SARCOMA

There is a type of sarcoma which starts in the medulla by destroying adjacent bone and producing an abscess-like cavity that may or may not have reactive changes in the adjacent bony wall. Its boundaries are not clearly defined as in the case of the simple bone cyst. It may lead to spontaneous fracture, and subsequent radiographic appearances may give the suspicion of a sequestrum within the abscess-like cavity. The short history and the paucity of clinical signs and symptoms associated with the radiographic features should arouse suspicions of the gravity of the lesion: further radiographs after a week or so may reveal conclusive evidence of its nature. Often the bone in the region of the fracture will now show periosteal spicular formation.

ENDOTHELIAL MYELOMA

Endothelial myeloma of the bone occurs at about the same age periods as we find with chronic bone abscess. Like bone abscess it may be associated with lesions in other parts of the skeleton. It often shows intermittency of symptoms. The clinical features, however, do not reveal the chronicity of the bone abscess; the progress of the lesion is more rapid. The radiographic features, which bear some resemblance to those of chronic bone sepsis, I have dealt with elsewhere. Often a marked response to x-radiation therapy is seen in endothelioma, and this is of diagnostic significance. Serial radiographic study of the lesion will usually suffice for identification.

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PARASITIC FOETUS SUCCESSFULLY REMOVED BY OPERATION *

BY

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(WITH SPECIAL PLATE)

A male child born on April 6, 1937, was admitted to the Transvaal Memorial Hospital for Children under my care on April 26. He was born normally in a right occipito-anterior position, there being no difficulty with the labour in spite of the child being the mother's first. The period of gestation was normal.

On examination an incompletely symmetrical conjoined twin was found attached to the epigastric area of the host by a fleshy pedicle, and consisted of a right arm, an abdomen, lower limbs, penis, and scrotum. The lower limbs were kept in a frog position astride the abdomen of the host, the penis and scrotum being opposite the host's umbilicus (Figs. A and B). On palpation a bony pelvis and sacrum could be made out, but no vertebral column or ribs. A rounded firm mass could be felt in the abdomen of the parasite, and there was an imperforate anal dimple; a heart-beat could not be felt or heard, and no movements were observed, the parasite appearing devoid of sensation. Both the host and the parasite passed urine at different times. The host, except for the attachment of the parasite, was normal.

Barium was given to the child by mouth, and was observed under an x-ray screen. It was found to pass through the stomach and small and large bowels of the

* Shown at the March meeting of the Southern Transvaal Branch of the Medical Association of South Africa (B.M.A.).

host, but not in the parasite, suggesting that even if there were bowel in the parasite there was no communication between the two.

Four cubic centimetres of uroselectan B were later injected into a vein and radiographs were taken at frequent intervals for an hour. The dye was easily visible in the parasite, revealing a normally functioning kidney, but it

FIG. A

FIG. B

Illustrations showing the relative positions of host and parasite. (Redrawn, from photographs, by Audrey J. Arnott.)

was poorly shown in the host, owing to there being a large quantity of intestinal gas; but the secretory systems were present and the dye collected in the bladders of host and parasite.

The host during the following two months was growing normally, while the parasite remained stationary, the ratio of host to parasite having risen from approximately $2\frac{1}{2}$ to 1 at birth to 4 to 1 on June 15. The child continued making this progress till August 23, when surgical removal of the parasite was decided upon.

The Operation

Under general anaesthesia an incision was made round the parasite through skin and subcutaneous tissue, and it was then noticed that the peritoneal cavities of the host and parasite were continuous. A loop of blind-ending bowel from the parasite lay free in the host's part of the peritoneal cavity, and a fibrous cord, apparently a urachus, joined both bladders. The host's abdominal cavity contained its normal viscera, but in the parasite's peritoneal cavity there was only a horse-shoe kidney with two ureters entering a bladder.

The peritoneum was cut close to the parasite, leaving enough for the host's abdominal cavity, the blind loop of bowel was returned to the parasite, and the fibrous cord joining the two bladders was ligatured and cut near to the host's bladder. The host's abdomen was then closed in layers. The wound healed by first intention, and the child was discharged from hospital on October 2, 1937. The parasite is shown in Fig. 1 of the Plate.

On February 2, 1938, the child was again seen, being then in perfect health. He had put on weight, and there was no sign of ventral hernia having developed at the site of operation (Plate, Fig. 2).

W. SAMPSON HANDLEY : CHRONIC MASTITIS AND BREAST CANCER : A FAMILY HISTORY

FIG. 1.—Sister C. Right breast; Diffuse innocent papillomatosis of the ducts. Magnification $\times 120$. (Photo by Bland-Sutton Institute.)

FIG. 2.—Sister C. Right breast; Incipient carcinoma. Duct distended by epithelium, infiltration beginning. Magnification $\times 200$. (Photo by Bland-Sutton Institute.)

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FIG. 1.—Parasite after removal.

FIG. 2.—Child at age of 10 months.