55° to 56° C. in about 30 minutes and is called thermolabile.

Thermostable.

Amboceptor remains still active after the serum containing it is heated at 55° to 56° C. for 30 minutes, and is said to be thermostable.

Toxins.

A general term for a group of substances mostly of bacterial elaboration, possessing a powerful toxicity and one or more of the following characteristics. Thermolability, incubation period for action, unknown chemical constitution, difficulty in separating from protein molecule, capability of producing antibodies. Best known examples are diphtheria toxin and tetanus toxin, both of which belong to true toxins and are of extracellular origin. The toxic principles of cholera vibrio, meningococcus, gonococcus, typhoid bacillus, dysentery bacillus are chiefly contained in the cell-body and are called endotoxins. Tuberculin is an atypical, extracellular toxin. Toxalbumins of higher plants and toxic secretions of snakes, spiders, and bees resemble bacterial toxins in many respects.

Toxoids.

Ehrlich modified various toxins by chemicals in such a manner as to reduce or remove their toxic property without destroying their immunizing property. They may arise spontaneously under certain circumstances and combine, like toxins, with antitoxins. The modified toxins are called toxoids.

Toxophore group.

Analogous with zymotoxic group of complement.

Zymotoxic group.

Analogous with toxophore group of a toxin and represents the active dissolving atom-complex of a complement. The destruction of this group leads to the formation of a complementoid.

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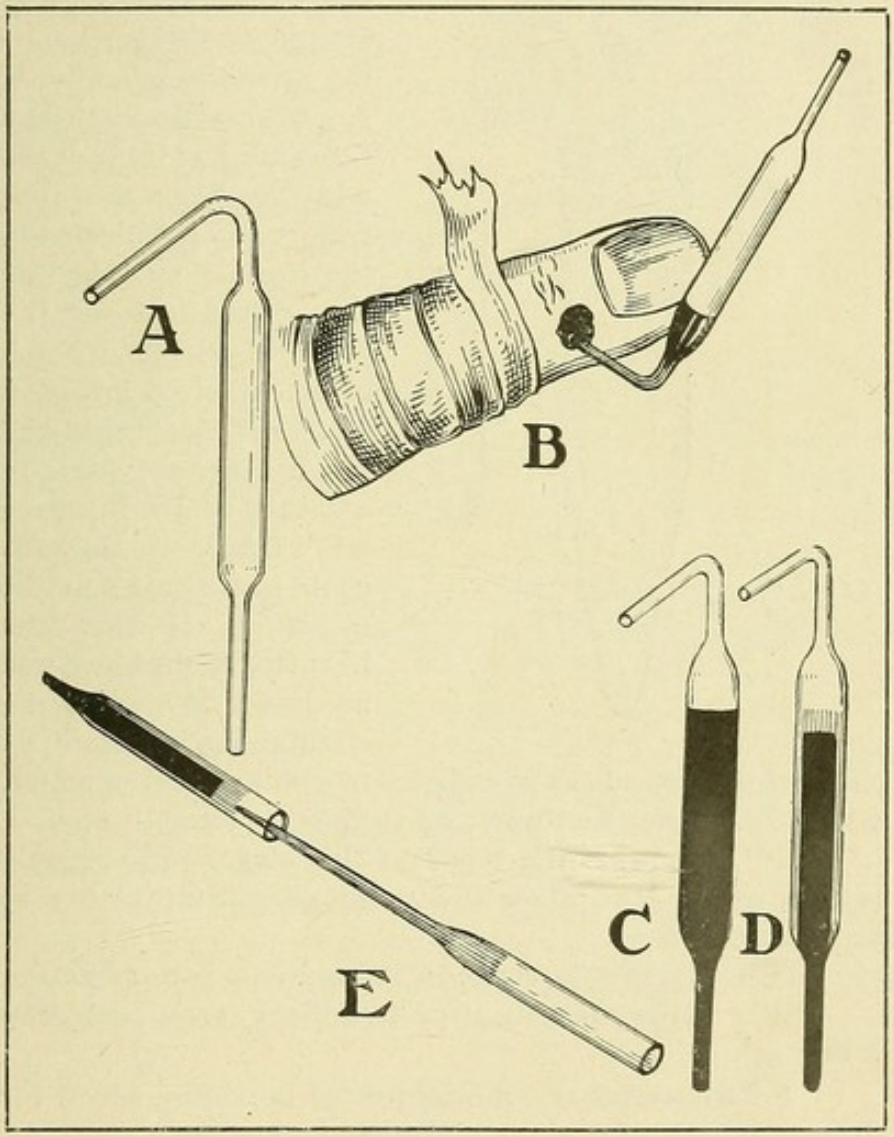
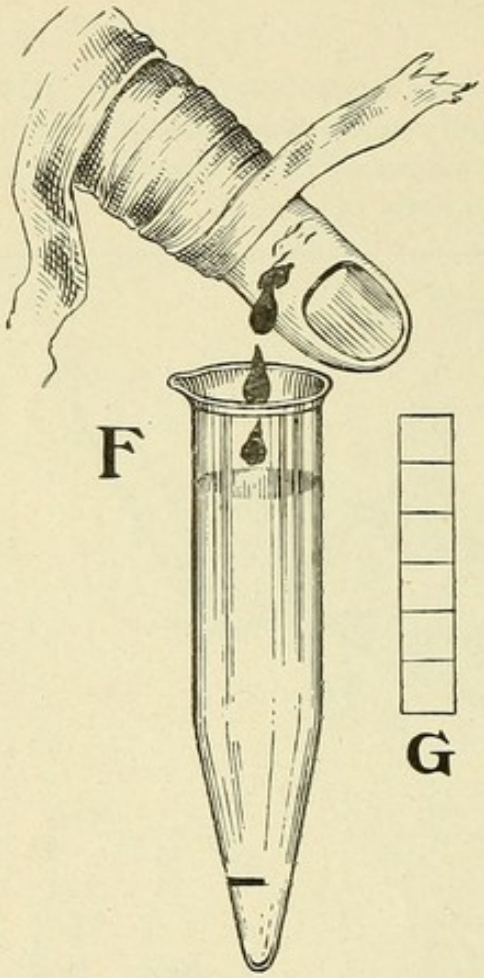
THE NOGUCHI TEST

Dr. Hideyo Noguchi, of the Rockefeller Institute, New York, has succeeded in simplifying the Wassermann reaction so that any physician, after mastering the technic properly, may make an accurate diagnosis of syphilis.



To make a series of tests one should proceed according to the following directions:

Collecting Blood and Obtaining the Serum.—"A" represents the capsule for collecting blood from the patient. Sufficient blood should be obtained to enable one to get at least five large drops of serum. If it is desired to use inactivated serum for the test, about four times this quantity is necessary.



"B" represents the method of obtaining the patient's blood. A bandage is wrapped tightly around the finger, starting at the proximal end. A prick is made in the thin skin just back of the nail; the blood flows out readily and is collected in the capsule by touching the curved end to the drop of blood. When sufficient blood has been collected the straight end is warmed very carefully and then sealed in a very small flame. As the tube cools (great care must be taken not to heat the blood itself) the blood will be drawn down into the straight portion; then, by shaking the capsule as one shakes a clinical thermometer, all the blood may be thrown down into the straight end.

"C" represents the blood at this stage. The capsule is then set aside to allow the serum to separate or it may be centrifugalized.

"D" represents the clotted blood and the separated serum.

"E" capillary pipette used to collect serum and drop it into test tube.

"F" illustrates the procedure for obtaining blood for the suspension of human red blood-corpuscles.

"G" represents the antihuman hemolytic amboceptor paper.

Making Suspensions of Red Blood Corpuscles.—The proper suspension is obtained in the following way: Supposing one wishes to make 1 c.c., sufficient for ten tubes (or less), including controls. Take an ordinary centrifuge tube, put into it with a graduated pipette 1 c.c. of sodium chloride (0.9 per cent) solution. Mark the tube at the surface of the liquid with a wax pencil or file. Now fill up the tube with sodium chloride solution to within one-half inch of the top and mark at the surface of the liquid. Draw out 0.1 c.c. and discard it. Allow blood to drop into the tube until it reaches the last mark on the tube. Centrifugalize and decant the supernatant fluid. Fill the tube with saline solution to the first mark 1 c.c. This represents the suspension of washed red corpuscles in saline solution from 10 per cent whole blood. 0.1 c.c. is the quantity used for each tube.

Testing Antigen.—The concentrated antigen solution is to be diluted with 0.9 per cent sodium chloride solution, 1 to 10.

It is to be tested in the following way:

Dilute the concentrated alcoholic solution with 9 parts sodium chloride solution (0.9 per cent). This makes an opalescent liquid.

Test it for:

1. Hemolytic power:
   0.4 c.c. should not be hemolytic.
2. Anticomplementary power:
   0.4 c.c. should not inhibit hemolysis.
3. Antigenic power:
   0.02 c.c. must give complete inhibition with syphilitic serum.

Five units or 0.1 c.c. of the diluted solution is to be used in each tube.

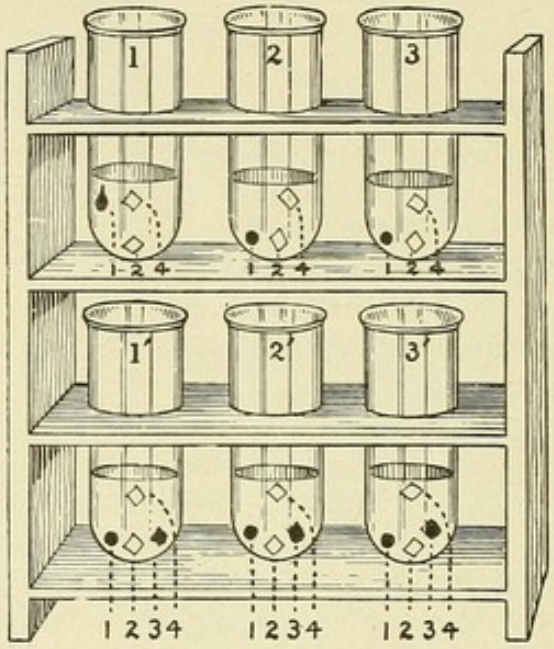
Procedure for Making Test.—After one has at hand the necessary apparatus and reagents (namely, test tubes, patient's serum, serum from a known healthy individual, serum from a known syphilitic, suspension of human red corpuscles, diluted antigen, complement, amboceptor, scissors and pipettes), the mixtures are made as follows:

1. Into each of the tubes 1 and 1′ is placed one drop of the patient's serum. Use four drops when inactivated serum is used.

2. Into each of the tubes 2 and 2′ is placed one drop of serum from a known healthy individual. Use four drops when inactivated serum is used.

3. Into each of the tubes 3 and 3′ is placed one drop of serum from a known syphilitic. Use four drops when an inactivated serum is used. A drop of serum is represented by the figures 1-1-1.

4. Into all the tubes is placed 0.04 c.c. of complement, *i. e.*, fresh guinea-pig serum, marked 2-2-2. This quantity is readily obtained by diluting 1 c.c. fresh guinea-pig serum



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with 9.0 c.c. sterile normal saline solution (0.9 per cent). Then 0.4 c.c. of the dilution represents 0.04 c.c. of guinea-pig serum.

5. Into each of the tubes is placed 0.3 or 0.4 c.c. (as stated in table) sodium chloride solution (0.9 per cent).

6. Into each of the tubes 1′, 2′ and 3′ is placed 0.1 c.c. of diluted antigen (1:10) solution, represented by the figures 3-3-3.

Table Showing Arrangement of Test Tubes and Reagents

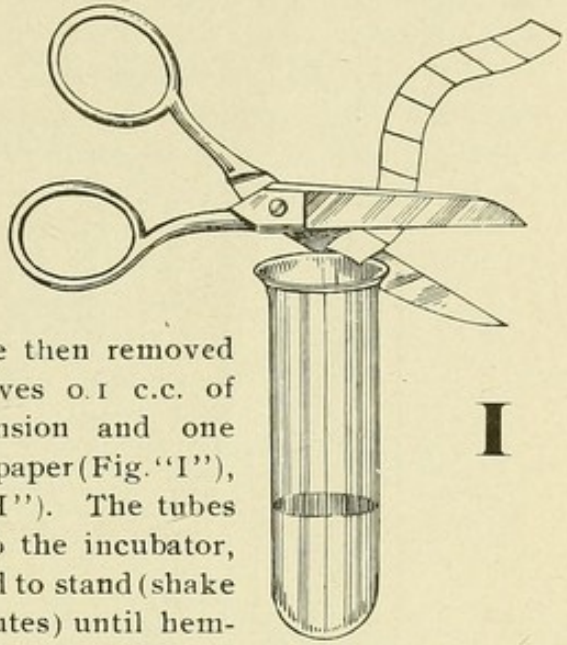
Tube	NaCl.	1:10 Antigen	Serum	1:10 Complement	1:10 Corp.	Amboceptor
1	0.4	0	1 gtt. patient's	.4	.1	2 units
1′	0.3	0.1	1 " "	.4	.1	2 units
2	0.4	0	1 gtt. normal	.4	.1	2 units
2′	0.3	0.1	1 " "	.4	.1	2 units
3	0.4	0	1 gtt. syphilitic	.4	.1	2 units
3′	0.3	0.1	1 " "	.4	.1	2 units

Incubate 1 hour

Incubate 1 hour

The tubes are then placed in a water-bath at 37° C, the temperature of the body, for one-half hour (or in an incuba-

tor for one hour). During this time in any tubes containing serum from a syphilitic individual the antigen will unite with something in the syphilitic serum—the so-called syphilitic antibody—and these two will in turn unite with the complement, fixing it. After incubation the tubes are then removed and each tube receives 0.1 c.c. of red corpuscle suspension and one square of amboceptor paper (Fig. "I"), marked 4-4-4 (Fig. "H"). The tubes are then returned to the incubator, where they are allowed to stand (shake gently every 15 minutes) until hemolysis has occurred in tubes 1, 2 and 3, which are controls because they contain no antigen, and in the tube to which was added one drop of known healthy serum—that is, tube 2′. The tube 3′, containing a drop of serum from a known syphilitic individual, will still be cloudy, as it was when placed in the incubator, while the tube 1′, containing serum from the patient, will be a bright, clear red (hemolysis), or cloudy, according to whether or not the patient has syphilis. Hemolysis means a negative reaction, while lack of hemolysis is a positive reaction and denotes the presence of syphilis.



I

Some exceptions have been found to this last statement. Serum from persons afflicted with tubercular and mixed types of leprosy, sleeping sickness and yaws may also react positively.

The application of the Noguchi system requires a certain amount of laboratory technique which can only be obtained by experience. If difficulties arise in using the test, more explicit directions may be obtained by addressing

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Method of Preparing Reagents

AMBOCEPTOR.—This is obtained by repeatedly injecting washed human blood corpuscles (erythrocytes) into rabbits, at intervals of three to five days. Ten days are allowed to elapse after the last injection. The rabbits are then bled and the serum collected. Paper is now saturated with this serum and allowed to dry. The paper is cut in strips and set aside until wanted for use. In this form amboceptor will keep for a considerable length of time.

Amboceptor paper is standardized by measuring its specific activity. The measurement of specific activity consists in finding the amount of amboceptor necessary to cause hemolysis in 1 c.c. of a 10 per cent suspension of washed human red corpuscles with 0.04 c.c. of fresh guinea-pig serum. Incubate this at a temperature of 37° C. for one hour. The quantity of paper necessary to cause hemolysis under these conditions is known as one unit. In the syphilis test use two units.

COMPLEMENT.—Guinea-pigs are bled into a sterile Petri dish. This can be done several hours before the tests are to be made, and the Petri dish kept in the dark at room temperature until desired for use. If the serum has not separated by the time it is wanted, place the Petri dish containing the blood into an incubator at 37° C. for ten or fifteen minutes. Then pipette off the serum. Any corpuscles remaining in the serum must be separated by centrifugalizing.

Unless some method be devised to preserve the complement for sufficient time to make it available commercially, fresh guinea-pig serum should be used—0.04 c c. to each tube.

ANTIGEN.—This is made by rubbing liver or heart tissue with sand and extracting with absolute alcohol. Macerate 10 grams of tissue in 100 c.c. of alcohol for one week at 37° C., shaking the container every day. Filter until clear. Evaporate the filtrate. Dissolve the resulting extract in ether. Pour this solution into a large quantity of acetone. The acetone precipitates certain lipoid substances which are then collected and re-dissolved in methyl alcohol, in ratio of 3 per cent. This constitutes the antigen solution. For use mix one part of this with 9 parts, 0.9 per cent sodium chloride solution. This dilution should not cause hemolysis in an amount of 0.4 c.c., and 0.4 c.c. should not inhibit hemolysis. The quantity for each tube should be 0.1 c c., containing at least 5 units.

INACTIVATION means the destruction of complement by heating the serum at a temperature of 56° C. for one-half hour.

For rinsing tubes, pipettes, etc., normal saline solution should be used, otherwise they should be perfectly dry. Do not use water, alcohol, or antiseptics.