

The real treatment must be prompt, and can be summarized in the old surgical axiom: Cut down and tie the bleeding vessels. Remove the sac, clean out the effused blood, and if possible close the abdominal wound without drainage. Why hesitate to operate? All agree as to the terrible fatality, if left to nature, of these cases after rupture and hemorrhage. You are going to operate upon an aseptic intra-abdominal wound, where you know that no vital organ is injured; where there is no antecedent disease to militate against success, and no adhesions to threaten secondary hemorrhage or intestinal obstruction later. There is no inflammation, impaired vitality from pressure, dyscrasia or senile changes to offer trouble to the operator now, or later make life a burden for the family physician, as is apt to be the case after so many elective laparotomies. Here it really seems as if there could be no alternative. Let me emphasize. Don't let the corpse-like appearance of peritonism make you withhold from the pallid creature her one chance of life. Here, as in happier circumstances, "Faint heart ne'er won fair lady." Several times when I was giving ether in two of my cases, the pulse has almost disappeared, but rallied again under full doses of strychnia hypodermically. In another case the rigid exactness of the peritoneal toilet had to be omitted, so low was the patient, and still both cases made full recoveries. If, therefore, you are far from expert help, don't hesitate to do the best you can, using aseptic precautions. The gynecologists say that it is not a difficult operation in itself, and bi-chloride and boiling water are everywhere obtainable.

Although I have never performed a laparotomy, I should not hesitate to attempt it, if I met one of these cases so remote as to require many hours to get greater skill. Our fathers were expected to be equal to strangulated hernia or to an amputation above the knee, and with the better training of to-day no practitioner ought to shirk the relatively no greater responsibility of an emergency laparotomy for an ectopic gestation after rupture. Fortunately, however, there are few communities now where special skill cannot be obtained. Let the general practitioner make the diagnosis, and no operator will hesitate. If within reach of a hospital, by all means get the patient into it. One of my cases was carried in the horizontal position, in a hack, three miles without much suffering and no apparent injury.

Of the technique of the operation it is not my place to speak. Hardly less important is the after-care for the first two or three days succeeding the operation. Sterilized salt solution, one drachm to one pint, and strychnia subcutaneously, have given remarkably good results in the state of peritoneal collapse, in my cases, before, during and after operation.

(To be continued.)

GERMANY OFFICIALLY INVESTIGATES COLORADO CLIMATE.—Dr. Engel Reimers, chief physician to the public hospital in Hamburg, Germany, has been sent to the United States, and Colorado particularly, to investigate the influence of the climate upon tubercular patients. The doctor believes that the experiments made with lymph and other alleged cures are as naught compared with the outdoor treatment, and that the dry climate of Colorado is ideal for that purpose.—*Colorado Medical Journal*.

## Clinical Department.

### TACHYCARDIA, WITH SUDDEN RESUMPTION OF NORMAL PULSE-RATE.

BY ADDISON S. THAYER, M.D., PORTLAND, ME.

AT the annual meeting of the American Neurological Association in Philadelphia, June 3d, the President, Dr. F. X. Dercum, showed how greatly our theories of nerve-function may be simplified by supposing the neuron to be endowed with motility. For example, the cessation of hysterical paralysis, he says, might merely mean that neuraxons from the cortex cease to be retracted and resume their normal connection with neurons from the spine.

Dr. Dercum is at least to be thanked for his theory. To medical teachers it may prove exceedingly useful, rivalling in value those blessed comparisons which liken the nervous system to a telephone-exchange, and the cerebral cortex to the coil of a phonograph.

The ascription of kinetic power to the neurons of the cerebrum is not only suggestive as regards the phenomena of hysteria, of hypnotism, and of sleep, but also affords a ready explanation of the performances of nerve-structures which are rarely, if ever, controlled by the will,—as illustrated by the following exploit of the pneumogastric nerve.

June 30, 1896, I was called in consultation by Dr. H. H. Allen, of Scarborough, with whose permission the case is reported, to see Mrs. A., age forty-one. For more than fifty hours the patient's pulse had ranged between 140 and 170. The carotids throbbed somewhat violently, while the pulsation of the radial was barely perceptible. There was no evidence of organic cardiac lesion. The patient complained of precordial discomfort, rather than pain, and was not in the least perturbed mentally. She had secured short intervals of sleep since the onset of the attack, which occurred in the night, while she was apparently enjoying sound rest from the effects of a dose of bromide.

For half a dozen years Mrs. A. has had similar paroxysms of tachycardia several times a year, the duration of which has averaged perhaps half a day, and none of which, except the attack now described, had lasted more than thirty-six hours. External applications, including ice, have given no relief. Numerous drugs in moderate doses and in large doses have been used repeatedly, with little effect. Sometimes the attack would cease gradually; but more often as the patient herself expressed it—adopting, I suppose, the pathology of her various medical advisers—"the nerve would connect on, I would feel and hear a snap which would almost take my breath away, and then would be all right again."

Whatever the pathology, my own fingers and watch were witnesses to the following facts. At a given time the pulse was 152. Five minutes later Mrs. A.'s husband came from her room with the announcement, "It has snapped back." I stepped hastily in, counted the pulse and found it 96.

A misplaced switch at the cerebral centres of the pneumogastric, as an anatomical conception, is complicated; but it is easy to imagine the re-making of a nerve-current that has been broken by the retraction of a neuraxon.

THE Medical Society of Virginia will meet at Rockbridge Alum Springs, September 8th to 10th.