"crowned" during pains. The pains were now very strong, and came on in rapid succession. The foetal heart could be auscultated only with difficulty, but was evidently becoming slower. At this stage the perineum was infiltrated with local anaesthetic and an episiotomy was performed. No further advance resulting from this, Wrigley's short forceps were slipped on and the head delivered (in the occipito-anterior position). The head did not, however, come down fully, and the chin was freed with difficulty. The appearance was as if something were pulling the head back again into the vagina. There was no sign of respiration. By employing head-traction and pressure on the fundus the arms were eventually and with great difficulty delivered. The trunk had not advanced during this manœuvre, and, the head and shoulders being born, it was clear that some uncommon cause of obstruction must be present. The uterine contractions by this time were becoming dangerously tetanic, so that a speedy delivery was imperative.

General anaesthesia having been started, a hand was passed into the vagina to determine the cause of the obstruction. Foetal limbs were felt in the region of the pelvic brim, tightly gripped by the lower uterine segment. Amyl nitrate was administered—effecting a slight degree of relaxation—but attempts to deliver the trunk again proved unsuccessful. The thorax was now opened and eviscerated. Exploration being thus rendered less difficult, the presence of twins was established by the discovery of a third arm. A little later it was realized that some kind of double monster must be present, as foetal parts could be palpated without a break in continuity from the arm of the second twin on to the trunk of the first. After this, delivery of what proved to be a double monster of the thoracopagus type was effected in a few seconds. The third arm, mentioned above, was pulled down, and after it the fourth, then all four legs in succession. Traction on the legs brought out the buttocks, and lastly came the trunk, shoulders, and head of the second half of the monster.

The third stage was completed in a normal manner. The uterus was well contracted afterwards, and the general condition of the mother was good. The puerperium was quite normal, and the patient was discharged home on the 12th day.

The Specimen.—The two halves of the thoracopagus were approximately equal in size, each having a normally developed head and limbs (see accompanying photographs). They were joined face to face, by soft tissues only, down the front of chest

FIG. 1

FIG. 2

and upper abdomen. The placenta was single, and there was a large common exomphalos, into which ran the single umbilical cord and inside which coils of intestine were visible. The monster weighed 8 lb. 7 oz., and the length of each half was approximately 19 in.

COMMENTARY

Delivery was not difficult after crushing of the thorax of the first twin had allowed adequate access for exploration and diagnosis. Had the monster been larger it would doubtless have needed dividing into its two halves to make delivery possible. The ventral connecting portion, being of soft tissues only, was lax enough to permit some movement of one twin relative to the other. At one point during the manipulations the two heads were stretched out so as to constitute the opposite extremities of the monster, with the two trunks and all the limbs between them.

In this connexion the following description from Whitridge Williams's *Obstetrics* may be quoted: "Thoracopagi are frequently so loosely connected with one another that considerable motility is possible. Indeed, it is not unusual for the two children to present in a different manner. When possible, it is advisable to bring down all four feet at the same time and to effect extraction in such a way that the posterior head is first delivered. In cephalic presentations the head and body of the first child is expelled and the second child is then born very much as in an ordinary twin pregnancy. If, however, the latter presents transversely, its delivery can be effected only by version and extraction."

I am indebted to Dr. James Clark, medical superintendent, and Dr. W. J. Clancy, senior obstetrician, for permission to publish this case.

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A Case of Polyradiculoneuritis

The following case seems to be interesting enough to merit publication.

CASE REPORT

The patient, a ham-curer aged 50, was admitted to the Victoria Infirmary, Glasgow, on Sept. 1, 1941, suffering from symptoms of polyneuritis which conformed very closely to the syndrome first described by Guillain, Barré, and Strohl (1916). The symptoms also closely resembled those described by H. Stuart Barber (1940).

For some weeks before the onset of paralysis he had felt pain in the lumbar region. This was not very severe but was constant, and his doctor had given him some medicine for it. For a few days previous to the paralysis his urine was highly coloured; he described it as being "red." On Aug. 25 he had gone to work and had done his job as usual. The next morning he could not stand. He had no other complaints, apart from the slight pain in his back. He became very restless during that day, and did not sleep on the following night, an irritation of the skin causing him to scratch himself to the point of drawing blood. On Aug. 27 he had palsy of the left side of the face and some twitching of the muscles of the right side of the face.

On admission there was double facial palsy, with inability to close his eyes, definite muscular weakness of both arms, and complete paralysis of both legs. The biceps and triceps reflexes were weak. Abdominal reflexes, knee-jerks, and ankle-jerks were absent. There was no loss of sensation either to superficial or deep tactile stimuli or to pain. Pronounced nuchal rigidity and Kernig's sign were present. Sleeplessness was a marked feature of the acute stage of his illness, but headache was not complained of. The temperature was normal; there was some tachycardia, the pulse rate being about 100 during his first week in hospital, later falling to 80. The urine was normal and contained no blood. Lumbar puncture revealed a normal fluid pressure. The cell count was 4 per c.mm.; protein, 122 mg. per 100 ml.; chlorides, 733 mg. NaCl per 100 ml.; sugar, 84 mg. per 100 ml. The blood leucocyte count was 19,300 per c.mm.; the sedimentation rate was not estimated; the Wassermann reaction was negative.

Dr. Conway, ophthalmic surgeon to the hospital, reported on Sept. 4 that the edges of the left optic disk were blurred, but that the condition was short of true swelling of the disk. The right optic disk was well defined but showed definite nasal pallor. There was no paralysis of the external muscles of the eye.

The patient's condition became worse for a few days after admission, and he was incontinent of urine on several occasions. After a week improvement was noticed and he was able to move the legs slightly. The improvement continued without interruption, and eight weeks after the onset recovery was almost complete, except for slight paresis on the left side of the face, and he was able to walk with assistance. The knee-jerks and ankle-jerks were still absent.

Comment.—The features of this case are: the sudden onset of paralysis affecting the legs, arms, and facial muscles, distribution being symmetrical; the comparatively rapid, and complete recovery; the normal temperature throughout; the tachycardia; and the cerebrospinal fluid under normal pressure, with normal cell count but high protein content. These features are so similar to those described by H. Stuart Barber and others as to suggest that a specific virus might be the cause of this condition.

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