There is no family history of any particular tendency to nervous disorders or heart affections.

I have used the term "paroxysmal tachycardia" for this case without thereby meaning to imply any certainty as to the nature of the type of heart beat which characterized it.

Mackenzie (*Diseases of the Heart*, 1908, p. 129) would include under this term only those cases in which a "nodal rhythm" is present. Whether this case fulfilled his requirement or not I cannot say, since no tracing was taken during an attack, and no attacks have occurred since we have been in a position to take such tracings.

The case, however, is typical of the class described by Bouveret (*Revue de Médecine*, 1889) as "La tachycardie essentielle paroxystique," and concerning which Herringham (*Edinburgh Medical Journal*, 1897) has contributed a valuable monograph.

This case in most of its features agrees with one or other of the recorded cases, the variations being chiefly in minor and unessential details. The termination of the original attacks in vomiting and the artificial cutting short of subsequent ones by the administration of emetics is interesting, but does not warrant us in forming any wide inferences therefrom.

The feature which in this case seems to call for publication is the coincidence of an outbreak of herpes zoster of the left second dorsal area with complete cessation of the heart attacks.

Possibly it is no more than a "coincidence," in the popular sense of the word. Cases of paroxysmal tachycardia do cease spontaneously, and it is possible that in this case the cessation may only be a temporary one and that further attacks may occur later. On the other hand, the fact that the second left thoracic nerve is very closely associated with the nerve supply of the heart, and particularly with its accelerator fibres, and the fact that previous to the outbreak of zoster the heart attacks had recurred fairly regularly every two months for ten years, seem to suggest that the two things stand in some direct relation to each other.

TRAUMATIC RUPTURE OF THE SMALL INTESTINE: SUTURE AND APPENDICOSTOMY: RECOVERY.

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IN the BRITISH MEDICAL JOURNAL of May 29th, 1909, Mr. William Sheen of Cardiff records a case of traumatic rupture of the sigmoid colon, in which, after commenting upon the rarity of the lesion, he, by reference to a paper by Berry and Giuseppe, shows that the mortality in the London hospitals in cases of traumatic rupture of the intestine has been over 87 per cent. Under these circumstances it becomes a duty to record such cases, and especially so if, as in the following case, they present features of special interest attached to their treatment.

A. L., aged 33, bricksetter's labourer, was admitted to the Oldham Infirmary on May 10th, 1909, at 6 p.m. He said that he had received a violent blow from the end of a plank, which struck him in the epigastrium; that afterwards he was able to walk a few yards and descend a ladder, but then felt too ill to move. He lay upon the right side with the knees drawn up, and was evidently in great pain. The abdomen was of board-like rigidity, retracted to the scaphoid shape, with the skin thrown into transverse folds, and very sensitive to pressure. The flanks were dull on percussion, but this dullness did not move on changing the position of the patient. The liver dullness was normal in extent. There was no external mark of violence except a few small superficial scratches. Shortly after admission he vomited a little brownish fluid.

It was decided to operate, but the patient would not consent until he had seen his wife, thus delaying the operation until nearly 10 p.m.—that is to say, seven hours after the injury.

Operation.

Chloroform was administered by the junior house-surgeon, Dr. Gray, and I had the assistance of our senior house-surgeon, Dr. Mackenzie.

An incision was made in the middle line above the umbilicus. On opening the peritoneum there was an escape of brownish, clear fluid. On exposing the liver margin more of this fluid

welled up, and with it some bubbles of gas. Examination of the stomach revealed no lesion. The transverse colon and omentum were then drawn up, thus allowing more fluid to escape and with it some flakes of lymph. The intestines were deeply injected, and in places covered with large flakes of lymph. Systematic examination of the small intestine revealed a longitudinal rupture about $\frac{1}{2}$ in. in length, with pouting mucous membrane on the free border of the jejunum, about 2 ft. from its commencement. The rupture, after sponging with weak mercury biniodide lotion, was closed with a continuous Lembert suture, and the examination was continued but no other lesion was found. A suprapubic incision was then made, and on opening the peritoneum more fluid of the same slightly turbid character and containing small food particles escaped; through this opening a Keith's tube was passed down to the bottom of Douglas's pouch. Another incision was then made through the parietes over the appendix, which was brought through this incision, and its mesentery cut after ligaturing it. The appendix was then amputated, leaving about an inch of stump. This was dilated, and a rubber catheter inserted through it into the caecum and fixed by a purse-string suture; the stump of the appendix was anchored to the skin by two fine silk sutures, and this incision closed round the appendix. The epigastric incision was completely closed by through-and-through sutures and dressings applied. The patient was removed to bed and put into the Fowler position. The whole operation took less than an hour from the first incision to the patient being removed from the table.

After-Treatment.

A cistern was arranged about 2 ft. above the level of the patient's abdomen, and under it a spirit lamp; the cistern was connected by rubber tubing with the rubber catheter, and the tubing clamped so as to allow one drop of normal saline solution with which the cistern was filled to escape every second.

It was found that to ensure the drops of saline having a temperature of 98° F. we had to keep the cistern contents at 150° F. By this arrangement we were able to cause a continuous flow of saline solution into the caecum for forty-eight hours. The tube then came out, and on reintroduction there was so much pain that it was discontinued. The total quantity of saline solution introduced was two gallons.

The patient continually perspired, passed urine freely, and at the end of the time had some incontinence, passing faeces along with a moderate quantity of saline fluid. Moreover, what was more interesting, there was fluid continuously welling up through the Keith's tube, so that the pad over the tube had to be changed every half-hour.

On the fifth day the Keith's tube was removed, as the flow of fluid through it had almost ceased.

On the seventh day some flatus was passed through the appendix.

On the eighth day the stump of the appendix came away as a slough, and left a faecal fistula, which remained open for a fortnight. There was some suppuration along the track of the sutures in the epigastric wound.

The patient was out of bed at the end of three weeks, and walking in the garden within a month.

I relied entirely upon the infusion of saline solution into the caecum to rid the peritoneal cavity of its irritating contents, by causing the membrane to secrete instead of to absorb, and that this occurred was evident by the copious flow from the Keith's tube, continuing for five days, even after the infusion was discontinued.

The man's condition never caused any anxiety after the first twenty-four hours.

If I should meet with a similar case I would diminish the rate of flow of the saline after the first twenty-four hours, for the patient had considerable inconvenience, from the thirty-sixth to the forty-eighth hour after operation, from the rectal incontinence.

It is stated that a motion is about to be submitted to the Duma making vaccination compulsory in Russia. The Inspector-General of the Medical Department has asked the various administrative authorities and institutions to report on the subject, and the Minister of Public Instruction has sent out a circular to the faculties of medicine.