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EDITORIAL

Episiotomy – the present scenario

Prof (Dr) Hem Kanta Sarma

Correspondence: Prof (Dr) Hem Kanta Sarma, Professor & HOD, Department of Obstetrics & Gynaecology, Jorhat Medical College, Jorhat, Assam, India;
Email - sarmahemkanta@gmail.com

Episiotomy is a commonly performed procedure in Obstetrics. It is a surgical incision made over the perineum and vulva during delivery to increase the space available at the perineum in order to facilitate delivery of the foetus. Of course episiotomy prevents 3rd and 4th degree perineal tears and facilitates delivery in many cases; but it is not mandatory for all primigravida or first time vaginal birth. At one time there was perception that episiotomy prevents future prolapse, pelvic relaxation and urinary incontinence. But most studies have concluded that there was no such evidence. There is increasing evidence to indicate that episiotomy is rather associated with an increase risk of major perineal tears, incontinence, rectovaginal fistula, increase blood loss, postpartum pain, increased length of hospital stay and future dyspareunia. Hence the current consensus is for selective or restrictive episiotomy. This has been approved by ACOG, RCOG and WHO [1].

History

In 1942, episiotomy was first performed by Sir Fielding Ould for difficult deliveries; published in his 'Treatise of Midwifery' [2]. In 1900 it was considered as a method for preserving pelvic floor function and protecting baby's birth. In 1979, for 61% women episiotomy was performed. In 2000, it was done less frequently. In 2004, in average 25% cases it was used. In 2006, ACOG (American Congress of Obstetrics and Gynaecology) issued notification against routine use of episiotomy. In 2012, the incidence of episiotomy came down to less than 12% and National Evaluating Group in USA set target for less than 5% Incidence of episiotomy.

Why to shift to restrictive episiotomy?

The reason of this shift from liberal episiotomy to restrictive one is mostly due to the following reasons –

1) There are chances of worse damage (or tearing) of pelvic and perineal tissues than natural vaginal delivery.
2) Patient centered care which is now a days more encouraged. After proper evidence based explanation, it is likely that most patients will opt for natural one.

Justification - As per a systemic review and meta analysis regarding episiotomy practice and its associated factors in Africa [3].

1) The primipara women are 6.78 times more likely for episiotomy as compared to multipara women.

2) Episiotomy is 3.7 times more likely to be practiced when attended by medical doctors compared to midwives.

3) 2nd stage of labour delayed for more than 2 hrs was 5.5 times more likely to end in episiotomy.

4) Oxytocin when used in labour, increased 4.2 times the incidence of episiotomy.

5) Instrumental deliveries increase the incidence of episiotomy by 5.58% times.

6) Fetal body weight when more than 4 kg, increases the incidence of episiotomy by 5.32 times.

Ye et al[4] reported episiotomy rate of 41.7% in nulliparous and 21.5% in multipara in China. Vacchani A et al [5] when compared routine episiotomy with restrictive one observed as follows - Wound gap and haematoma - 5.41% v/s 1.35%; post partum perineal pain at 1 week - 14 v/s 5; post partum perineal pain at 2nd week- 5 v/s 1. Tantengco OAG [6] in a study of Philippians observed that clinical training of health care workers based on understanding and using the best evidence of episiotomy did not significantly reduce the episiotomy rate in Philippines. However this training resulted in higher rates of intact perineum among pregnant patients. Gachon B et al [7] from France observed a

massive increase in OASI (Obstetric Anal Sphincter in injury) rate in his study.

A retrospective cohort study report suggests that episiotomy use may put multiparous women at increase risk for 3rd and 4th degree tears [8]. A cochrane database systematic review suggests that selective use of episiotomy compared with its routine use during vaginal birth is associated with lower rates of posterior perineal trauma, less suturing and fewer healing complications [9]. Routine use of episiotomy increases the risk of perineal or vaginal trauma by 30% compared with selective use of episiotomy. They studied a group of 200 patients, 100 for routine episiotomy and 100 for restricted use of episiotomy (needed 27%) and found statistically significant better outcome in later group in terms of perineal trauma, post partum pain and maternal satisfaction. It was observed that though there is somewhat increase in 1st degree perineal tear there is significant decrease in 2nd degree perineal tear and 3rd or 4th degree perineal tear; in most of the cases there was no perineal injury.

How to avoid episiotomy?

Different authorities have recommended different methods for minimizing the need of episiotomy while there is a general consensus of restrictive episiotomy.

Warm Compress: It is recommended to apply warm compress to the perineum before and during labour, making the tissues of perineum and pelvis soft and pliable.

Perineal massage: It helps in reducing the risk of tearing perineal tissues by at least 10%. This is started from 34 weeks onward for 10 minutes every day.

Exercise for preparation of labour: There are different steps as follows; which should be done under supervision.

1. Child's pose: Kneel down; sit on heels; lean forward, stretched out arms long in front, breathe deeply.
2. Deep squats: Relaxes and lengthens pelvic floor muscles; stretches perineum while squatting one should bring hands in front and breathe deeply.
3. Quadruped cat/con: While exhaling the air one should make the back round and arch back downwards while inhaling this will ease discomfort and reduce low back pain.
4. Perineal bulges: It should be practiced during last 3 weeks prior to labour. One should observe before a mirror while performing to see that perineum bulges out and down.
5. Perineal massage: Warm bath is to be taken first, then warm compress for 10 minutes. Use the thumb lubricated with water soluble lubricants to put 1-1.5 inch inside vagina; massage for 3 weeks in U shaped motion back and front. Repeat another cycle. Deep breathing is required.

Recommended policy

According to WHO recommendation on episiotomy policy (29th August, 2021) routine or liberal use of episiotomy is not recommended for woman undergoing spontaneous vaginal birth. Episiotomies do not warrant the routine use of antibiotics. Women's informed consent is essential before the procedure. An effective local anesthesia is also essential provided the patient is not under other regional or general anesthesia. Preferred technique is mediolateral incision. The incision should start at the introitus in midline, then downward and laterally in 60 degree angulation (This angulation will become 45 degree at the time of suturing).

Contraindications

Episiotomy is contraindicated in the following conditions-

1. Abnormal perineum
2. Inflammatory bowel disease
3. Lmphogranuloma venerum infection
4. Severe perineal scarring
5. Refusal by the patient

Conclusion

In view of the increasing evidence in favour of the restrictive episiotomy policy due to lesser chance of perineal and pelvic trauma as compared to liberal episiotomy, most of the leading institutions and authorities have come into a consensus for adopting restrictive episiotomy as a norm. More and more studies in this regard in different parts of the world will through more lights into proper understanding and formulating a better policy. There should be more and more orientation as well as capacity building programmes amongst the health care personals for better implementation of the policies in a scientific way.

Conflict of interest: None. **Disclaimer:** Nil.

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