from the chest wall, and swayed violently to and fro with each respiratory movement. After about five minutes, however, the swaying lessened considerably, and the heart took up a position slightly nearer the chest wall. No disturbance was noted when the pericardium was gripped with a Spencer-Wells forceps.

Account of the Case.

A girl, 7 years old, was admitted to the Bolingbroke Hospital on March 2nd, 1920, with the history that a sewing-needle had been accidentally pushed into her chest. The place of entry was about an inch to the left of the sternum at the level of the upper border of the fourth costal cartilage. The house surgeon, under local anaesthesia, attempted to extract the needle; he cut down deep to the fibres of the pectoralis major and saw the extreme end of the needle in the depth of the wound. He was unable to grasp it, and the end completely disappeared whilst he was attempting to catch hold of it. He stated that it appeared to be sucked into the chest with each respiration.

I saw the child the same evening. Under the X rays the needle could be seen lying obliquely on a level with the fourth costal cartilage. It moved freely and completely with each heart beat, and it was clear that it was embedded in the heart. A general anaesthetic was administered by Major G. B. Lowe, and a slightly curved incision was made so as to expose the fourth and fifth left costal cartilages from which the muscular fibres were detached. About an inch of the fifth costal cartilage was removed, the portion resected being just internal to the vertical nipple line.

The pleura was opened, and for a time the swaying of the mediastinum and the cardiac pulsation made accurate observation impossible. The position of the needle had been observed from time to time during the operation by means of the fluorescent screen, and it was noteworthy that after the opening of the pleura the level of the shadow immediately became considerably lower than before. The mediastinal swaying gradually became less in extent, and by means of a good light it was possible to see about a quarter of an inch of the needle protruding near the left cardiac border. In order to steady the heart the pericardium was grasped by a Spencer-Wells forceps, and a similar forceps was passed into the pleural cavity so as to grasp and extract the needle. The parietal pleura could not be sewn, but the soft parts were brought together by two rows of catgut sutures, and the skin apposed by silkworm gut. The child stood the operation well, and the pulse-rate was neither irregular nor increased in rapidity at the end of the operation. The needle was $1\frac{5}{8}$ inches in length.

When the child left hospital on March 22nd the wound was soundly healed, the left-sided pneumothorax was completely absorbed, and she felt perfectly well.

A DICEPHALOUS MONSTER.

BY M. Z. SHAFËI,

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THE following case may be of some interest.

I was called at 7 A.M. on Feb. 24th to a woman said to have been in labour for three days. On arrival I found the patient (aged 20) in bed looking well. The history I got from her and from the midwife was that she had felt pain in the back and abdomen three days ago, and the midwife felt a head presentation. The head presented in the vagina for 24 hours. The midwife stated that she pulled the head as hard as she could but nothing more presented.

On examination I found a multiparous woman. Temperature normal, pulse 95, but not weak, and face not anxious. I felt a hard tumour in the right side of the true pelvis, and she complained of pain in the right thigh. Head and neck were outside the vagina, and the face was very congested. No pulsation felt in the facial artery, and no foetal heart sounds heard. After

evacuation of a full bladder and rectum I felt the shoulders filling the whole breadth of the pelvis. I tried in vain to move them to one side, but finding it impossible to pull down more than one arm, I decapitated the head, dislocated the arm at the shoulder, and did a version. On pulling the leg it disarticulated at the hip; then, helped by the pains, all the body came down and, to my astonishment, another head and neck was delivered, followed by the placenta. I douched the patient with lysol and gave her 10 c.cm. of antistreptococcal serum.

The condition of patient three days after was very good. She had no hæmorrhage and no rise of temperature, no tear in the perineum, and she promises, as I write, to continue a normal puerperium.

On examining the foetus, I found it to be a male dicephalous monster, with two heads and necks, as seen in the appended photograph. The heads are fully developed. The monster was alive till six hours before delivery, as the patient felt its movements; one head was presenting. Although there is only one thorax, there are two vertebral columns, easily separable, reaching down to the sacrum. The two tracheas unite as one tube at the top of the thorax.

There is one set of viscera in the thorax and abdomen. There is an imperforate anus and a phimosi. The testes are in the scrotum, which is bigger than normal and looks like two labia. The hair is well developed on both scalps. The length is 46 cm. and the weight 5 kg. The diagnosis was impossible and the treatment was circumstantial.

Dicephalous monster, male, with one thorax but two fully developed heads.

A CASE OF HYPOSPADIAS PERINEALIS.

BY S. CHELLIAH, M.B., C.M.,

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THE patient here described had the anatomical characteristics of a man, but was brought up as a woman and was known by a feminine name, Punchi Nona. He was unmarried, and lived with and was supported by his sister's son. He was admitted into the female Diarrhoea Ward of the General Hospital, Colombo, on Nov. 24th, 1919, with anæmia, œdema of legs, and breathlessness of six months' duration, and died on Dec. 1st, at the age of 50, of uræmia due to chronic parenchymatous nephritis.

General appearance.—As shown in photo, with slight growth of hair on the chin and over the upper lip, larger growths in the armpits, slightly prominent pomum Adami, pyramidal growth of hair over the pubes, and deep and manly voice.

External genitalia.—The penis is small, imperfectly developed, looking not unlike a hypertrophied clitoris, adherent on either side to the scrotal integument, with no meatus urinarius. The scrotum is cleft, looking like the labia majora; the right half contains a testis, the left half is empty. The other testis was found in the left inguinal canal, together with a semi-solid blue mass close to it of the shape and size of the testis, due to phlebectasis of the veins of the pampiniform plexus. This mass was punctured by accident.