had once encountered such a sensation as that now experienced in the case of a mesenteric cyst, but in that case the anatomical situation was quite different. He would like to be favoured with an alternative diagnosis. He would be glad to afford Mr. Mummery an opportunity of using the sigmoidoscope in the case, but it must be realized that the pelvic outlet in infants was small.

Case of Acrocephaly, with other Congenital Malformations—Autopsy.

By GEORGE CARPENTER, M.D.

THE head and upper part of the neck exhibited is that of Charles G., the 5-weeks-old infant who was shown at the meeting held on November 27, 1908, and a report on whose case will be found on pp. 45 to 53 of the *Proceedings*, vol. ii, No. 2 (Section for the Study of Disease in Children). The description given there of the presumed formation of the skull requires certain modifications. The occipital and frontal bones, which were thought to meet and form the peak of the skull, do not so articulate, and the parietal bones do intervene and do meet in the mid-line. The large, prominent mass of bone and the ridges of bone on each side, which were regarded as the external occipital protuberance and the superior curved lines of the occipital bone, are found not to be exaggerated anatomical regions, but are distributed along the occipito-parietal suture. The frontal bones are studded with a number of small, round, white areas, which are soft and yielding and membranous. There are some similar areas, but elongated in shape, on both parietal bones, near the apex of the skull. The orbits are exceedingly shallow (fig. 1), but there is a very decided orbital margin all round, except on the nasal side; they are very shallow, spoon-shaped, and about the size of a large teaspoon, their axes converging at about the apex of the skull. There is no abnormal ossification at the base of the skull. A sagittal section through the skull and brain and spine shows what appears to be a well-developed though crumpled-up brain. The brain has accommodated itself to the shape of the skull—its front and back are approximated and its vertex arched up so that the frontal lobe is brought to within about 1 in. of the occipital lobe, the pons and crura alone intervening (fig. 2). There is a clot of blood surrounding and compressing the cervical cord, which appears to be the immediate cause of death. The child died a fortnight after its exhibition.

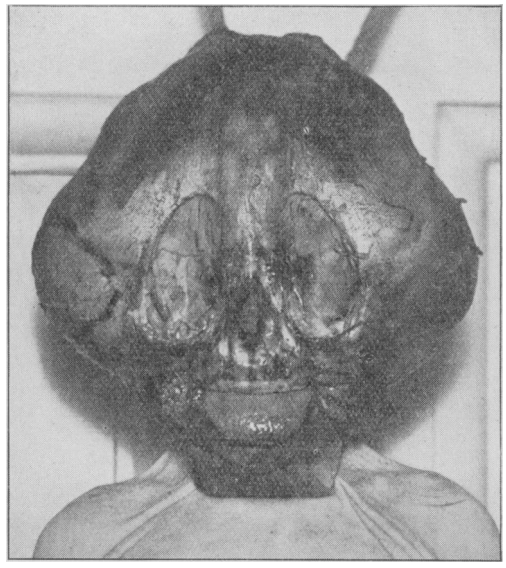

FIG. 1.

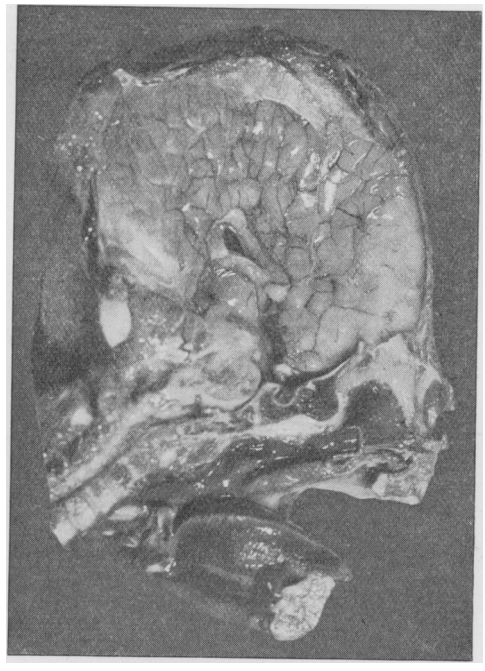

FIG. 2.

DISCUSSION.

The CHAIRMAN (Mr. Clement Lucas) commented on the rarity of the condition, and said he believed there was no specimen of the kind in the College of Surgeons' Museum.

Dr. CAUTLEY suggested that the specimen should be referred to an anatomist for report.

Solution of Continuity of the Right Clavicle since Birth.

By A. R. THOMPSON, F.R.C.S.

THE mother had fallen down some two weeks before the birth of the child. No deformity was noticed at birth. The boy showed a right clavicle which had apparently been fractured, the two portions being connected by a false joint and forming an inverted V. Mr. Thompson thought the case was one of fracture, although such cases suggested the possibility of cleidocranial dysostosis.

DISCUSSION.

Mr. A. H. TUBBY said a case similar to the condition brought forward by Mr. Thompson came under his own notice two or three months ago in a child aged 10 months, with the history that the labour was a difficult one. The arms were behind the shoulder, and on bringing the arm down a distinct crack was heard and there was found to be a deformity of the clavicle. When the infant was 10 months old the case was sent to him (Mr. Tubby) for an opinion. He found a deformity precisely similar to that seen in Mr. Thompson's case, and decided to operate. On cutting down to the bone he found much prominence in the middle of the clavicle, an ununited fracture, and a false joint. He removed the prominence of bone, excised the false joint, and wired the fragments together. He remembered a similar case some time ago in which, despite wiring, no union took place; and in Mr. Thompson's case, if it were operated upon and the prominence removed he feared there would be no true union, even if the false joint were excised; at least such had been his experience in other cases of the same kind.

Dr. SPRIGGS agreed that the case was a fracture of the clavicle, and not cleidocranial dysostosis. In the published cases of congenital deformity of the clavicle one could usually find some evidence of deficiency of other membrane bones. The late Mr. Walsham, Dr. Carpenter, and others, had published cases of deficiency of the clavicle, and on reading such accounts it was found that other features of cleidocranial dysostosis were present; either a fontanelle was not closed, or there was a globular cranium, a high-arched palate, irregular teeth, or some deformity of the lower part of the sternum. The present boy showed