Natural Position in Childbirth

SIR,—I was much interested in Dr. Kathleen Vaughan's letter (Jan. 31, p. 222). I have seen women in Persia deliver themselves in the squatting position, walking to the doorway of their hut to do so. Placenta followed baby almost immediately, and there were never any perineal tears. The babies, however, were always small, averaging 5½ lb. (2.5 kg.), and with much smaller heads than most English ones.

In practice I have found the best position for the woman is on her back, with plenty of pillows under her shoulders, and the knees well-flexed—in fact the nearest thing to squatting. The women tell me they can use their pains much better than in the lateral position, and indeed it seems natural that it should be so. If one happens to be single-handed it is easier to control the patient, and for doctor and mother to co-operate. I believe this is the French practice.

As regards perineal tears and stretching of the perineum (which can result in much more lasting damage than a simple tear), I am inclined to think that episiotomy is the answer.

I would like to add that I am the mother of four children, my eldest being born when I was 32. I was never delivered in the "natural" position, but I practised squatting frequently during the last month of pregnancy and during labour. My babies were always born quickly and easily.—I am, etc.,

Kendal, Westmorland.

FRANCES M. TAYLOR.

Health of Students

SIR,—May I comment on some of Dr. John Pemberton's conclusions (March 13, p. 490)? He states that "some 20% (of students) were found to be suffering from minor anxiety states and depression." He gives as an example of this that they were afraid of failing their examinations, with all that that entails nowadays. Surely, Sir, this is a normal and very temporary state to be in, or does Dr. Pemberton consider it abnormal to be afraid of ploughing an examination? His other example of anxiety state is that 9% had insomnia (whether permanent or just before examinations is not stated). He uses as a standard an inability to fall asleep after being in bed for one hour. Is this really meant as a scientific standard? I suggest that Dr. Pemberton talks to a junior probationer nurse, who will tell him about patients who "never sleep a wink" yet manage to snore all night.

In the section on orthopaedic defects he claims an incidence of 34%, with 14% having flat foot. I wonder if Dr. Pemberton realizes that there is a difference between a flat foot and a foot which looks flat but which stands up to playing tennis, Saturday night dances at the Union, Sunday hikes, and other strenuous activities. Those of us with considerable experience of having cases referred to us after routine inspections of school-children and Service men know that this is a common error.

There is claimed to be a 16% incidence of postural defects of the spine, that is "scoliosis, kyphosis, and lordosis" (*sic*). Even if I were prepared to believe that such a high incidence of abnormalities was present, I must disagree with his conclusions. He states, "Most of the orthopaedic abnormalities found were due to lack of muscle tone and physical development, and could perhaps have been prevented by better previous physical education. They emphasize again the value of adequate and easily available facilities for athletics, sports, and gymnastics as a positive contribution to student health." Later he further states, "The frequency of postural and other orthopaedic defects raises the question of the value of compulsory physical education such as has been introduced for freshmen in at least one British university." Has Dr. Pemberton the slightest evidence to support these conclusions? Does he think that gymnasts never suffer from flat foot or postural scoliosis? Has he any proof that exercises have ever prevented or cured these conditions? I am, of course, quite aware that this is a very common but nevertheless erroneous belief, and that in your leading article you state, "Yet even a young person with severe kyphosis and unfit for most sports may overcome his handicap by learning to swim on his back." If a kyphosis is amenable to treatment it is by developing secondary curves above and below the lesion, and surely a breast and not a back stroke would best do this.

Social medicine has been claimed as "a new scientific approach to medicine." Where are Dr. Pemberton's controls? Has he examined a similar group of non-students to find out how many of them had postural defects or had ever lain awake

at night? Did he discover the relative incidence of postural defects in those students who do and those who do not play games? Is there a significant difference between those who had compulsory physical exercises and games at school and those who did not?

Many medical men have wondered what the exact function of social medicine is. I hope it is not to produce field surveys without any controls.—I am, etc.,

Sheffield.

SIDNEY PAPPWORTH.

Intervertebral Disk Lesions

SIR,—Dr. J. Donaldson Craig and Mr. A. W. Lipmann-Kessel's letter (March 20, p. 570) on this subject is most illuminating. Andrew Taylor Still and, subsequently, the osteopaths have for sixty years suggested that sciatica and many other referred neuralgic pains are "due to joint disturbances." Evidence is gradually accumulating to prove there is more truth and value in the osteopathic theory than has so far been admitted by the orthodox medical profession.

While from the patient's point of view it is probably unimportant where and by whom knowledge is developed, it is only fair, in my opinion, that medical writers should give credit to the author of any theory they propound or elaborate.—I am, etc.,

London, W.1.

GEORGE MACDONALD.

Diagnosis of Relapsing Fever

SIR,—With reference to the interesting paper of Drs. R. I. Bodman and I. S. Stewart (Feb. 14, p. 291) the following notes on diagnostic difficulties in sporadic cases of relapsing fever might be of some interest.

Sporadic cases of comparatively rare diseases often present diagnostic difficulties. Four cases of relapsing fever were observed here in the period from May, 1946, to November, 1947. Three ran a typical course, and *Spirochaeta recurrentis* could easily be found in the blood smears of two, whilst all responded well to neosarsphenamine. The fourth case caused considerable anxiety and was first considered an acute abdominal condition, then typhoid, until his temperature chart and prompt response to a single injection of 0.45 g. of neosarsphenamine disclosed the true nature of his grave condition.

The case history was as follows. A farmer aged 40 was taken ill with high temperature on May 5, 1946. Next day he was admitted to a surgical ward with colicky pain in the right hypogastric region. W.B.C., 15,000; B.S.R., 20-40 mm. He was given sulphadiazine orally (28 g.) and his temperature returned to normal. On May 13, seven days after his admission, he was discharged at his own request, only to be readmitted on May 25. Once more his temperature was around 38° C. (100.4° F.), which did not subside after another course of sulphadiazine (30 g.) and 180,000 units of sodium penicillin. His spleen was enlarged, and he was transferred to the fever department. The Widal was negative, and, as his temperature chart took on a recurrent character with attacks of fever alternating with temperature-free intervals, relapsing fever was suspected. By now, nearly 5 weeks from his first attack, his general condition had become very critical, and without microscopical confirmation 0.45 g. neosarsphenamine was injected. He responded promptly, and his temperature dropped to normal within 24 hours, after which his general condition improved steadily. He was in perfect health when last seen in September, 1947, more than a year after his illness.

—I am, etc.,

Kosice, Czechoslovakia.

I. FRIEDMANN.

Appendicular Dysfunction

SIR,—Chronic appendicitis or appendicular dysfunction is a difficult condition to diagnose with any degree of certainty. The physical signs are minimal or even absent, excepting perhaps during an exacerbation.

The surgeon has therefore to make a diagnosis from the history and exclusion by investigation of other types of right-sided pain. It was with interest, therefore, that I elicited a physical sign during the examination of a case of abdominal pain and indigestion which pointed quite definitely to the appendix being the cause of a patient's symptoms. The patient