that similar mechanisms underlay P's apparent irrational and masochistic behaviour. Since the "withdrawal" symptoms when these patients are deprived of hospital experiences appear to be the substitution of even more anti-social and dangerous behaviour (Barker and Lucas, 1965; Chapman, 1957) the suggestion (Barker, 1962) that the term "Hospital addiction" should be used for the syndrome seems legitimate.

The "blacklists" of such patients mentioned by some non-psychiatric writers (Harold, 1951; Williams, 1951) are not only likely to be ineffective but may thus be potentially hazardous. It seems reasonable to regard "Munchausen" patients as mentally ill, as constituting an overt suicidal risk (Barker, 1962) and they can therefore be dealt with under the provisions of the Mental Health Act, 1959.

From P's career it seems depressingly clear that the usual psychiatric treatments are not effective in these cases, nor can conventional psychiatric units (or their staff) usually (Barker and Lucas, 1965) cope with the disruptive behaviour of such patients without material damage to the treatment of other patients. The best treatment is a matter for conjecture but a specialised unit, with selected staff (Baker, 1962) may perhaps be able to achieve useful results. There are indications both from this case and others (Barker, 1962; Barker and Lucas, 1965) that at present such a unit would need a security hospital setting.

Summary

A case of "Munchausen Syndrome" whose early life is documented and who came under psychiatric care, is reported. Possible psychopathology, terminology and treatment are discussed.

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VESICO — VAGINAL FISTULA FOLLOWING THE USE OF VACUUM EXTRACTOR

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SINCE the introduction of the vacuum extractor in 1954, its use is becoming more and more popular in different world centres — particularly those in Europe. Indeed, in the Scandinavian countries the use of the vacuum extractor has almost replaced that of the forceps. Malmstrom in Sweden reported 500 deliveries by the use

of vacuum, none by forceps. Lange in Denmark reported 895 deliveries again by vacuum and only 46 by forceps. Th. Brat in Brussels during a period of 10 years (1954 - 1964) had 1,135 deliveries by vacuum and 54 by forceps. In the Government Maternity and Gynaecology Hospital in Amman, Jordan, during 20 months (January 1964 to August 1965) there were 110 deliveries by vacuum extractor and 111 by forceps. In the latter hospital where there is more than one attending obstetrician the

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use of the vacuum or that of forceps seems to depend on the obstetricians' personal preference.

It is still debatable whether the use of the vacuum extractor reduces the rate of Caesarean section. Malmstrom and Lange emphasise that the use of the vacuum does not reduce Caesarean section rate, and even that it should not do so. In Berggren's cases in Sweden, Caesarean section rate was reduced from 2.4% - 1.4%; this reduction seems to be due to his use of vacuum extractor on floating head-cases excluded from the list indications in the use of vacuum by Malmstrom and Lange.

It is not proposed in this report to discuss the complications following the use of either instrument. It is however established that the vacuum extractor is the safer and easier instrument to use, since it is less traumatising to both mother and foetus, and, consequently anesthetic becomes unnecessary. The following case report — a vesicovaginal fistula — illustrates however a serious complication following the use of vacuum extractor by unskilled hands.

Case Report

Mrs. K. H. 40 years old P9 + 0, whose last delivery was by Caesarean section because of placenta praevia, was admitted to the Government Maternity and Gynaecology Hospital, on January 14th, 1965 in labour for six hours.

Examination showed a foetus in vertex presentation, the head dipping at the inlet, ruptured membranes and 8 cm. dilated cervix. Foetal heart rate 140 per minute. The patient was immediately prepared for delivery. The vacuum extractor was applied for 30 minutes without any appreciable progress. Caesarean section was performed and a female stillborn 3.100 g. was delivered. The postoperative course of two weeks in hospital was uneventful and the patient was discharged on February 3rd, 1965.

On February 15th, 1965, the patient reported back to the hospital complaining of urinary incontinence of two days duration. Examination revealed a vesico-vaginal fistula about 1.5 × 0.5 cm. and a large cysto-urethro-rectocele. Further cystoscopic studies showed that the fistula was at the trigon and had not involved ureters or urethra. After suitable preparation, the patient's fistula was successfully repaired on April 20th 1965.

Discussion

Obviously, the fistula described above was one caused by pressure necrosis. It is quite possible that part of anterior vaginal wall was included within the vacuum cup for a period of 30 minutes, a period long enough to produce such disastrous complication. An operator subscribing to the use of the vacuum extractor to floating and midpelvic heads, may well be advised to ensure that only foetal scalp is included with the vacuum cup. Probably, a routine examination of the circumference of the vacuum cup by the tip of the index finger at the first stage of air suction offers the security needed to avoid such a complication.

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