had an enema, and probably this was related to her subsequent infection. Seven babies in each group showed evidence of infection. Table III shows the site of each positive swab together with the infecting organism and degree of faecal contamination. There was no significant difference in the incidence of infection between the two groups. Bowel organisms were isolated from four infections in the no-enema group (cases 1-4) and from two in the control group (cases 8 and 9).

TABLE II—*Durations of labour in untreated (no enema) and control (enema) groups of mothers (combined series)*

	Duration of labour (hours)						Total
	≤4	−6	−8	−10	−12	>12	
No enema							
Primiparae ..	14	12	7	9	5	6	53
Multiparae ..	36	11	7	15	2	1	72
Total	50	23	14	24	7	7	125
Enema							
Primiparae ..	14	8	11	12	6	10	61
Multiparae ..	40	20	14	8	4	2	88
Total	54	28	25	20	10	12	149

TABLE III—*Degrees of faecal contamination at delivery and sources of positive culture in 14 neonates in untreated and control groups with evidence of infection*

Case No	Grade of faecal contamination (0–3)		Site of positive swab	Organisms isolated
	1st stage	2nd stage		
No enema				
1	0	2	Eye	*Escherichia coli, Streptococcus faecalis*
2	0	3	Skin	*Streptococcus faecalis*
3	0	0	Nose	*Escherichia coli, Streptococcus faecalis*
4	0	0	Nose	*Streptococcus faecalis*
5	2	1	Umbilicus	*Staphylococcus aureus*
6	1	1	Eye	*Staphylococcus epidermidis*
7	0	1	Eye	*Staphylococcus epidermidis*
Enema				
8	0	2	MSU	*Streptococcus faecalis*
9	0	1	Skin	*Coliforms, Proteus*
10	1	1	Skin	*Staphylococcus aureus*
11	0	0	Eye	*Staphylococcus aureus*
12	0	0	Skin	*Staphylococcus epidermidis*
13	0	1	Eye	*Staphylococcus aureus*
14	0	1	Eye	*Staphylococcus aureus*

MSU = Midstream specimen of urine.

Discussion

Perhaps the most interesting feature of the study was the attitudes of the midwives attending the patients in labour. At the start there was some hostility to the trial, which caused problems in design. During the study, however, the midwives' opinions changed, and the random study was terminated prematurely, when objections were raised to subjecting patients to an enema without good reason.

We found no evidence that enemas were harmful, but they caused distress to a few patients and discomfort to many. The enemas did not reduce the incidence of faecal contamination or infection, and nor was there any evidence of a significant influence on the duration of labour.

Constipation is generally regarded as common in pregnancy, possibly due to a combination of relaxation of smooth muscle and increased absorption of water from the colon.[2] Levy *et al*,[3] however, disagree. In a study of 1000 healthy Israeli women they found that most reported no change. Increased frequency of bowel motion occurred in 344 of the women, and 49 had diarrhoea, mostly in the last trimester. Only 110 reported increasing constipation. Hence the widely held belief that women start labour with a chronically overloaded colon likely to interfere with labour is probably fallacious. Our study suggests that normal physiology will deal with bowel function without aid in most cases.

It may be that the small-volume disposable enema is ineffective and that different results would be obtained with a larger-volume conventional soap-and-water enema. This is, however, more time consuming and unpleasant for the patient; and from our data it could be of only marginal benefit.

It was clear that most of our patients disliked the enema and accepted it only because of the advantages claimed, especially a clean delivery. We found no evidence to support these claims. We therefore suggest that the enema should be reserved for patients who have not had their bowels open in the past 24 hours and who have an obviously loaded rectum palpable at the time of initial pelvic examination. For those women who claim to enjoy the enema, in the absence of a good medical reason, it is dubious if their enema is a legitimate charge on National Health Service time and resources.

It is not easy to challenge a procedure which has been an integral part of obstetric practice for over 300 years. Our non-randomised initial study was necessary to provide evidence that a randomised study was ethical. What we did not expect was the resistance by both patients and midwifery staff to the continuation of the controlled trial. We soon foresaw refusal of an enema by patients or its sly omission by staff, which would have endangered the statistical validity of the whole trial. It therefore seemed prudent to terminate the study.

Though our conclusions are justified by the results, there may be some lingering doubts because of the relatively small numbers studied. Similar trials in other centres could reinforce our conclusion that such rectal assaults on women in labour should be discouraged.

References

[1] Romney ML. Predelivery shaving: an unjustified assault? *Journal of Obstetrics and Gynaecology* 1980;1:33-5.

[2] Hytten FE. The alimentary system. In: Chamberlain G, ed. *Clinical physiology in obstetrics*. London: Blackwell Scientific, 1980:ch 5:147-62.

[3] Levy N, Lemberg E, Sharf M. Bowel habit in pregnancy. *Digestion* 1971;4:216-22.

(*Accepted 27 February 1981*)

DUCK'S MEAT is so well known to swim on the tops of standing waters, as ponds, pools, and ditches, that it is needless further to describe it.

Cancer claims the herb, and the Moon will be Lady of it; a word is enough to a wise man. It is effectual to help inflammations, and St Anthony's Fire, as also the gout, either applied by itself, or in a poultice with Barley meal. The distilled water by some is highly esteemed against all inward inflammations and pestilent fevers; as also to help the redness of the eyes, and swellings of privities, and of the breasts before they be grown too much. The fresh herb applied to the forehead, eases the pains of the head-ache coming of heat. (Nicholas Culpeper (1616-54) *The Complete Herbal*, 1850.)

Corrections

Electric convulsion therapy in depression: a double-blind controlled trial

The dose of atropine as a premedication was wrongly quoted in this paper by Dr Eric D West (31 January, p 355). This should have been 0·8 mg, not 80 mg as stated.

Relapse rate and long-term management of plaque psoriasis after treatment with photochemotherapy and dithranol

In this paper by Dr D Vella Briffa and others (21 March, p 937) the appointment of Dr A P Warin should have read "consultant dermatologist and senior lecturer."