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.

He was then suffering very much pain and he said that he felt that if his bowels were opened he would be better. It was therefore agreed to give him a simple enema, but before it could be prepared he suddenly became comatose and died in a quarter of an hour. Just before he became comatose he said that he "felt as if he were full of wind but could not bring it up."

A post-mortem examination was made in the afternoon. On opening the abdomen it was at once seen that there were large flakes of lymph all over the peritoneum. On the anterior surface of the stomach near the pylorus was an ulcer which had perforated. The ulcer measured half an inch by a quarter of an inch and was a quarter of an inch deep, conical, and with smooth edges. The portion of the stomach wall for from three-quarters of an inch to one inch around was thickened, tough, smooth, and discoloured. The ulcer was thus chronic. It has since been ascertained from his employer that he had complained of "pains in the stomach" for some days before.

Shaftesbury-avenue, W.

A CASE OF RARE OBSTETRIC ACCIDENT.

BY H. MALLINS, M.B., M.CH. DUB.

ON July 29th, 1899, I was sent for to attend a woman, a primipara, with reference to whose case I was rather anxious, as she had early in her pregnancy exhibited a tendency to eclampsia. On my arrival at her house I was told that she had already had two slight "stoppages." Finding the os to be fully dilated I gave her chloroform and proceeded to apply forceps. The blades slipped over the head with the greatest facility, but when it came to locking the handles that of the upper blade refused to coapt with its fellow notwithstanding the most careful manipulation. After several failures I decided to withdraw the forceps and re-apply them. The lower one came away easily, but on attempting to extract the upper one I found it impossible to do so for more than a certain distance. On seeking for the cause of the difficulty the tip of the blade could be felt to be wedged between the head and a much smaller body of an equally firm nature. Any traction on the handle only served to bring this smaller body lower down and increase the impaction of the blade. As the pains were strong and regular and the head was steadily descending I determined to leave things to nature and await the solution of the puzzling phenomenon, doing nothing beyond guiding the handle of the imprisoned blade in the right direction. As the delivery of the upper shoulder and arm followed that of the head the tip of the blade came into view resting in the bend of the elbow, the hand and forearm having through some extraordinary mischance slipped through the fenestrum of the blade. As might have been anticipated the arm was for some days somewhat deficient in power as a result of the accident, but it is steadily improving. Never having heard of such a case I wrote to Dr. G. E. Herman, the experienced author of "Difficult Labour," to ask if he had ever met with a similar one. In a courteous reply he stated that he had never met with, or heard of, such a case. The rarity of the case may therefore justify its publication.

Watton, Norfolk.

TIVERTON INFIRMARY.—The new wing of the Tiverton Infirmary, which has been erected to celebrate Her Majesty's Diamond Jubilee, was formally opened by Sir Stafford Northcote, M.P., on August 10th, in the presence of a large gathering. The new building comprises two wards of two beds each for male and female patients, an operation room, nurses' room, waiting-room, &c. The cost was about £1550.

A NEW LUNATIC ASYLUM.—At the quarterly meeting of the Breconshire County Council held on August 4th it was stated that the estimated cost for the new asylum for the counties of Brecon and Radnor which is to be erected at Newent would be £140,000. The share of Breconshire would be £98,314, and towards this £29,000 would be contributed by Monmouthshire. The council decided to negotiate a loan for the required amount to be repayable over a period of 30 years.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

MIDDLESEX HOSPITAL.

TWO CASES OF PAPILLOMATOUS CYSTS.

(Under the care of Mr. PEARCE GOULD.)

PAPILLOMATOUS cysts of the ovary are usually derived from the paroöphoron and that was their origin in the following two cases which illustrate well the tendency the intra-cystic growth has to pierce the cyst wall and cause ascites and to give rise to papillomatous growths on the outer surface of the cyst, of the ovary, the broad ligament, and the neighbouring structures. As in these cases, there is always a great probability of these growths being diagnosed as malignant either with or without a laparotomy, but they are in their essential nature absolutely benign and if the primary disease is completely removed they do not return. In these cases the warty masses were almost limited to the broad ligament, though in the second case one mass was found on the rectum; often they are widely scattered over the peritoneum; these secondary growths wither and disappear when the primary tumour is removed. When, as occasionally occurs, these growths get into the space between the two layers of the broad ligament and spread on to the pelvic wall their removal is very difficult and may be impossible. Sometimes the spread of the papillary masses over the peritoneum is caused by the bursting of the cyst. As Pfannenstiel¹ points out, malignant growths of the ovary may present a papillomatous appearance, but these are to be distinguished from the true papillomatous growths of the paroöphoron. The ascites which is so markedly present in cases of papillomatous cysts disappears at once when the growth is removed and no drainage of the peritoneum is required. For the notes of the first case we are indebted to Mr. J. B. Davey, and for the notes of the second case to Mr. Blandy.

CASE 1.—A married woman, aged 47 years, was admitted into the Middlesex Hospital on Oct. 15th, 1898. In her past history there was nothing of importance to record. She had had five children, the youngest of whom was 18 years old, and they were all in good health. Her illness began at the beginning of the previous April—that is, about six months before her admission into the hospital—with pains in the right side which she described as shooting and paroxysmal in character, having no definite relation to meals. The pains were felt by night as well as by day and they seemed to shoot into the right arm and right leg, but they were never at any time very severe. After about a fortnight she began to vomit and she also noticed some swelling of the abdomen which steadily increased. The attacks of vomiting, like the pains, occurred during both day and night and were not relieved by medicine. As a rule, the vomit consisted of pale yellowish fluid, but occasionally it was of a dark-brown coffee colour. As the swelling of the abdomen continued to increase the patient went into the hospital at Eastbourne and there laparotomy was performed and a quantity of reddish serous fluid was drawn off; at the same time a growth was seen at the brim of the pelvis which was compared to a number of white currants and the peritoneum was described as being hyperæmic and villous. No attempt was made to remove the growth and the abdomen was at once closed. After this operation the abdomen was for a time smaller, but soon it began again to increase rapidly in size. Menstruation continued to be regular and there was no difficulty in micturition, but constipation was throughout a troublesome symptom and the bowels were only relieved by purgatives.

On her admission to the Middlesex Hospital the patient was found to be somewhat emaciated and to have numerous

¹ Archiv für Gynäkologie, Band xlviii., 1895.