greatest facilities for studying the disease. That the susceptibility to the disease is transmitted from parents to their offspring rather than the disease itself is rendered still more probable by the experience of American observers that rickets is more prone to attack the children of aliens than those of parents who are indigenous to the soil. Haven of Boston⁴ noted that it was most prevalent among the coloured population and that the majority of white rachitics of foreign ancestry were born of parents who came from the south of Europe where the disease is by no means common. Thus emigrants from the "sunny south" would appear to transmit in more uncongenial climes the necessary susceptibility to their offspring. Whether this be ceded or not we are still far from being able to say why the assumed causes of rickets act with such signal partiality and why it is that in other quarters of the globe—such as New York, where the conditions under which the children live cannot be so very dissimilar from those that obtain here—the disease is said to be so strikingly less frequent.⁵

Windsor.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A BICEPHALIC FŒTUS.

By W. C. F. SMITH, L.R.C.P. EDIN., L.F.P.S. GLASG.

THE illustration which is reproduced from a photograph shows a bicephalic foetus which was born on April 6th, 1899, after a natural labour and at full term. The mother

entirely recovered from the pregnancy. I attended her in her previous confinements, when labour was quite normal and the children are living. As will be seen, the foetus has two distinct heads and necks well formed.

Necropsy.—At the post-mortem examination there were

found two separate and distinct heads and necks, fusing at the level of the shoulders into one trunk which was, however, marked by the existence of two spines, lying some little distance apart, and uniting at the sacrum, which was single. There was no other abnormality of the skeleton, and the arms and legs were normal in number and conformation. The thoracic cavity was partially divided into three compartments by the projection forwards into it of the two spinal columns, the interval between the latter being bridged across by soft tissue. In the central compartment of the three was the single and normally formed heart, and the two lateral were occupied by normal lungs. The arch of the aorta was normally formed but gave off arterial trunks to both necks. The condition of the specimen at the time of the post-mortem examination did not admit of further examination of the arterial system. There were two separate and complete oesophagi. The most remarkable feature disclosed by examination of the abdominal cavity was an extensive reduplication of the alimentary canal. The two oesophagi each led into a separate stomach. The right of these was a cul-de-sac and was hour-glass in shape. The left was small but otherwise normal. The intestine leading from the left stomach was normal in itself, but was accompanied throughout the greater part of its extent by an imperfect gut which fused with it one inch above the ileo-cæcal valve, the latter as well as the large intestine being normal in every respect. This small intestine of the right side lay side by side with the other below the duodeno-jejunal flexure. Above that level it was represented by a cul-de-sac extending in the direction of the pyloric end of the right stomach and united to it by fibrous tissue. There was a separate spleen on each side of the abdomen, one in connexion with each stomach.

Halifax.

NOTE ON A CASE OF PERFORATED GASTRIC ULCER IN A MAN.

By S. L. CRAIGIE MONDY, L.R.C.P. LOND., M.R.C.S. ENG.

THE following case shows the great difficulty in diagnosing gastric ulcer in the absence of a history of gastric symptoms, and also proves that perforation is not always followed at once by collapse.

I was called to see a man, aged 42 years, at 1.45 A.M. on July 13th. When I saw him he was suffering from very severe pain in the epigastrium. He said that he had eaten a heavy supper consisting of fried fish and plums and had had a pint of beer. He was suddenly seized with the pain at 12.45 A.M. and he forced himself to vomit to try to obtain relief. The vomited matter consisted of what he had had for supper. There was extreme tenderness over the abdomen, most marked over the epigastrium, but the abdomen was not distended. The pulse was of fairly good tension and numbered 94 in the minute. The temperature was 101.2° F. The bowels had acted at about 8 A.M. on the previous day and had been regular "every day of his life." He had two or three sudden twitches of pain in my presence which caused him to cry out and to draw his knees up on his abdomen. Taking the case to be one of acute gastritis I put the patient on the following mixture—one and a half drachms of bicarbonate of sodium, one drachm of carbonate of bismuth, one drachm of solution of opium, with mucilage of tragacanth in suitable quantity and water to six ounces, one ounce to be taken every two hours for the first two doses and then one ounce every four hours. The pain still continued very severe and at 4.20 A.M. I was again called to see the patient. I then found him in much the same condition as before, with a temperature of 102°. I ordered hot fomentations for the abdomen and gave glycerine of belladonna to be painted on where the pain was and also a one-drachm glycerine suppository to get the bowels to act. There was one action of the bowels after this, but no relief from the pain. The patient was seen again at 9.40 A.M. The abdomen was then somewhat distended and there was a good deal of tympanites, but no coils of intestine were visible on the surface. The pulse was then 84 and the temperature was 94°. He was again visited in the afternoon and was then suffering less pain, which was doubtless due to the opium, but he seemed on the whole better. The mixture was repeated. At 1.30 A.M. on July 14th a messenger came to say that the patient was much worse.

⁴ THE LANCET, Feb. 20th, 1886, p. 367.

⁵ Practitioner, vol. ii., 1890, p. 273.