

impressive machinery, that cancer can only be helped at all by treatment in one of the large centres with "something atomic," as a recent patient has put it, so again there is a denial of the confidence placed in the ordinary facilities provided for medical treatment at provincial level. It seems that the word "cancer" conveys much of the despondency, and just as the gradual substitution of "T.B." for "consumption," with its sinister connotation, has accompanied the change in outlook about this disease, so should we hope to find some new general term to cover the neoplastic diseases.

But, until such time as we can fully control new growth, it can be shown that we have much to offer, and that it is just as possible to live with a tumour as with arthritis.—I am, etc.,

Hove.

E. MILLINGTON.

**Asphyxia by the Cord**

SIR,—I should like to comment on Dr. H. E. Reiss's scholarly and well-documented article on "Foetal Asphyxia Associated with Umbilical Cord Around the Neck" (*Journal*, June 14, p. 1394). I assume that the foetal distress was caused by tension during labour on a relatively short cord and not solely by the number of coils.

At first sight it seems strange that, while cord round the neck is common, foetal distress is rare, but Nature has provided two compensating mechanisms. First, if the length of cord from placenta to neck is very short, the breech presents and will not turn spontaneously. Secondly, Nature provides a push on the fundus by means of the voluntary contractions of the diaphragm and abdominal muscles during the second stage of labour. This helps to relieve tension. It follows that, if the child can survive the squeeze of the uterus, which increases the length of the uterine cavity during the first stage, it ought to be able to survive the push and squeeze of the second stage. Dr. Reiss's case illustrates very clearly that foetal distress appeared during the second stage. When the os is fully dilated it is undoubtedly proper to correct any malposition and deliver with forceps so long as firm fundal pressure is maintained during delivery. Push, and tension is released; pull, and tension is increased. If the cord is intact when the head is delivered, it is always possible to deliver the body by fundal pressure without dividing the cord.

It is a pity that British textbooks accept the findings of Gardiner,<sup>1</sup> as they are demonstrably false. It is untrue to say that a cord of nearly 13 in. (32 cm.) is necessary for spontaneous delivery. Gardiner forgot that the fundus can follow the foetus and be pushed down nearly to the symphysis pubis either by the mother's own efforts or by the obstetrician. Nature provides the human foetus with a very long cord, usually 20 in. (50 cm.) or more, not because it is necessary for delivery—indeed, the longer the cord the more likely it is to become coiled round the foetus and so be relatively short—but because it was necessary for many hundreds of thousands of years for the mother to be able to pick up her child immediately after delivery without tension on the placenta during the hazardous third stage. But that, Sir, is another story.—I am, etc.,

Cambridge.

C. W. WALKER.

REFERENCE

<sup>1</sup> Gardiner, J. P., *Surg. Gynec. Obstet.*, 1922, 34, 252.

SIR,—Cord round the neck is a common condition at birth, and Dr. H. E. Reiss (*Journal*, June 14, p. 1394) rightly points out that it may cause serious foetal asphyxia and even foetal death. Whether or not the foetus shows signs of distress from compression of the umbilical vessels depends, firstly, on the tightness of the cord round the neck, and, secondly, on its thickness. The amount of Wharton's jelly in cords is variable, and, when it is reduced, the umbilical vessels, deprived of its cushioning effect, are more easily compressed.

During an investigation of 100 cases of foetal distress at St. Helier Hospital, Carshalton, several years ago, I attributed 24 of them to cord round the neck. What impressed

me most was that signs of distress appeared late in labour. In 20 cases it occurred in the second stage and in the remaining 4 at three-quarters dilatation. I believe that the reason for this is that the cord is liable to be nipped by the foetal chin during flexion and rotation of the head on the pelvic floor. Since delivery can usually be readily effected when the danger signs appear, the baby is saved in most cases and stillbirths from cord round the neck are relatively rare.—I am, etc.,

Birmingham, 16.

D. B. WHITEHOUSE.

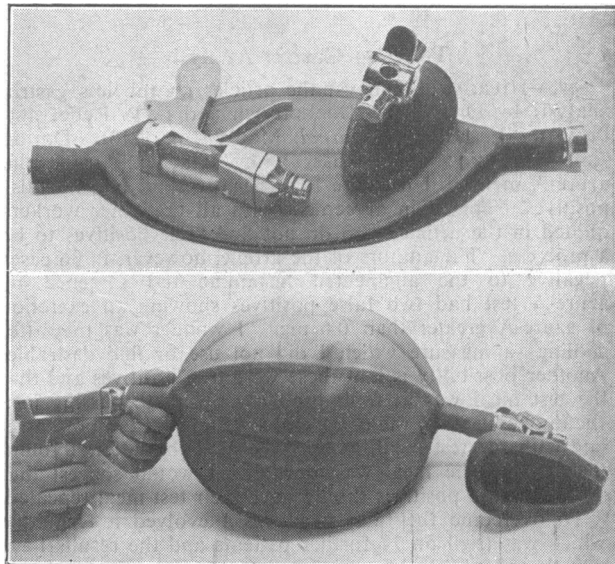
SIR,—I read with interest the article by Dr. H. E. Reiss (*Journal*, June 14, p. 1394), not so much on account of the coiling of the umbilical cord around the foetal neck five times, but because general inhalation anaesthesia was used when it was known foetal distress had been present for some time. It is not surprising there was delay in establishing regular respiration in a baby when, in addition to the distress, a second dose of pethidine, 125 mg., was given two and a half hours before the administration of cyclopropane, gas, oxygen, and ether. Caudal analgesia by the single-dose technique would have been well worth attempting. In the majority of patients it is simple to administer, effective, and always safe to mother and baby. Moreover, it takes little time and one knows well within fifteen minutes if one has been successful. The time to have given it would have been just prior to full dilatation. This would not have delayed, but probably hastened, labour. That the method is a practical one I have proved to myself, and now it is my method of choice in all vertex presentations requiring forceps unless the head is very low, in which case local analgesia is used. In the last 225 cases there have been 25 failures and not all these have failed completely. General inhalation anaesthesia is not only dangerous to the mother but also to the baby, particularly to the latter when there has been evidence of foetal distress.—I am, etc.,

Haywards Heath, Sussex

C. J. FARR.

**Out-patient Anaesthesia**

SIR,—Professor William W. Mushin and Dr. Peter W. Thompson's favourable report (*Journal*, June 14, p. 1376) on cyclopropane in out-patient anaesthesia may help to persuade manufacturers in this country to make the necessary apparatus. More than two and a half years ago I



Apparatus for administering cyclopropane in dentistry.

developed in conjunction with Sparklets Ltd. the apparatus shown in the photograph; but it was not put into production because the value and safety of this method of anaesthesia did not seem to have gained wide acceptance by