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MEDICAL PRACTICE

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Episiotomy

SIR,—The article from Dr A E Reading and others (23 January, p 243) on how women view postepisiotomy pain was interesting but not particularly enlightening. We hardly require psychologists to tell us that pain is unpleasant and something which most people can recall with displeasure, or that tenderness can persist for several months at the site of a considerable wound.

My own observations are of rather more than the 101 patients referred to by your contributors: they comprise personal interviews, conducted during the past decade or so, with more than 20 000 women who have given birth on each successive day (up to the sixth) following delivery. Only simple human acumen is required to realise that in the majority of cases the relief of postepisiotomy pain requires the dispensing of oral analgesics. Usually Distalgesic (dextropopoxyphene and paracetamol), two tablets two hourly on request for the first 12 hours, then paracetamol are sufficient, but sometimes paracetamol alone is enough and sometimes dihydrocodeine tartrate (DF-118) is needed. Infrequently, the pain from a very severely bruised perineum demands the application of an ice pack; even less frequently, in my experience, narcotic analgesia is indicated. The proposition, referred to by your contributors, that the transmission of a proportion of the dosage of such drugs administered to the mother to the neonate via breast milk might be harmful to the infant is, in my opinion, unworthy of serious consideration.

As Dr Reading and others obliquely suggest, there is a contention that postepisiotomy pain is appreciated more exquisitely by the mother who has had an epidural for labour and delivery. Certainly our experience in earlier years supported this view, although latterly, as we have become more "aggressive" in the treatment of such pain, the distinction between epidural and non-epidural has become more blurred. We did at one time consider that the difference lay in the fact that in "non-epidural" patients the line of proposed episiotomy was infiltrated with local anaesthetic, whereas in the "epidural" patients it was not; thus in the latter group the sutures might be so tight as to fail to accommodate for the local oedema which inevitably occurs as part of the healing process. To test this postulate we conducted a small study in which, under the epidural, the proposed line of episiotomy was infiltrated with N/5 saline, but this did not afford any advantage. We are thus left to conjecture that the potential for more severely felt postepisiotomy pain among the epidural patients is related to the fact that they have not had much pain during labour and delivery.

That being said, I contend that Dr Reading and his colleagues have aimed at the less important target. I have been impressed, during the clinical activities referred to, by the misery and at times profound debilitation caused by postnatal symptomatic haemorrhoids, which, of course, are quite unrelated to an episiotomy. I cannot understand why obstetricians and, indeed, general practitioners have over the decades failed to apply their talents to diminution of this scourge. I am aware of no effort having been made to define, antenatally, which mothers are likely to develop severe symptoms from piles postnatally, much less of attempts to thwart the onset of the condition or vigorously to treat it. All that appears to happen is that the haggard mother is given simple analgesics and ice packs to apply and told that the condition will right itself in about a week.

Doubtless there are no long-term sequelae, other than in exceptional circumstances, of postnatal haemorrhoids. I do wonder, however, about episiotomy, or rather its omission. I well recall an initial observation when I first worked in the United States. I had previously been accustomed, as an anaesthetist in Britain in the early 1950s, to the inclusion in almost every gynaecology operating list of three or four colporrhaphies, yet in the United States the operation was apparently a rare event. The explanation, I was told, was that in the United States an episiotomy was almost a routine procedure, and hence the prospect that disruption of the perineal musculature at delivery would go undetected was avoided. Is this opinion valid, and indeed has the incidence of vaginal prolapse in Britain fallen subsequent to the increased conduct of episiotomy? If so, maybe the price paid post partum is not so high.

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SIR,—Your leading article by Professor J K Russell (23 January, p 220) and the paper by Dr A E Reading and others (p 243) from King's College Hospital should bestir the profession to a renewed appraisal of the whole subject of episiotomy. Public outcry is sometimes unjustified, but is it so here?