Examination of the twins showed them to be well formed and symmetrical (see photograph). Both had normal female external genital organs. The combined weight was 4 lb. 10 oz. (2,100 g.). They were joined by a bridge of skin-covered soft tissue at a level just below the xiphoid processes. Both infants showed exomphalos and there appeared to be a large common liver. The monster can be classed as an omphalopagus (Hirst and Piersol, 1892). The specimen is being preserved.

Comment

The incidence of conjoined twins is difficult to ascertain. Aird (1954) suggests that the greater frequency of case reports is "due to the increasing accessibility of very large populations in Asia and Africa, to the greater possibility of the successful birth of conjoined twins in improved modern obstetrical circumstances," and, of course, to the greater possibility of successful surgical separation should they be born alive.

From the clinical aspect it is interesting to note how most standard textbooks agree that double monsters can be delivered spontaneously in many cases. They also agree that when the monsters give rise to dystocia dangerous and complicated operations are often needed to effect delivery. Many cases, of course, come into premature labour when the foetuses are small and vaginal delivery is thus possible. In general, delivery is easier by the breech, and Munro Kerr and Chassar Moir (1949) advise version if the heads are presenting. The advantage of breech extraction is that destructive operations, if they become necessary, can be more easily carried out. An interesting case of a thoracopagus delivered through the vaginal route in a very unusual fashion, the foetuses being extracted one after the other in cephalic presentation, has been described by Morrone (1954).

As regards the diagnosis, the association between hydramnios and foetal abnormality is so frequent that the latter should be suspected whenever hydramnios occurs. Careful abdominal palpation and internal examination, if the dilatation of the cervix is adequate, are important. Radiography is valuable, and in the case described suggested the possibility of conjoined twins, as the two heads were at the same level, faced each other, and the thoracic cages of the foetuses were together. However, if the union be very flexible the two heads may well be at different levels, as in a case described by Rawlings and Warwick (1951).

My thanks are due to Professor B. H. Sheares for permission to publish this case report, and to Mr. Austin Bennett for the photograph of the monster.

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A considerable range of lecture courses are now offered to Cambridge medical students during the Long Vacation. These cover not only the preclinical and transitional periods of medical studies but also provide opportunities for continuing a general education in the arts. For the preclinical student there is a course in pharmacology as well as the usual lectures and demonstrations in anatomy and physiology. Practical experience in the department of pathology may be arranged, and formal instruction in biochemistry is also available. For the student who has passed in anatomy and physiology, the Medical School offers a course of instruction in elementary clinical methods at Addenbrooke's Hospital, and there is also an introductory course in psychology. The Faculty of Modern Languages under the Pressland Bequest provides an elementary course of 24 lectures in German, Russian, and Italian for science and medical students. More advanced courses are also available in some of these languages. A special series of lectures in English literature and poetry for students in scientific faculties is arranged by the Faculty of English.—*Cambridge University Reporter*, March 8.

Medical Memoranda

Lichen Urticatus as an Allergic Manifestation of Pregnancy

It has been noted (Urbach and Gottlieb, 1946) that, in general, pregnancy has an influence which tends to diminish a pre-existing allergy, and this can be frequently observed in cases of asthma and hay-fever. Various theories have been postulated to explain this (Ahlmark, 1944; Zondek and Bromberg, 1945a, 1945b).

There are, however, certain conditions of an allergic nature which can be actually brought about by the pregnant state. During pregnancy the skin can show a definite hypersensitivity to substances originating in the foetus and also to the placental protein (Urbach and Gottlieb, 1946), and in some women various dermatoses of pregnancy can result, due, it is believed, to the production of an abnormal amount of endogenous allergens from the foetus or placenta. It is assumed that, normally, specific antibodies are produced in the pregnant woman as a reaction to this foetal or placental protein (Seegal and Loeb, 1943). The assumed presence of such specific antibodies has been used to explain (Freund, 1909) the good results achieved with systematic injections of the serum of pregnant women in the treatment of the dermatoses of pregnancy, a form of treatment used with success in America. The presence of these antibodies in the injected serum effectively neutralizes the increased supply of antigen which presumably causes the condition.

Lichen urticatus is one of the ways in which an allergic manifestation of pregnancy can show itself; the following three cases illustrate this.

CASE REPORTS

Case 1.—A primigravida aged 22, blood group O, Rh positive, developed, seven days before delivery, a typical papular urticarial rash covering the entire body, which was extremely itchy and caused great discomfort. Both the rash and the irritation were completely unresponsive to phenindamine or diphenhydramine in full dosage. In an attempt to afford her relief a subcutaneous injection of adrenaline was given without any effect. Within 24 hours of the normal delivery of the baby (full term) there was definite relief from the irritation, and the lichen urticatus began to fade, but took nearly two weeks to disappear completely. There was no personal or family history of allergy or allergic response to any drugs excepting that her mother suffered with migraine.

Case 2.—A primigravida aged 23, blood group A, Rh positive, began to develop, when 33 weeks pregnant, a typical lichen urticatus with irritation, covering the body and upper parts of the arms and legs. She was given full doses of mepyramine maleate and mepyramine maleate cream to apply locally. In four to five days the rash disappeared, whereupon she stopped the treatment. The irritation and resulting distress returned within 12 hours, and two days later the papular urticaria had reappeared. Recourse was had once more to mepyramine maleate tablets and cream, but this time with no relief. Within a few hours of the normal delivery of the baby (full term) the pruritus had gone, and the rash began to fade within 24–48 hours, the final traces taking nearly three weeks to completely disappear. There was no personal history of allergy or allergic response to any drugs, but the family history showed that the mother had asthma.

Case 3.—A primigravida aged 23, blood group O, Rh positive, developed, about the fourth month of pregnancy, lichen urticatus with pruritus covering the body, especially the front of the chest. No treatment, except calamine lotion locally, was given, and the rash persisted throughout the remainder of the pregnancy. Within 24 hours of the normal delivery of the baby (full term), the rash and

irritation had completely disappeared. There was a definite history of allergy in this patient, when as a young girl she suffered with severe asthma.

COMMENT

Not infrequently pregnant women exhibit urticaria, but in most cases it can be related to an external cause, the removal of which brings about the disappearance of the rash, sometimes accelerated by the use of antihistamines. In the three cases described above, lichen urticatus was due to the foetus or placenta only, and persisted until the cause was removed with the expulsion of the child and placenta. In all three cases relief from irritation occurred soon after, and the papular urticaria began to fade as quickly, finally disappearing when the last traces of the antigenic substances were removed from the blood.

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Range of Movement of Testicle

One of the peculiarities of present habits of thought in our profession is that matters of demonstrable fact are treated as matters of opinion. Anatomy is essentially concerned with matters of fact, yet I have found in a number of instances that assertions of the inaccuracy of generally accepted anatomical teaching are treated as if they had to do with religion or politics—subjects in which opinions incapable of proof are held on grounds of habit or emotion. An instance is that of the range of movements of the testicle. It is common knowledge that in all children and many adults the testicles can move upwards out of the scrotum over the pubic bone. The anatomists have not described any cavity into which they could go, and in consequence the strange idea has arisen that the cremaster dragged them into the inguinal canal. I say the idea was strange, since the normal testicle is far too big to go into the normal external ring at any age; and to bring it into the canal the cremaster would need a contractility totally unlike that possessed by similar muscle elsewhere.

What actually happens can easily be demonstrated at an operation for inguinal hernia on a child, if the testicle is pushed upwards out of the scrotum and held there by an assistant pressing from below while the surgeon cautiously dissects down on it. The fascia of Scarpa is first defined, and when it is opened the testicle will be found lying in an extremely loose areolar space between it and the external oblique. (Incidentally the nature of tissue which permits such extreme mobility would be an interesting study.)

I described this upward prolongation of the scrotal cavity as the "superficial inguinal pouch" (Browne, 1938) and suggested that much bad treatment and inaccurate prognoses in cases of maldescent of the testicle could be avoided if it were understood. My statement produced an annotation and many letters disagreeing with it; but no one then or since suggested examining the human body to see who was right. I do not think that in sciences such as physics or chemistry a similar question would be left similarly in the air; it would be promptly settled one way or the other.

An interesting and important paper by Mr. John Baty (1956) illustrates the persistence of the anatomical error and throws a light on the significance of this upward extension of the scrotum. He states that it is well known that in small boys the testicle may temporarily disappear up the inguinal canal or into the abdominal cavity; actually, as I have said, this is not a well-known fact but a widespread delusion. The purpose of his paper, however, is to describe a painful spasm of the cremaster dragging the testicle upwards and jamming it against the pubic bone. This spasm is apt to occur in mental stress, and it seems to me quite possible that it is an involuntary atavistic reflex to withdraw

the organ into the pouch away from possible danger; and that if this withdrawal could be completed the spasm would not occur. It is a common observation that the testicle tends to withdraw upwards in extreme cold; and, although the prudery so marked in our country and profession makes it difficult to obtain information, it does the same in certain males during sexual excitement.

The illustrations show a normal male in whom, as is not uncommon, the early range of movement has been retained. They show the remarkable nature of the belief that a testicle of that size could pass through the external ring.

FIG. 1.—Testicles in usual position at bottom of scrotum.

FIG. 2.—Right testicle pushed up out of scrotum into the superficial inguinal pouch.

This particular question raises a much larger one—that of the mechanism of distribution of knowledge throughout the profession. How long will it take for this piece of knowledge to get into the anatomy books, from thence to the students, and finally be applied to the benefit of the general population? We are all so conditioned by our medical education to reciting the orthodox anatomy by rote as gospel that surgeons are very unwilling to move without the authority of the professors. The professors, apart from the loss of face involved in admitting that they have been reproducing errors and omissions for generations, must all move together or not at all, since otherwise one of them might fail the students of another in an examination for reproducing what they had been taught. From my experience in several other cases, notably the pointing out of the dangerous vessel in tonsillectomy (Browne, 1928), I anticipate that it will take many years and be done gently in stages. The first stage probably will be a statement that, though the retracting testicle usually goes into the inguinal canal, in certain cases it goes into the recess I have described.

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