The excitement continued until July 15. During that time he was agitated, aggressive, noisy, restless, difficult with his food, and cantankerous. He slept for long hours between attacks, which lasted on the average about 20 minutes. On July 18 laboratory investigation revealed that trypanosomes were present in the gland juice and cerebrospinal fluid.

He entered into an apparently lucid period on July 16 and continued fairly well behaved and co-operative till August 8, when he again became noisy and confused and exhibited grotesque behaviour. He was auditorily and visually hallucinated. He spoke to imaginary people around him and complained that they said they were going to kill him. During the relapse on August 8 he had another attack of status epilepticus, and this recurred the following day. The cerebrospinal fluid was again examined, but this time trypanosomes were not present. This relapse lasted only two days, after which he became normal with only an occasional outburst of shouting and delusional displays.

He maintained his improvement and on August 16 inquired whether the man in his place had been informed that he was "well" and would soon go home. He became preoccupied with his discharge from hospital and continually inquired when he would be allowed out. This unstable recovery he maintained until his discharge on September 16. He was facile, childish, mentally retarded, stereotyped in behaviour, but easy to manage. He was discharged to the care of his relatives.

COMMENT

Trypanosomiasis with epilepsy has already been reported. This case had an additional symptom complex—namely, that of status epilepticus. It is to be noted that these epileptic episodes had no relation to the presence or absence of trypanosomes in the cerebrospinal fluid. It is possible that the attacks were due to a structural damage to the brain itself.

Medical practice in the Tropics is prejudiced by the delay before hospital facilities are sought. This is sometimes due to ignorance and sometimes to fear. It is possible that cases of this nature may not be brought to hospital until an attack of status has begun, or during the post-epileptic somnolent stage, which in the above case lasted for thirty-six hours. In trypanosomiasis endemic areas all patients brought to hospital in epileptic fits or seemingly unconscious must be suspected of having trypanosomiasis in addition to the other more common causes—cerebrospinal meningitis, cerebral malaria, and hysteria.

I wish to thank the Acting Director of Medical Services, Dr. T. P. Eddy, for permission to publish this case, and Dresser-dispenser Wilson for his invaluable assistance in the compilation of the record and for translating the patient's Mandinka.

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Case of Double-headed Monster

This is a case of twins united by the trunk (thoracopagus and dicephalus).

CASE REPORT

A 3-para aged 25 was at full term. Her first delivery was a breech, the second a vertex, both children being alive and normal. At the antenatal examination the presentation was diagnosed as breech. An unsuccessful attempt at external version was made at 34 weeks, but no further efforts were made as the patient was a multipara and had had a previous successful breech delivery.

Labour started at 4.30 a.m. and she was admitted at 5.30 a.m., when the cervix was near full dilatation. The membranes were intact and both feet could be felt. Labour was allowed to proceed normally. The membranes ruptured at 6.40 a.m. and the first foot was delivered in five minutes, followed by the second with the next pain. The descent of the foetus was slow,

but nothing was suspected until a third foot presented at the vulva. On examination another foot was felt and a second pelvis. The patient was fully anaesthetized and a hand was inserted to push up the posterior foetus in order to deliver the anterior twin. This was found to be impossible, and the correct diagnosis was made only after thorough palpation with the whole hand inserted.

As the two pelves were causing obstruction, one was amputated at the level of the superior crest of the ilium. Traction even then failed to effect any progress owing to the size of the trunk, and the second pelvis was also amputated at the same level. This allowed for the compression of the body, and all the four hands were brought down one after the other. The next problem was the delivery of the two heads. I decided to cut off one of them with a hook, and in order to reach it asked my assistant to exert steady traction on the trunk upwards towards the mother's abdomen while I inserted my hand from behind to reach the posterior neck to insert the hook round it.

This manoeuvre resulted in an unexpected delivery of both heads one after the other. The convexity of the anterior head fitted in the concavity of the posterior neck, and the posterior head was first delivered over the perineum followed rapidly by the anterior head, thus making the amputation of one of the heads unnecessary.

The third stage was quite normal: the placenta was delivered complete after 10 minutes at 8.10 a.m. There was only one umbilical cord. The perineum was not torn, though there was a good deal of bruising. Penicillin and sulphonamides were given as a prophylactic measure, and the patient made an uneventful recovery.

The Foetus.—Permission to preserve the specimen and for further post-mortem examination was refused. The combined trunk was very big, and the line of fusion of the two trunks is oblique and can be seen clearly in the accompanying photograph. The umbilical cord was inserted between the two pelves. The left anterior hand and the right posterior hand belonged to one of the twins and vice versa owing to the oblique plane in which the two trunks had joined. Both foetuses were female and completely separate from the neck upwards and from the pelvis downwards. The parts were fairly well developed, the total weight being 11 lb. (5 kg.). The heads were also of normal size, and I was surprised at their normal delivery, though the mother's pelvis was roomy.

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