MEDICAL PRACTICE

Hospital Topics

Is routine episiotomy necessary?

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Abstract

One hundred and eighty one primigravid women delivering vaginally in July and August 1982 in the Rotunda Hospital, Dublin, were randomly allocated to one of two groups. Patients in one group were to undergo episiotomy. Those in the other group were not to undergo episiotomy unless it was considered to be essential. The outcome was compared with that of the clinical practice over the previous six months at the hospital.

Of the 92 patients allocated not to undergo episiotomy, seven (8%) had one done for medical reasons compared with 507 (89%) in the previous six months. First degree tears occurred in 23 (25%) and second degree tears in 43 (47%). Nineteen (21%), however, retained an intact perineum compared with only 35 (6%) of the women who had delivered in the preceding six months. Assessments of perineal pain, bruising, swelling, and healing and records of ingestion of analgesics were made for the first four days after delivery, and again at a check up six weeks after delivery, in patients who had had spontaneous vertex deliveries. Forty patients who underwent episiotomy and 37 who sustained a second degree tear

formed two comparable groups. There was no difference in outcome between them. Data were also evaluated for 19 women who retained an intact perineum, 22 who sustained a first degree tear, and 11 who underwent episiotomy and epidural anaesthesia; all 52 of these women had spontaneous vertex deliveries. Despite severe soft tissue injury in two patients those who fared best were those who retained an intact perineum. First degree tears were associated with symptoms similar to those associated with second degree tears. Those who fared worst were women who underwent episiotomy after epidural anaesthesia.

The value of routine episiotomy in primigravid patients is questioned, but the final decision can be made only by the accoucheur at the time of imminent delivery.

Introduction

Episiotomy was first properly described by Sir Fielding Ould in 1741.¹ Since then the operation has become an established procedure in obstetrics and has been practised increasingly often in recent years, with a reported incidence of over 90% in primigravid patients at one centre.² The widely accepted justifications for episiotomy are that it facilitates delivery, spares the baby's head from trauma, and prevents perineal lacerations and undue stretching of the pelvic floor, which could predispose to subsequent uterovaginal prolapse. Recent concern has been expressed that these claims lack any scientific basis.³ In addition, the high level of pain reported by a series of women after episiotomy⁴ led to comment on the need for firm evidence to support or refute the belief "that a clean surgical incision in the perineum, correctly timed and repaired, is more likely than a ragged, bruised tear to heal by first intention and cause less trouble at the time and later."⁵

We report the results of a study in which we sought to compare in a group of primigravid women the pain and other symptoms suffered after episiotomy with those felt after a

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second degree tear was sustained. We also sought to compare the outcome in patients allocated not to undergo episiotomy with that in patients treated according to normal practice in the six months before the study at the Rotunda Hospital, Dublin.

Patients and methods

We studied 181 primigravid women admitted to the main labour ward at the Rotunda Hospital, Dublin, for delivery in July and August 1982. Patients were not considered for the study if they were aged under 16, delivered at less than 38 weeks' gestation, were suffering from any important medical or psychiatric condition or eclampsia, or did not deliver vaginally. All potential participants gave their signed informed consent. There were no refusals.

On admission the patients were allocated randomly to one of two groups: patients in one group were to undergo mediolateral episiotomy and patients in the other were not to undergo episiotomy unless it was considered to be medically essential by the midwife or obstetrician in charge—that is, if the accoucheur could see that a patient was going to sustain greater damage without episiotomy or if the intact perineum was thought to be hindering the achievement of a safe normal or operative delivery.

For each patient we recorded age, weight, attendance at antenatal classes, duration of first and second stages of labour, type of delivery, analgesia given during labour, the infant's birth weight, and the indication for episiotomy if carried out. The type of perineal injury sustained was recorded,⁸ first degree tear being defined as an injury affecting only the anterior part of the perineum and related posterior wall of the vagina; a second degree tear as one affecting up to but not including the external anal sphincter, with a corresponding tear in the vagina; and a third degree tear as a complete tear including the anal sphincter usually extending for 2 cm or more up the anal canal.

Suturing was done in all cases with 3.5 metric, 20 chromic sterile catgut on a heavy tapercut needle 45 mm (Ethicon 492). Continuous sutures were used for deep tissues and mattress sutures for skin. Local anaesthesia if necessary was with lignocaine 0.5%. A note was made of who did the suturing, whether it was immediate or delayed, and, if delayed, by how long. Patients were delivered in the left lateral position but sutured in the lithotomy position.

The intensity of pain and discomfort felt during the first four days after delivery was assessed in all patients delivering spontaneously by the vertex. (Women undergoing any other type of vaginal delivery were excluded from this part of the study in case severity of pain was affected.) A score was recorded for intensity of pain by a midwife observer at about 1000 and 1600 each day when patients were asked to walk about and then say whether they had no pain associated with their stitches, or if pain was mild, moderate, severe, or very severe. The intensity of pain was accordingly scored from 0 to 4.

Nursing staff were asked not to give analgesia during the study unless it was specifically requested by the patient, when two tablets of Codis (aspirin 500 mg, codeine phosphate 8 mg) could be given. The times of administration and indications for such analgesia were recorded, as were all other concurrent treatments and the number of baths or showers taken each day.

The extent of bruising, swelling, or infection of the perineum was recorded daily by the midwife observer on a scale of 0 to 3 (absent, mild to moderate, or severe). The time and date of occurrence of any other symptoms were recorded; such symptoms were scored for severity on a scale of 1 to 3 (mild, moderate, or severe) with a note as to whether mention of them was volunteered or elicited in response to the question, "Have you had any problems with your stitches?" which was asked at the time of each assessment of pain. On the fourth day after delivery, at the time of the last assessment of pain, a global assessment was made by the patient of her condition in relation to her stitches and by the midwife observer on the state of healing of the perineal injury. Each assessment was recorded on a scale of 0 to 3 (poor, fair, good, or excellent). At the follow up visit six weeks after delivery the severity of pain experienced with defecation, micturition, sitting, walking, and coitus was recalled by the patient and recorded by the midwife observer on a scale of 0 to 3 (no pain, mild, moderate, or severe pain), as were any other symptoms.

In the Rotunda Hospital epidural anaesthesia is available at all times. Unless medically contraindicated it is usually given at the request of the patient, sometimes with prior guidance from the midwife or doctor in charge of the case. During the study 39 patients received epidural anaesthesia during labour, of whom 11 had unassisted deliveries. They were not retained in the main study for comparison of severity of pain but were followed up separately as

previous reports have indicated that such patients are more susceptible to pain from the site of perineal injury.² Patients who had been allocated not to undergo episiotomy and who, after normal vertex delivery, retained an intact perineum (19 patients) or sustained only first degree or labial tears (22 patients) were also evaluated separately from the main study.

Within the framework of the main study a direct comparison of degree of pain and discomfort could thus be made between 40 patients who had undergone episiotomy and 37 patients who had sustained a second degree tear. (Neither group had had epidural anaesthesia or assisted delivery.) Moreover, the symptoms experienced by these two groups could be related to those experienced by other groups of patients. Apgar scores for babies born to mothers in the main study were recorded to compare the effect on the baby of episiotomy or of allowing delivery to proceed without episiotomy.

Hospital records (G R Henry, Rotunda Hospital clinical report 1982) showed that the incidences of epidural anaesthesia, forceps delivery, and other procedures were the same before and during the study. Details were also available of the incidence of perineal injury in all (569) primigravid patients who gave birth in the main labour ward of the Rotunda Hospital from 1 January to 30 June 1982. Thus the results obtained during the study in patients allocated not to undergo episiotomy unless it was essential could be compared with the results of hospital practice over the preceding six months.

Results

INCIDENCE OF EPISIOTOMY

Eighty nine patients were allocated to undergo routine episiotomy during the study. Two (2%) sustained additional lacerations, and five (6%) sustained third degree tears. Ninety two patients were allocated not to undergo episiotomy unless it was considered to be essential. Seven of them (8%) required episiotomy: two underwent forceps deliveries for fetal distress, two vacuum extractions (one for fetal distress, one for prolonged second stage), one forceps delivery for second stage delay, one episiotomy with breech delivery, and one episiotomy by the midwife for fetal distress.

In the preceding six months episiotomy had been done in 507 primigravid women (89%), of whom three (1%) had sustained lacerations and nine (2%) had sustained third degree tears; in 495 others (87%) there was no extension of episiotomy. Of the 92 patients allocated not to undergo episiotomy, 23 (25%) sustained a first degree tear, 43 (47%) sustained a second degree tear, and 19 (21%) retained an intact perineum. Only 35 women (6%) had retained an intact perineum during the preceding six months; 15 (3%) had sustained a first degree and 12 (2%) a second degree tear. None of the patients delivering without having an episiotomy during either the study or the preceding six months sustained a third degree tear.

COMPARISON OF PAIN AFTER EPISIOTOMY WITH PAIN AFTER SECOND DEGREE TEAR

We considered only two groups of patients to be strictly comparable for pain during the first four days after delivery—that is, the 40 patients who, after being allocated to undergo episiotomy, had spontaneous vertex deliveries and the 37 patients who, after being allocated not to undergo episiotomy, sustained a second degree tear during delivery. None of these 77 women received epidural analgesia or had assisted deliveries. Table I gives details of the two groups. They were well matched apart from some differences in distribution of age and duration of the first and second stages of labour. The significances of differences in age and the duration of the second stage of labour were analysed with the Mann-Whitney U test because in both groups the distribution of these variables was not normal. Only differences in age were found to be significant at the 5% level ($U=2.69$, $df=75$). The significance of difference in the duration of the first stage of labour was analysed with Student's t test and was found to be not significant ($t=1.54$, $df=75$).

Table II shows the severity of pain reported on eight occasions over the first four days after delivery by the patients in the two groups. The total sequence is given because the two groups showed a similar pattern in changing severity of pain, with a shift to milder pain, as would be expected, over the four days. Figure 1 shows a plot of the mean scores for pain over the eight occasions on which it was reported by the patients who had undergone episiotomy and those who had sustained second degree tear. The graph shows the

TABLE 1—Details of patients who either underwent episiotomy or sustained a second degree tear (in all cases suturing was done by a senior house officer)

	Patients sustaining second degree tear (n = 37)	Patients undergoing episiotomy (n = 40)
Median (range) age (years)	23 (17-31)	19 (16-36)
Median (range) weight (kg)	66.45 (51.4-99.3)	67.65 (51.0-86.0)
Median (range) birth weight of infant (g)	3190 (2730-4100)	3200 (2660-4100)
Attendance at prenatal classes:		
Yes	17	20
No	20	20
Median (range) duration of labour (min):		
Stage 1	300 (60-590)	345 (60-720)
Stage 2	35 (10-65)	32.5 (10-150)
Analgesia given during labour:		
Nitrous oxide-oxygen	8	8
Pethidine and promazine	24	25
Both	2	4
No of patients in whom suturing was delayed for:		
0 min	18	22
1-30 min	15	14
31-60 min		2
Over 60 min	4	2

TABLE II—Severity of pain recorded over first four days after delivery in 77 patients. Figures are numbers (%) of patients

Pain	Day 1		Day 2		Day 3		Day 4	
	am	pm	am	pm	am	pm	am	pm
<i>Patients undergoing episiotomy (n = 40)</i>								
No pain	3 (8)	2 (5)	6 (15)	12 (30)	16 (40)	17 (43)	24 (60)	26 (65)
Mild	18 (45)	17 (43)	24 (60)	14 (35)	15 (38)	14 (35)	11 (28)	8 (20)
Moderate	10 (25)	14 (35)	8 (20)	14 (35)	7 (18)	7 (18)	3 (8)	4 (10)
Severe	8 (20)	6 (15)	2 (5)		2 (5)	1 (3)	1 (3)	2 (5)
Very severe	1 (3)	1 (3)						
<i>Patients sustaining second degree tear (n = 37)</i>								
No pain	7 (19)	5 (14)	5 (14)	6 (16)	13 (35)	16 (43)	17 (46)	22 (59)
Mild	15 (41)	15 (41)	22 (59)	20 (54)	15 (41)	12 (32)	16 (43)	9 (24)
Moderate	11 (30)	13 (35)	7 (19)	8 (22)	8 (22)	7 (19)	4 (11)	6 (16)
Severe	2 (5)	2 (5)	3 (8)	3 (8)	1 (3)	2 (5)		
Very severe	2 (5)	2 (5)						

TABLE III—Details of patients in three subgroups in whom postpartum symptoms were studied. (All had unassisted deliveries)

	Patients undergoing epidural anaesthesia and episiotomy (n = 11)	Patients retaining intact perineum (n = 19)	Patients sustaining first degree tear (n = 22)
Median (range) age (years)	23 (17-29)	21 (17-32)	22 (17-33)
Median (range) weight (kg)	61.5 (54-84)	64.0 (51.0-92.1)	66.45 (52.7-83.7)
Median (range) birth weight of infant (g)	3200 (2260-4000)	2760 (2260-3960)	3200 (2260-4090)
Attendance at prenatal classes:			
Yes	5	6	10
No	6	12	12
Median (range) duration of labour (min):			
Stage 1	360 (150-600)	300 (120-840)	300 (60-660)
Stage 2	43 (20-77)	40 (15-70)	42.5 (10-105)
Analgesia given during labour:			
Nitrous oxide-oxygen		4	11
Pethidine and promazine		12	9
Both			1
No of patients in whom suturing was delayed for:			
0 min	6		15
1-30 min	4		3
31-60 min	1		1
Over 60 min			
No of patients in whom suturing was done by:			
Consultant			1
Registrar			18
Senior house officer	10		

expected downward trend over time for both groups, the only real difference between them occurring in the first two measurements.

The models of McCullagh,⁷ as implemented by the computer program PLUM, were thought to be suitable for analysing the distribution of pain scores in these two groups of patients as the data were categorised and the categories ordered. Such analysis would be expected to have more power to detect a shift in location of the underlying pain distribution in one group of patients compared with the other than the standard χ^2 test. Our analysis with McCullagh's models, however, failed to show any significant differences (5% level) in the severity of pain between the groups on any of the occasions on which it was recorded.

FIG 1—Mean pain score against time for 40 patients who underwent episiotomy and 37 patients who sustained a second degree tear. (All patients included had unassisted deliveries.)

COMPARISON OF OTHER VARIABLES MEASURED AFTER EPISIOTOMY OR SECOND DEGREE TEAR

Other variables were also compared only in those patients who, when having a spontaneous vertex delivery, either underwent episiotomy or sustained a second degree tear. Severities of bruising and swelling showed a similar pattern in the two groups as did the frequency of baths or showers taken during the first four days after delivery. The Apgar scores at one and 10 minutes for babies born to mothers in the two groups did not indicate a difference in rating.

SEVERITY OF PAIN IN THE OTHER SUBGROUPS

From the 92 patients originally allocated not to undergo episiotomy two subgroups of patients, who all had spontaneous vertex deliveries, were analysed separately. One subgroup consisted of 19 patients who retained an intact perineum, the other of 22 patients who sustained

only a first degree tear. The six patients with a second degree tear who had received epidural anaesthesia were considered to form too small a group for analysis, and the seven patients from the group allocated not to undergo episiotomy but who required episiotomy were not included in the analysis as they did not belong either to the group allocated to undergo episiotomy or to any of the subgroups allocated not to undergo episiotomy. Only 11 of the 39 patients who underwent episiotomy after epidural anaesthesia had unassisted deliveries of singleton infants. They also were analysed separately from the patients allocated to undergo episiotomy in the main study. For convenience all features of these three subgroups are included in the same tables.

Table III shows the features of these three subgroups of patients. The main points to emerge were that the mothers who retained intact perineums tended to have smaller babies and that mothers who underwent episiotomy after receiving epidural anaesthesia had longer first stages of labour, although the differences were not significant.

TABLE IV—Severity of pain recorded over first four days after delivery in 52 patients. Figures are numbers (%) of patients

Pain	Day 1		Day 2		Day 3		Day 4	
	am	pm	am	pm	am	pm	am	pm
Patients retaining an intact perineum (n = 19)								
No pain	8 (42)	7 (37)	11 (58)	12 (63)	15 (79)	14 (74)	16 (84)	17 (89)
Mild	8 (42)	8 (42)	7 (37)	4 (21)	3 (16)	5 (26)	3 (16)	1 (5)
Moderate	3 (16)	4 (21)	1 (5)	2 (11)	1 (5)			
Severe				1 (5)				
Very severe								
Patients sustaining a first degree tear (n = 22)								
No pain	5 (23)	3 (14)	9 (41)	8 (36)	9 (41)	10 (45)	15 (68)	15 (68)
Mild	10 (45)	12 (55)	8 (36)	10 (45)	11 (50)	9 (41)	5 (23)	5 (23)
Moderate	6 (27)	5 (23)	4 (18)	3 (14)	1 (5)	2 (9)	1 (5)	1 (5)
Severe	1 (5)	3 (14)	1 (5)	1 (5)	1 (5)	2 (9)	2 (9)	2 (9)
Very severe	1 (5)		1 (5)	1 (5)	2 (9)	1 (5)		
Patients undergoing epidural anaesthesia and episiotomy (n = 11)								
No pain	2 (18)	2 (18)	2 (18)	2 (18)	2 (18)	3 (27)	5 (45)	6 (55)
Mild	4 (36)	1 (9)	4 (36)	2 (18)	6 (55)	6 (55)	4 (36)	4 (36)
Moderate	2 (18)	4 (36)	3 (27)	5 (45)	2 (18)	2 (18)	2 (18)	1 (9)
Severe	2 (18)	2 (18)	1 (9)	1 (9)	1 (9)			
Very severe	1 (9)	2 (18)	1 (9)	1 (9)

FIG 2—Mean pain score against time for five subgroups in the study. (All patients included had unassisted deliveries.)

Table IV gives the degrees of pain reported by the three subgroups of patients. There was a difference in the pattern of severity of pain in the three groups, with patients who retained an intact perineum generally recording the lowest pain scores, patients who sustained a first degree tear mainly recording low to intermediate scores, and some patients who underwent epidural anaesthesia and episiotomy recording the higher pain scores. Figure 2 shows this particularly clearly: it plots the mean pain score recorded on eight occasions, not only for these three subgroups but also for the patients who underwent episiotomy and those who sustained a second degree tear (all unassisted deliveries). Interestingly, the patients who underwent epidural anaesthesia and episiotomy recorded the highest mean pain scores on the first five occasions while those with intact perineums recorded the lowest mean scores throughout. The mean scores for patients sustaining a first degree tear did not differ greatly from those for patients undergoing episiotomy or those sustaining a second degree tear.

OTHER VARIABLES MEASURED IN THE OTHER SUBGROUPS

Records of severity of bruising and swelling showed that in patients retaining an intact perineum there was no bruising and a low incidence of swelling. Patients sustaining a first degree tear recorded severities of these variables similar to those found in the two main groups (patients who underwent episiotomy and patients who sustained a second degree tear), whereas patients who underwent epidural anaesthesia and episiotomy recorded the most severe swelling and bruising, particularly on day 1. All three subgroups took baths or showers as often as patients in the main groups during the first four days after delivery.

COMPARISON OF REQUIREMENTS OF ANALGESIA

Table V shows the mean daily consumption of analgesics for perineal pain in each group of patients studied. This correlated reasonably well with the mean pain scores for these groups, as shown in figure 2; patients who had undergone epidural anaesthesia and episiotomy ingested most analgesics and those who retained an intact perineum least.

OTHER SYMPTOMS SEEN AFTER DELIVERY

No cases of infection, wound breakdown, or delayed healing were reported during the study. Only one patient who had sustained a second degree tear developed postpartum retention of urine.

TABLE V—Mean daily number of analgesics taken solely for perineal pain by patients who had unassisted deliveries

	Patients undergoing epidural anaesthesia and episiotomy (n = 11)	Patients not undergoing epidural anaesthesia and:			
		Retaining intact perineum (n = 19)	Sustaining first degree tear (n = 22)	Sustaining second degree tear (n = 37)	Undergoing episiotomy (n = 40)
Day 1	3.818	0.947	0.909	1.892	1.550
Day 2	3.636	1.263	0.818	1.838	1.900
Day 3	1.091	0.632	0.818	1.243	0.990
Day 4	0.364	0.105	0.727	0.919	0.500
Overall mean	2.23	0.74	0.82	1.47	1.24

TABLE VI—Mean score at global assessment of healing of perineum on two occasions in patients who had had unassisted deliveries*

Assessment by:	Patients undergoing epidural anaesthesia and episiotomy (n = 11)	Patients not undergoing epidural anaesthesia and:			
		Retaining intact perineum (n = 19)	Sustaining first degree tear (n = 22)	Sustaining second degree tear (n = 37)	Undergoing episiotomy (n = 40)
		<i>Day 4</i>			
Patient	2.82	3.00	2.59	2.80	2.59
Nurse	2.91	3.00	2.82	2.80	2.67
		<i>Six weeks after delivery</i>			
Patient	3.00	3.00	3.00	3.00	2.96
Nurse	3.00	3.00	3.00	3.00	2.96

*Score is from 0 to 3; 3 = excellent healing.

GLOBAL ASSESSMENT ON DAY 4 AND AT SIX WEEKS' FOLLOW UP

Table VI gives the results of the global assessments of the state of healing of the perineum made by the patient and midwife. The patients with intact perineums scored 3 (excellent) on both occasions, but there was little difference between the other groups, who all showed an improvement in scores between day 4 and the follow up visit six weeks after delivery. Of the 99 patients who returned for the six week follow up, only four had any complaints, none of which was serious.

Discussion

In this study primigravid patients allocated not to undergo episiotomy generally fared better than they would have done with normal hospital practice, as is shown by comparison with the preceding six month period in this unit. By refraining from performing episiotomy unless it was considered to be essential by the accoucheur the incidence of episiotomy was reduced to 8% from an incidence of 89% in the preceding six months. Nineteen patients (21%) retained an intact perineum and 23 (25%) sustained only a first degree tear.

Careful comparison of pain and other symptoms in patients who underwent episiotomy or sustained second degree tearing showed that the degrees of pain, bruising, swelling, consumption of analgesics, and perineal symptoms recorded six weeks after delivery were no greater in patients who had sustained a second degree tear than in those who had undergone episiotomy. The second stage of labour was not prolonged in patients who sustained a second degree tear, and the infants born to this group of mothers did not have lower Apgar scores than those born to mothers who underwent episiotomy. Healing of the perineal wound was rated similarly in the two groups.

The patients who fared best among the other subgroups studied were those who retained an intact perineum. This group recorded the lowest scores of pain throughout, scoring zero more times than would be expected if their experiences of pain were the same as those for the remaining subgroups of patients. They also showed little perineal bruising or swelling, although two had severe vaginal lacerations necessitating suture that might have been prevented by timely intervention. First degree tears were associated with levels of postpartum pain similar to those associated with second degree tears, but the patients who fared worst in this study were those who underwent episiotomy after epidural anaesthesia. These patients

had longer first stages of labour and a higher incidence of forceps delivery and recorded considerably higher severities of pain and consumption of analgesics during the period immediately after delivery than any other group. This last finding confirms similar observations by Buchan and Nicholls.²

This study produced no evidence of prolongation of the second stage of labour, trauma to the baby's head, or greater damage to the pelvic floor when episiotomy was not performed. The question of long term prolapse must await further study; meanwhile our findings reinforce the doubts already voiced^{3,6} and question the current practice in many obstetric units of carrying out episiotomies routinely in most primigravid patients.

The findings of this study suggest that primigravid patients have a reasonable chance (21% in this study) of retaining an intact perineum if episiotomy is carried out only when considered to be essential. Moreover, if primigravid patients do sustain a second degree tear (25% in this study) they will fare no worse in terms of postpartum pain than if they had undergone episiotomy and their perineal wound will heal just as well. Severe soft tissue injury, however, can occur even with an intact perineum, and as there can be valid medical indications for episiotomy the final decision whether to perform episiotomy can be made only at the time of imminent delivery and must therefore rest with the accoucheur.

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Indian reflections: operation "Crank"

I was at the time a resident at a hospital in Yorkshire. I had finished my evening round and was writing up the case notes in the duty room adjoining the ward. Suddenly, I heard frantic calls from the nurse of the ward. I left my work and rushed into the ward to find out what the matter was. There was a commotion at John's bed. He was a young patient suffering from rheumatic fever. "Oh Doctor, he has jumped out of the window. Look there," the nurse said in a panic stricken voice. The ward was on the second floor so her panic was justified. I could see only the back of the lower half of a body in pyjamas, the other half was bent through the window, was outside and not visible. So it was John. What was he up to? Being a case of rheumatic fever he had strict orders to remain in bed. He was otherwise quite a hefty young fellow. He was in the Royal Navy. I put both my arms around his waist and started pulling hard. "What do you think you are doing, John? Get back to your bed," I said admonishingly. "It is not me, Doctor. It is Mr Robinson who is out here," John said. I found Robinson's bed vacant. He was the patient next to John. I looked out. In the poor light I could make out a figure dangling precariously in the air, struggling to free himself from John's strong grip, cursing violently and shouting "Lemme go! Lemme go!"

John, who was in a most uncomfortable and dangerous position,

just managed to hold with one hand Robinson's one arm. He needed help quickly. There was no time to think or plan. I broke a fixed glass pane with a Lucozade bottle, leaned out as far as I could, and reinforced John's grip with mine. Now both of us had a good hold of Robinson though he continued struggling and shouting. All this happened in seconds. Now the long wait started. Other staff came running to our aid. We could now hold out for some time. But how was Robinson to be rescued? Obviously he was out of his mind otherwise he would not think of jumping out of the window and behave the way he was doing. John and I found it difficult and risky to drag him back into the ward, and to reach him from the yard below it required a very long ladder. The resident surgical officer took stock of what was an extraordinary non-medical emergency and took an immediate decision. He summoned the fire brigade for the rescue operation. It was a most unusual case for them, as it was for us. In the meantime, hospital porters took positions in the yard below as though to catch Robinson in case he slipped out of our hands. After what seemed to us an interminable time the fire brigade arrived. With some manoeuvring Robinson was at last brought down to terra firma. He was whisked away post haste to the psychiatric ward.

The next morning, while nursing my arm scratched and cut by glass splinters, I found that we were in the news.—S K MAJUMDAR, director, HHRD Medical Trust, Jodhpur, Rajasthan, India.