with smooth and regular margins, and apparently without the surrounding vessels' showing evidence of previous thrombosis or injury. This is the "Treves's field," as described by him in 1885 (*British Medical Journal*, 1885, **1**, 470). Mr. Martin states that trauma and inflammation are aetiological factors, but this is very much a minority view, the general opinion being that the hole results from a developmental fault, and that intestinal movements ultimately, though not inevitably, cause a knuckle of bowel to pass through and initiate the obstruction.

Neither Mr. Martin, Mr. Moroney, nor Mr. Leech mentions any relevant previous history of abdominal injury or disease in any of their patients, which again supports the view of a congenital origin. I am quite sure that trauma sufficient to cause a breach in such a thin yet strong membrane would have to be (*a*) localized and crushing, and (*b*) of considerable force, with inevitable severe injury to surrounding tissues—such as bowel rupture and vascular damage. Again, I can conceive of no tearing injury applied to the mesentery which, if sufficient to cause a localized tear, would not also result in widespread mesenteric rupture with accompanying haemorrhage. Inflammation could only cause such a defect by localized adherence of some inflamed organ to the mesentery, followed by sufficiently violent peristaltic movements or trauma to tear the viscus off either with a small attached portion of mesentery or leaving behind a slit. Again, this has to occur without vascular damage, and has to leave a smooth margined defect with no thickening or irregularity of its edges, and without surrounding adhesions or bands, to concur with the conditions found at operation in all these cases.

Careful consideration therefore of trauma or inflammation in a causatory role leads us to reject both as quite impossible, and I submit that all such mesenteric defects are congenital in origin. I feel that this opinion is confirmed by the occasional finding of such defects without other related pathology in post-mortem examinations of persons dying from other causes—e.g., Watson's 3 cases in 1,600 necropsies. May I point out to Mr. Martin that his case is not the 49th on record but at least the 78th.—I am, etc.,

Woking. E. G. DOLTON.

"Cord Round the Neck"

SIR,—The recent correspondence on this controversial topic justifies a report of yet another case of stillbirth attributable, presumably, to "cord round the neck."

I was called in by a midwife because of delay in the second stage of labour. The patient was a primipara, 27 years of age. Antenatal supervision had been adequate and periodic B.P. and urine tests revealed no abnormality. There was however some oedema of both ankles during the later weeks of her pregnancy, but the patient was otherwise in excellent health. There was no obvious pelvic disproportion, and the presentation was a vertex. She went into labour on the calculated date of delivery. When I saw her she had been nearly five hours in second stage. She was having good pains and strong contractions every five minutes, but once the head reached the perineum its subsequent progress was slow. Time after time a good contraction caused the *caput* to appear, only to disappear tantalizingly on the cessation of the pain. It seemed as if something was hindering the downward progress of the head, and when the neck was palpated a single loop of feebly pulsating cord was found tightly wound round it and incapable of being slipped off. A finger was insinuated with difficulty between the neck and the cord and the latter immediately divided between ligatures. The child was delivered shortly afterwards. The foetal heart rate just prior to delivery was 120 per minute. Despite the adoption of the usual methods of resuscitation, the child never took a breath, though the heart continued to beat for at least 30 mins., 100 per minute at first and then gradually less. There was no mark of constriction round the neck, and the face and body were pale. There was no congenital malformation of the upper respiratory passages. The cause of death was presumably pressure on the cord and consequent asphyxiation of the child before delivery. The cord was of average length, and the placenta and membranes normal and complete. There was no perineal tear.

It is unjustifiable on the basis of a single case to attempt to lay down hard and fast rules regarding the early recognition of this anomaly, but three suspicious signs may be of value, namely: (1) Undue delay in the second stage of labour in an apparently straightforward case. (2) A diminishing foetal heart rate. (3) The appearance and disappearance of the *caput* with but little downward progress when the head is well down on the perineum. The early recognition of "cord round the neck" and the application of forceps might conceivably save the child, but one feels that, for the occasional obstetrician at any rate, once the diagnosis is made it is probably too late to do anything except sever the cord and deliver the child as speedily as possible, with or without instrumental assistance.—I am, etc.,

Glasgow. LESLIE R. C. AGNEW.

Smallpox in the Vaccinated

SIR,—In regard to smallpox in the vaccinated, Dr. F. K. Beaumont's (Sept. 21, p. 437) and Dr. C. Killick Millard's (Oct. 12, p. 552) comments seem to me most helpful and sound. The latter proposes annual revaccination for those in repeated contact with smallpox cases. May I support this out of an experience of eight years with Europeans in India?

In a population of some 500 Europeans living in an Indian industrial town, where smallpox was as everyday and as common as a sore throat, it was our practice annually to revaccinate the whole population at risk. There was no case of smallpox in these people, not even modified smallpox, but when the war brought imperfectly protected vaccinated persons from England among us these unfortunates were in grave danger, and there were some appallingly bad clinical cases of smallpox. One such case, of confluent smallpox, was vaccinated in infancy (scar not visible) and had a certificate of three negative results from vaccination done before leaving England.

It is of course not practicable to vaccinate and revaccinate the whole population of Britain annually, but I suspect that to follow the modified course of doing it every five years would end the worries of the public health people about introduced epidemics.—I am, etc.,

Edinburgh. J. ROSS INNES.

SIR,—It is refreshing to find Dr. Killick Millard advocating more frequent vaccination. In the early days of the century he was claimed by the Anti-Vaccination Society as their chief supporter in the medical world, although I remember hearing him at that time open a meeting against compulsory vaccination with the words: "I want you first of all to agree that vaccination does protect against smallpox."

We public vaccinators did not receive much encouragement from the Local Government Board. If we revaccinated a person within ten years of the last revaccination we could charge no fee for it. We were instructed to obtain four vesicles in infant vaccination. I refused to do more than three and put forward the suggestion that infant vaccination should be done in two stages—the first the "minimum-of-trauma" method, to be followed a year later by a more "vigorous" vaccination. The suggestion was turned down, partly, I suspect, because of the double fee.

I endorse Dr. Killick Millard's recommendation "little and often": recent vaccination protects not only against smallpox but against a sore arm. To the question that was frequently asked, "Is it necessary for me to be vaccinated again now?" my answer was, "I can only answer that question by vaccinating you."—I am, etc.,

Leavesden. H. ANGELL LANE.

Legal and Medical "Insanity"

SIR,—The letters and article are of importance in trying to assess correctly where one condition passes into the other, and the correct treatment in each case. The diagnosis of "psychopathic personality" is now so frequently, lightly, and dangerously made by young psychiatrists that it could easily be applied in some way or other to a large proportion of the nation, including not a few psychiatrists. Once thus labelled, a psychiatric patient is at the mercy of any malicious or ignorant person who may wish to exploit the patient or any particular situation to his own advantage. Thus the patient's condition gets worse and will continue to get worse under the present system, where cause and effect are so often confused.

A nervous breakdown may be due to intrinsic or extrinsic causes. In the cases which are due to extrinsic causes, we must be very careful to distinguish between those extrinsic causes to which the patient is unfortunately exposed through no fault of