Why and how not to do episiotomy – theory and practical

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Long ago ....

- In 1979, episiotomy rates were 65% in US (Schoon 2001)
- Ireland in 1984, 54% in nulliparous women (Begley 2002)
- In 1990s, episiotomy rates were 92% in Latin America (Althabe 2002), 62% in US, 38% in Canada (Goldberg 2002)

Now we know ….

- Episiotomy does not prevent severe perineal trauma, healing complications, painful intercourse or urinary incontinence (Carroli et al 2012)

- In the absence of a valid reason to do one, episiotomy is an unjustifiable assault on women.

Episiotomy rates now

- Rates have fallen to 4.9% in Denmark and 6.6% in Sweden (EURO-PERISTAT 2013)
- Rates in Czech Republic still high ?31
- Needs to change in line with good practice across Europe

Episiotomy study

Group (Para 0)	Number	Epis %	Intact %	1st degree %	2nd degree %
Study 1	582	54	16	10.5	19.5
Study 2	564	34.5	24	19.2	19.3
		Sig.	Sig.	Sig.	NS

One year later episiotomy rate was down to 25%

Episiotomy study

Group (Para 1)	Number	Epis %	Intact %	1st degree %	2nd degree %
Study 1	684	25	27	20	28
Study 2	603	7	34	34.5	24.5
		Sig.	Sig.	Sig.	NS

Episiotomy study

Group (Para 2)	Number	Epis %	Intact %	1st degree %	2nd degree %
Study 1	1156	5	53	24	18
Study 2	977	2	59	28	
		Sig.	Sig.	Sig.	

Episiotomy study

Group (Para 2)	Number	Epis %	Intact %	1st degree %	2nd degree %
Study 1	1156	5	53	24	18
Study 2	977	2	59	28	11
		Sig.	Sig.	Sig.	Sig.

So, episiotomy should never be done "to avoid a tear"

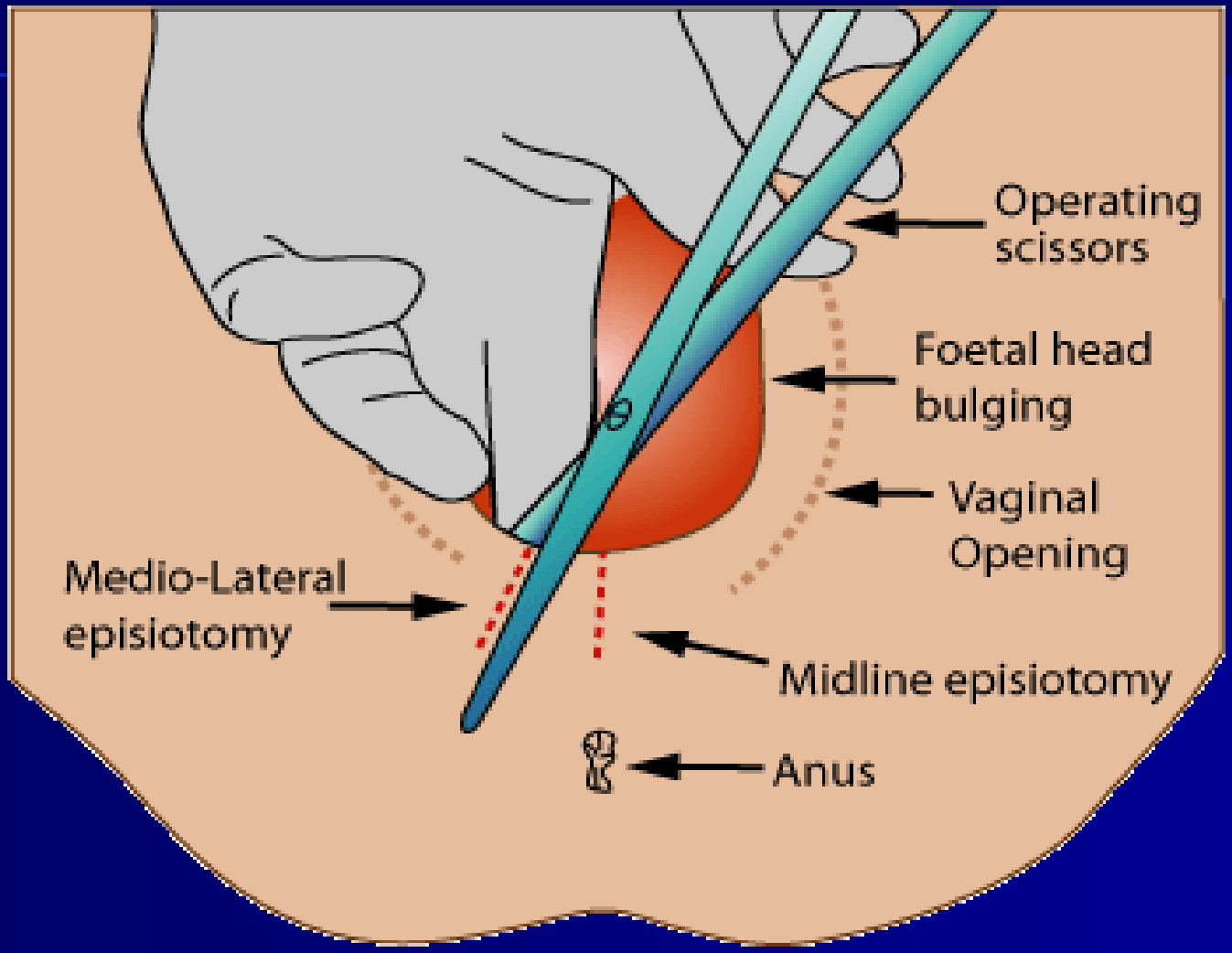
Indications for episiotomy

- Fetal distress, when the head is on the perineum – the head should come out with the cut.
- Fetal distress before then – forceps/ventouse
- If you do it too early, you damage more muscle tissue, there is more bleeding (possibly PPH), and you still cannot birth the baby's head.

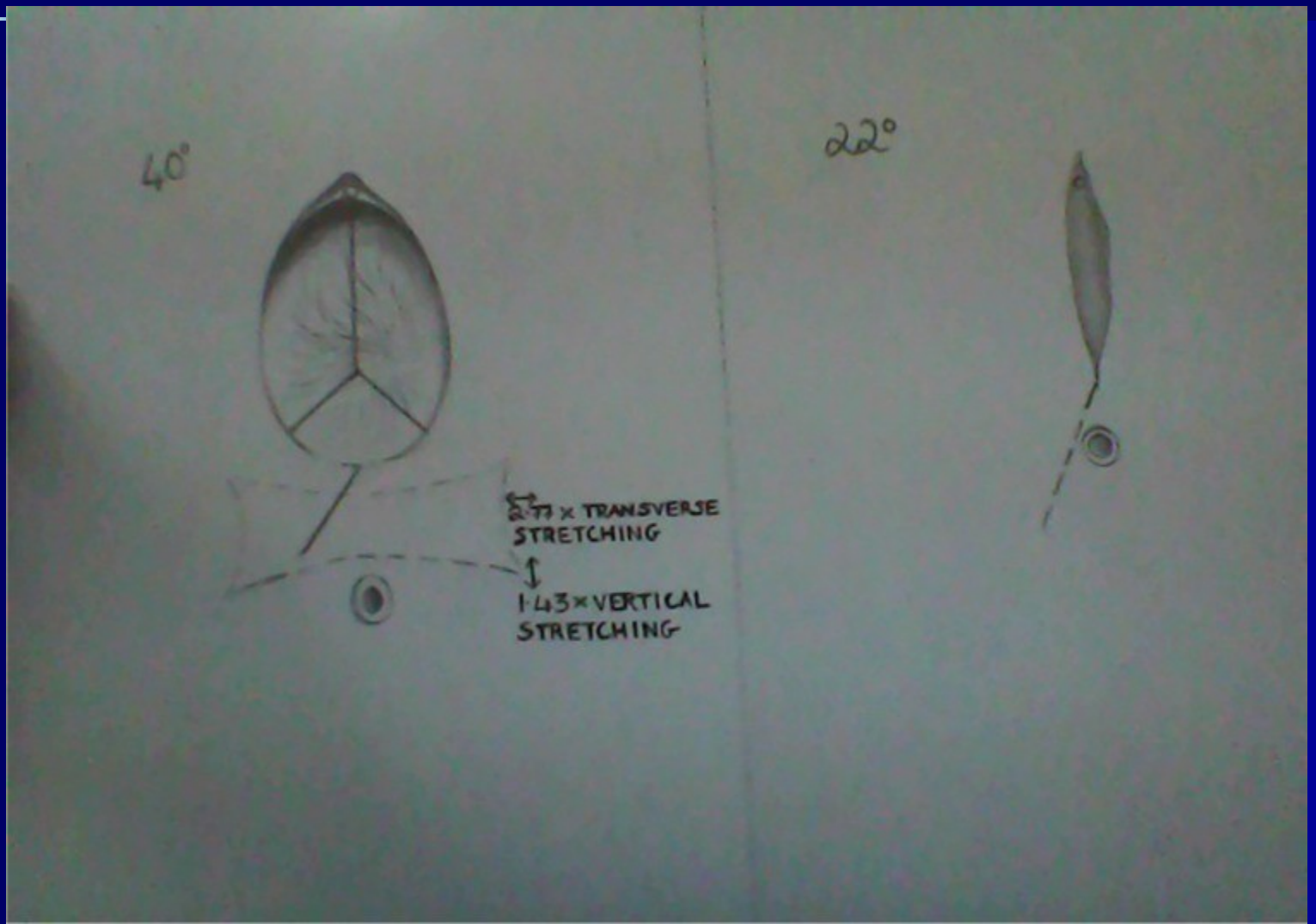
Episiotomy

- Should be used less than 10% in spontaneous vaginal birth when caring for nulliparous women, almost never in caring for multiparous women
- What is the correct angle to cut?
- (Practical session)

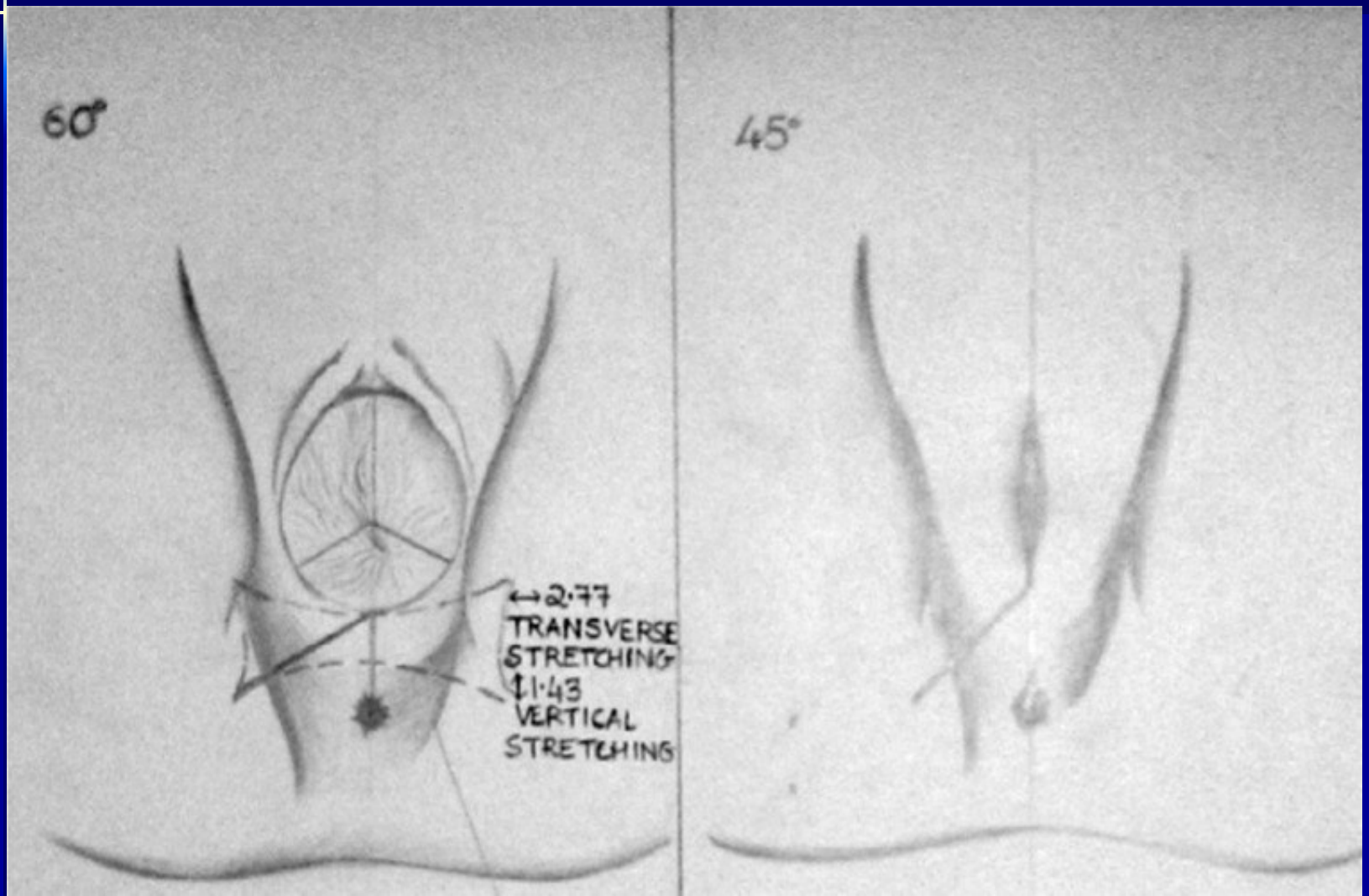
This angle (45 degrees) is WRONG!!!



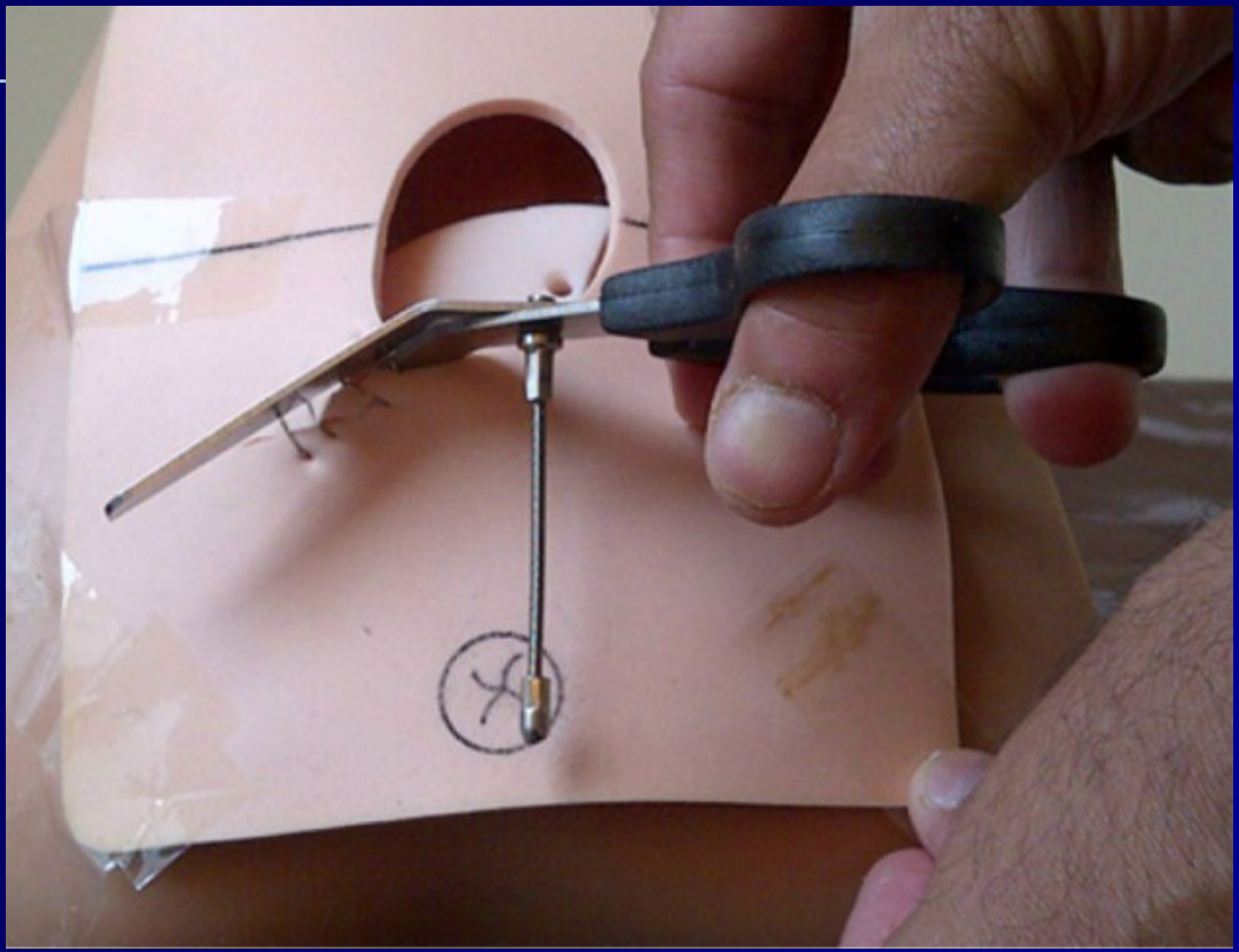
40 degree episiotomy at crowning resulting in a 22 degree post-delivery angle



60 degree episiotomy at crowning resulting in a 45 degree post-delivery angle – this is correct



Episcissors-60 (gives mean 43 degree angle post birth)



Episiotomy - infiltration

- Infiltrate perineum with 10ml Lignocaine 1%:
- Insert two fingers to protect baby's head
- Insert the needle at the centre of the fourchette, direct it at a 60 degree angle, right "up to the hub."
- Inject 3mls while withdrawing along the just-created sub-dermal tunnel; this minimises tissue distension and pain.
- Do not withdraw the needle fully from the tissue, redirect it along a path, first 20 degrees above the original angle and then 20 degrees below.
- Inject 3mls each time while withdrawing along each path.
- Last 1ml is injected as you withdraw the tip. Massage gently.

Episiotomy - decision

- If the fetal heart is acceptable, wait another contraction, with the woman pushing. The fetal heart may have recovered fully, in which case just continue to birth naturally over the next few contractions.
- If episiotomy is still needed, explain to the woman that you need her to breathe or pant in and out, instead of pushing with the next contraction. She needs to do this with wide open mouth, to relax her perineal muscles.
- With the next contraction, as the head distends the perineum, ask the woman to breathe/pant.

Episiotomy - incision

- When the woman is breathing, and not pushing, with good control, insert two fingers to protect baby's head. Insert scissors at 60 degree medio-lateral angle and withdraw fingers.
- Make one cut, 3-4 cm, while holding the perineum together with the index finger and thumb of the other hand. If the episiotomy is done at the right time, the perineum will be thin and will part under the scissors with no effort.
- The head should ease gently out. If not, ask the woman for a gentle push and then breathe, gentle push and then breathe support the perineum by easing the edges of the cut together.

Remember – for 9 out of 10 nulliparous women (and almost all others), you should NOT do an episiotomy

References

- Althabe F, Belizán JM, Bergel E. Episiotomy rates in primiparous women in Latin America: hospital based descriptive study. BMJ 2002; 324:945.1 *doi: http://dx.doi.org/10.1136/bmj.324.7343.945*
- Begley CM. Episiotomy rates may change after evidence based intervention. BMJ 2002;325:335
- Carroli G, Mignini L. Episiotomy for vaginal birth. *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD000081. DOI: 10.1002/14651858.CD000081.pub2
- EURO-PERISTAT:. European Perinatal Health Report: The health and care of pregnantwomen and babies in Europe in 2010. 2013 [http://www.europeristat.com/reports/european-perinatal-health-report-2010.html
- Goldberg J, Holtz D, Hyslop T, et al. Has the use of routine episiotomy decreased? Examination of episiotomy rates from 1983 to 2000. Obstet Gynecol 2002; 99(3):395-400.
- Schoon PG. A Guest Editorial: Episiotomy: Yea or Nay. Obstetrical & Gynecological Survey, 2001, 56(11):667-669.