tighten, loops which form around the foetus, and even torsion of the cord, sometimes cause foetal death and abortion as early as the 12th week. Usually, however, such arrangements of the cord remain loose enough to avoid interference with the circulation in the umbilical vessels until labour is in progress. Then, with the descent of the foetus, the knot or loop tightens sufficiently to cause asphyxia. Looping of the cord around the foetal neck can sometimes be suspected or diagnosed as a cause of asphyxia during labour—one test being to study the behaviour of the foetal heart when the head is deliberately pushed down towards the pelvis.

Nevertheless, the cord is very often looped once or twice round the foetal neck without any harm resulting. It remains loose until the foetal head is actually delivered. Moreover, "cord round the neck" is such an easy explanation to offer for the death of the foetus that it becomes suspect as a cover for bad obstetrics. This diagnosis is undoubtedly made more often than is justified, and it is therefore often viewed with suspicion. Despite this, there can be no doubt that tightening of a loop of cord round the foetal neck or trunk, or tightening of a true knot, is a definite although rare cause of foetal asphyxia.

Coital Posture and Obesity

Q.—*What coital position is best for a man with a small penis who is married to an obese wife? At present they are having difficulty in the act.*

A.—Variation in the size of the male phallus, and obesity in one or other partner, are common, and yet it is surprisingly rare for such mechanical factors to prevent coitus, even though they make it less satisfactory. The case in question should be reviewed to make sure that the blame for failure in coitus is not being wrongly placed, and that other causes such as male impotence or vaginismus are not present. If the trouble proves to be entirely mechanical then an intelligent couple might be expected to find the most satisfactory posture by experiment, and in this they could be helped by some book such as Van de Velde's *Ideal Marriage* (Wm. Heinemann Medical Books), which devotes a whole chapter to coital postures. The position which might prove most satisfactory is the one in which the wife lies on her back and extends her trunk either by placing a firm pillow under the lumbar spine or by allowing her legs to hang downwards over the edge of a couch, as in Walcher's position, which was formerly used in obstetric practice.

Recurrent Gall-stones

Q.—*What is the likelihood of stones recurring in the common bile duct after cholecystectomy or choledochotomy? Is there any satisfactory way of preventing recurrence?*

A.—Most of the so-called "recurrent stones" have been overlooked at the original operation, and the incidence of recurrence therefore bears an inverse relationship to the diligence with which the original operation has been carried out. Even with routine exploration of the common bile and hepatic ducts it is possible for stones to be missed, for they may easily slip far up into the latter, or a small stone can be missed at the lower end of the common duct as a result of a bougie or forceps being passed beside it. For this reason many authorities on biliary surgery have advocated cholangiography on the operation table, but this is not a method which is likely to be of any practical value outside a large surgical centre.

Truly recurrent stones are more likely to occur in the presence of residual infection, or because a fragment of stone has been left behind. A piece of suture material in the duct may act as a nidus for further stone formation, as also may a small stump of cystic duct. Poor drainage through the sphincter of Oddi may occur as a result of narrowing at the lower end of the common duct, and dilatation with bougies may be advisable at the primary operation in these circumstances. A measure which has not attained wide popularity is the practice of side-to-side choledochoduodenostomy to assist drainage. This alternative channel may certainly allow an overlooked stone to be passed subsequent to operation, but many regard the possible regurgitation of duodenal contents as a real objection to the procedure.

To summarize, therefore, most recurrent stones have been previously overlooked, and even with the most careful surgery this may still occur, although the likelihood is then very largely ruled out. Mere scrutiny of the ducts and external palpation are often a very unsatisfactory method of exploration.

Compensation and Industrial Pulmonary Disease

Q.—*What industrial pulmonary diseases are eligible for compensation?*

A.—The important industrial lung diseases for which benefit is paid under the National Insurance (Industrial Injuries) Act, 1946, are pneumoconiosis and byssinosis. Where the pneumoconiosis is accompanied by respiratory tuberculosis, the effects of the tuberculosis are treated as the effects of the pneumoconiosis. Pneumoconiosis is defined in the Act as meaning "fibrosis of the lungs due to silica dust, asbestos dust, or other dust, and includes the condition of the lungs known as dust reticulation." Claimants for benefit must have worked in specified occupations and processes after July 5, 1948. These occupations and processes cover practically all processes where there is a risk, and they are listed in Ministry of National Insurance Leaflet N.I.3, obtainable at any local office of the Ministry of National Insurance. Claimants who have worked in these occupations, but not since July 5, 1948, may be able to claim compensation under the Workmen's Compensation Acts. Byssinosis is not included in the above definition, as it is not a fibrosis of the lung. Claimants to benefit for byssinosis must have been employed "in any occupation in any room where any process up to and including the carding process is performed in factories in which the spinning or manipulation of raw or waste cotton is carried on" for at least 20 years.

Beryllium poisoning, with its pulmonary manifestations, is prescribed disease No. 36. In the same way, pulmonary tuberculosis is an industrial disease (disease No. 38) when contracted by those whose insurable employment involves close and frequent contact with some source of tuberculous infection in certain occupations. These occupations are, shortly, those involving the treatment or nursing of cases of tuberculosis, attendance as a health visitor or home help, or research or laboratory work connected with tuberculosis.

Correction.—William Harvey was physician to Charles I, not Charles II as stated in the *Journal* of May 30, p. 1208, and he was not President of the Royal College of Physicians: though offered the honour, he declined it.

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