acetabulum cannot be examined. But there can be little doubt that severe limitation of function must have been present in this hip joint, probably with advanced osteoarthritis of the socket. The absence of the innominate, together with the impossibility

FIG. 1.—Anterior aspect of femoral head and neck. Note eburnated articular surface surrounded by craggy osteophytes masking part of the neck. The head has slipped downwards and backwards, shortening the distance between the fovea and the lateral surface of the great trochanter.

FIG. 2.—Inferomedial aspect of femoral head and neck. Note the groove made by the ligamentum teres which dips down into a deep tunnel towards the fovea. Note also the posterior displacement of the head.

of obtaining a clinical history, adds difficulty and interest to the diagnosis. The transverse diameter of the head of the bone is very close to 51.5 mm. In 12 normal mediaeval femora chosen because their femoral head diameters ranged from 50.53 mm the distance from the fovea to the most lateral part of the greater trochanter ranged from 98.3 mm to 117.6 mm. In the Carrow Abbey specimen this distance is only about 84.5 mm, which might suggest that the diminution is due to a fractured neck. There is no evidence of this, however; as far as can be seen the neck is nearly normal beneath its carapace of osteophytes.

The abnormality here seems to be primarily in the head of the bone, which has diverged posteriorly and downwards from its normal position. This is the characteristic feature of a slipped capital epiphysis spontaneously occurring in early adolescence, and there is little doubt that this accounts for the present lesion. It might

possibly be a simple osteoarthritis, although this is extremely unlikely. Osteoarthritis is very common in mediaeval femora but its usual form is quite different from the specimen shown here.¹

It is difficult to assess the age at which this person died. The epiphyses of the head and the trochanter had fused long before death and it is probable, from the severity and extent of the osteophytic reaction, that he was at least 30 years old. Be this as it may, the fragment seems to be highly typical of the late results of a juvenile slipped femoral epiphysis.

In contrast to fractures and osteoarthritis of the femur, this is an exceedingly rare condition in early burial grounds, if indeed it has ever been diagnosed. The fact that in the course of examining thousands of archaic femora I have never seen a similar specimen is, perhaps, sufficient justification for reporting this case.

My thanks are due to Mr. F. W. Cheetham, director, City of Norwich Museums, for permission to record this note.

—I am, etc.,

CALVIN WELLS

Castle Museum
Norwich

¹ Wells, C., *Bones, Bodies and Disease*. London, Thames and Hudson, 1964.

Cullen's Sign in Perforated Duodenal Ulcer

SIR,—Mr. D. M. Evans (16 January, p. 154) records an example of Cullen's sign in a case of perforated duodenal ulcer. He quotes Cope¹ and Bailey² as stating that haemorrhagic staining at the umbilicus is pathognomonic of acute pancreatitis. In my experience it is more common in natural ectopic gestation and in spontaneous haemorrhage into the rectus sheath. The latter condition can be particularly deceptive as there is marked local tenderness and guarding.

It appears that in Mr. Evans's case there was no blood-stained abdominal free fluid. The possibility would seem to arise that in this case the blood staining at the umbilicus was due to a muscle tear.—I am, etc.,

S. C. RAW

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¹ Cope, Sir Z., *The Early Diagnosis of the Acute Abdomen*, 12th edn., p. 89. London, Oxford University Press, 1963.

² Bailey, H., *Emergency Surgery*, ed. T. J. McNair, 8th edn., p. 536. Bristol, Wright, 1967.

Unusual Cause of Varicocele

SIR,—We report a case of abdominal aortic aneurysm presenting as a left varicocele.

A 63-year-old man presented with a two-month history of aching and enlargement of the left side of the scrotum. Examination revealed a large left varicocele and an abdominal aortic aneurysm. The aneurysm had been symptomless, though on further questioning he admitted to a throbbing sensation in the epigastrium on occasions over the last two months. At operation the aneurysm arose 3 cm below the left renal vein. It was resected and a Dacron aortailiac bifurcation graft inserted. Two months after operation the varicocele was considerably smaller and symptomless.

Renal lesions, particularly hypernephroma, are known to present with a left varicocele. In this case the aneurysm probably caused the varicocele by obstruction of the left testicular vein or by stretching the left renal vein.—We are, etc.,

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Myocardial Infarction and the G.P.

SIR,—May I comment on the letter by Dr. R. D. Martin (7 November, p. 367), in which the use of procainamide as a prophylactic agent against ventricular dysrhythmias complicating myocardial infarction is advocated in general practice. The Boston study¹ concluded procainamide afforded highly significant protection against all types of active ventricular arrhythmias, markedly reduced the need for acute therapy of arrhythmias, and prevented death from active arrhythmias. Ventricular extrasystoles have been recorded in 80% and ventricular tachycardia in 27% of closely monitored patients.²

However, heart block has been reported to complicate myocardial infarction in 23% of patients.² Since procainamide reduces both the excitability and conduction velocity of the conducting system of the heart, any tendency towards impaired A.V. conduction may be exaggerated resulting in asystole. Since it is clinically impossible to exclude first-degree heart block, we consider that prophylactic therapy with procainamide should be delayed until E.C.G. evidence is available. Heart block of any type is a definite contraindication to the use of procainamide.—I am, etc.,

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¹ Koch-Weser, J., Klein, S. W., Foo-Canto, L. L., Kastor, J. A., and DeSanctis, R. W., *New England Journal of Medicine*, 1969, 281, 1253.

² Lown, B., et al., *American Journal of Cardiology*, 1967, 20, 494.

Vaccinia in a Patient with Acne

SIR,—Prior to proceeding on a Mediterranean cruise a 15-year-old girl requested vaccination against smallpox. This had not previously been performed. There was no family history of eczema and the girl was healthy apart from mild acne on the face and neck which at that time was not active. Primary vaccination was carried out on the right upper arm. Ten days after vaccination she developed primary lesions on the face and a temperature of 103°F (39.5°C). When first seen the original vaccination showed considerable but not excessive reaction. Four similar lesions were present on the face, two others on the trunk, and two on the other arm. All these lesions were superimposed on the old acneiform rash. Tetracycline was given to prevent secondary infection and by the next day a further four lesions had developed on the face and four more on the trunk. In view of this 2 g of antivaccinal gamma globulin were given by