(3.74 kg.). On Aug. 25 a partial resuture of the abdomen was required, but otherwise the patient made an excellent recovery, and was discharged on Oct. 24, 1940. Her weight was then 11 lb. 4 oz. (5.12 kg.).

The Foetus

This is illustrated in the accompanying photograph. There was a globular cephalic portion constituting rather more than half the total bulk of the foetus. Inside this cephalic portion were a number of fluid-containing cavities, covered in the greater part by skin only. There were two clearly recognizable upper limbs. The right upper limb showed flexures in the

position of elbow and wrist and had four distinct digits with well-defined nails. The left upper limb showed a distinct elbow and wrist, but the hand was less well developed, consisting of a mass in which five partly fused digits appeared to be represented, with a sixth, apparently supernumerary, digit at some distance from the rest. The nails were distinctly seen. There was a wedge-shaped caudal mass with a small terminal appendage arising from the bottom of a small pit-like depression. There was a short slender stump of "umbilical

cord," about 1 in. (2.5 cm.) long, attached to the ventral surface between the upper limb processes. This was not felt before delivering the foetus, but appeared to have been ruptured in doing so. It was apparently the only slender communicating link between parasite and autosite, and, since the foetus at operation had presented by the dorsal surface, it had presumably been attached to the posterior abdominal wall of the infant. The whole foetus was of a pinkish-grey colour and was covered in parts with a thin layer of sebaceous matter exactly resembling vernix caseosa. There was patchy lanugo over the dorsal aspect and the limbs, and a patch of well-developed hair on the anterior aspect of the "head." The length of the foetus was 6 in. (15 cm.) and its weight, as stated, 1 lb. 10 oz. The foetus was therefore approximately one-fifth the weight of the infant at the time of removal, and there was no doubt that it was then still "alive" in the sense that it was continuing to grow.

A skiagram of the foetus was taken after removal. Unfortunately, since a diagnosis was not made before operation, it was not x-rayed *in situ*. A rudimentary spine could be seen and also the long bones in the upper limbs. In the left upper limb the humerus, radius, and ulna were well developed. The wedge-shaped caudal portion of the foetus showed a single long bone, presumably a femur, and apparently represented a rudimentary lower limb.

I have to thank Dr. H. Silvester Evans, Acting Director of Medical Services, Fiji, for permission to publish the case.

BIBLIOGRAPHY

- Feldman, W. M. (1937). "Foetus Diseases, Malformations, and Monstrosities." *Brit. Ency. med. Pract.*, 5, 380. London.
Gould, George M., and Pyle, Walter L. (1897). *Anomalies and Curiosities of Medicine*, p. 199. London.

The latter work contains a number of other references to literature on this subject.

The Minister of Health has adopted the following recommendations of the Nurses Salaries Committee concerning the salaries of nurses employed in part-time service. If employed for not more than 30 hours a week: female ward sister, 2s. 11d.; female staff nurse (general trained), 2s. 3d.; female enrolled assistant nurse, 2s. If regularly employed for not more than 30 hours a week, but required on occasion to work for a few hours more, a nurse should be paid for the first 30 hours at the rates listed above and for additional hours as follows: female ward sister, 2s. 7d.; female staff nurse (general trained), 2s.; female enrolled assistant nurse, 1s. 10d. Nurses who regularly work more than 30 hours a week should be paid on the non-resident salary scale for the grade, provided that no nurse employed for more than 30 hours a week receives less than a member of her grade employed for only 30 hours.

Medical Memoranda

Severe Anaemia due to Diaphragmatic Hernia

It does not appear to be widely recognized that herniation of the stomach through the oesophageal hiatus of the diaphragm, often with minimal gastro-intestinal symptoms, may be associated with severe anaemia.

Hiatus hernia with ulceration was described by Richard Bright in 1836, but it was considered an uncommon condition until recent years, when improvements in radiological technique have made it clear that it is not infrequently the cause of upper abdominal symptoms. Radiological examination should include examination of the stomach in the supine, prone, and Trendelenburg positions in addition to the erect.

That hiatus hernia is capable of causing bleeding was emphasized by two American workers in 1943. Murphy and Hay (1943), examining the findings in 72 patients with hiatus hernia, of whom 84% were females, found the average age to be 60 years; pain was a prominent feature and anaemia was almost as frequent, for 27% of patients had a marked microcytic anaemia. Sahler and Hampton (1943) found either anaemia or a history of gastro-intestinal haemorrhage in 14.5% of a series of 221 patients with hiatus hernia. Chevallier and Danel (1944) and Mendelsohn (1946) reported cases of hiatus hernia with severe anaemia, the latter finding hiatus hernia in 16 out of 1,000 consecutive gastro-intestinal radiographs, three of which patients had bleeding as a symptom.

Gastroscopic and post-mortem examinations in cases of hiatus hernia with anaemia (Sahler and Hampton, 1943) have indicated the cause of the bleeding to be the constricting effect of the diaphragm on the herniated stomach, so that venous engorgement and oedema, with submucosal haemorrhages and shallow ulcerations, occur. Peptic ulcer of the lower oesophagus is a rare cause (Bock, Dulin, and Brooke, 1933).

CASE REPORT

A married woman aged 64, with two children, had always enjoyed good health and had run a small shop unaided. For two weeks before admission to hospital she had been feeling increasingly weak and tired, was dyspnoeic on little effort, and had noticed swelling of the ankles. Appetite and bowel habit were unchanged, no darkening of the stools had been apparent, and she had not lost weight. On direct questioning the only other symptom to which she would admit was a feeling of fullness behind the mid-sternum. This was not troublesome and was attributed by the patient to having her meals disturbed by attending to customers in her shop. This symptom had been present for six months.

On examination the patient was seen to be somewhat obese, with marked pallor of skin and mucous membranes, ankle oedema, and dyspnoea on slight effort. There were no other abnormal physical findings. A blood count showed: haemoglobin (Haldane), 30%; red cells, 2,424,000, moderate anisocytosis and poikilocytosis; colour index, 0.63; white cells, 6,800. Examination of the sternal marrow revealed erythropoiesis, normoblastic in type and active. The faeces contained no macroscopic blood, but occult blood was present. Fractional gastric analysis revealed normal acidity. Gastric radiographs taken in the supine position showed the oesophagus entering the stomach in the abdomen, and a large part of the stomach herniated through the oesophageal hiatus into the thorax. The hernia was not visible in the erect position. Ulceration was not seen in oesophagus, stomach, or duodenum. A barium enema showed no colonic abnormality. Chest radiographs revealed no abnormality. The patient responded very rapidly to blood transfusion (2 pints (1.14 litres) of concentrated cells) and intensive iron therapy. Two weeks after admission the haemoglobin was 72% and red cells numbered 4,660,000. One must conclude that in any case of unexplained microcytic anaemia full consideration should be given to the possibility of hiatus hernia.

Our thanks are due to Dr. S. Almond for helpful criticism and for permission to publish this case, to Dr. Goldman for examination of the sternal marrow, and to Dr. Morris and Miss Lowe for radiological examinations.

N. J. ROUSSAK, B.Sc., M.B., Ch.B.

Jewish Hospital, Manchester. S. EDEN, M.R.C.S., L.R.C.P.

REFERENCES

- Bock, A. V., Dulin, J. W., and Brooke, P. A. (1933). *New Engl. J. Med.*, 209, 615.
Chevallier, P., and Danel (1944). *Sang.*, 16, 67.
Mendelsohn, E. A. (1946). *Radiology*, 48, 502.
Murphy, W. P., and Hay, W. E. (1943). *Arch. intern. Med.*, 72, 58.
Sahler, O. D., and Hampton, A. O. (1943). *Amer. J. Roentgen.*, 49, 433.