

Editorial

Episiotomy : Need for Rethinking



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Sound medical practice should be based on good scientific evidence. During the last century episiotomy is almost routinely employed while delivering nulliparas and primiparas. Williams Obstetrics (Pritchard and MacDonald, 1980) labels episiotomy as the commonest obstetric operation barring cutting and tying of the umbilical cord. Thacker and Banta (1983) in their review state that episiotomy is performed in 60% of all deliveries in USA and in much larger percent in primigravidas. This excellent review instigated and triggered many scientific evaluation studies on episiotomy in the last two decades. These studies have shaken up our beliefs on which our practice of very liberal routine use of episiotomy is based.

Various advantages and benefits attributed to episiotomy are that it - 1) spares the baby's head, especially premature one's, from possible intracranial injury 2) shortens 2nd stage 3) reduces likelihood of 3rd and 4th degree lacerations 4) preserves pelvic floor and perineum 5) replaces ragged lacerations of perineal tear by clean linear surgical incision 6) is easier to repair than perineal tear 7) heals better than perineal tear. For generations we blindly accepted these claims to be scientifically supported and true. But recent studies prove that these claims do not stand scientific evidence and very often episiotomy is a futile infliction of unnecessary surgery.

Signorello et al (2000) found that midline episiotomy does not protect the perineum and sphincters during childbirth and may even increase the risk of sphincter injury and impair anal continence due to occult sphincter trauma.

Thorp et al (1987) find that selective and restrictive use of midline episiotomy appears to lower the incidence of perineal trauma when compared to its unrestricted routine use and results in significant decline in 3rd and 4th degree lacerations in multiparas. In fact, 3rd and 4th degree lacerations occurred without antecedent episiotomy. Goldberg et al (2002) find episiotomy to be associated with increased risk of 3rd or 4th degree lacerations. Argentine episiotomy trial collaborative group (1993) found no evidence that routine episiotomy reduces the risk of serious perineal trauma. Sleep and Grant (1987) report that liberal use of episiotomy does not reduce the occurrence of urinary incontinence or dyspareunia. While Sleep et al (1984) found that episiotomy patients are less likely to resume sex within one month of delivery. They also report that episiotomy does not benefit neonatal state, maternal pain and incidence of urinary symptoms. (Woolley's 1995 a) findings are similar. The only advantage of routine episiotomy is that it reduces the incidence of anterior perineal trauma like labial lacerations which carry minimal morbidity and usually are of no consequence (Woolley, 1995 b)

In the light of these and many other reports published in the last decade it is obvious that routine episiotomy as it is currently practiced confers no benefit to the mother or the infant and hence has no justification. The traditional teaching that 'do episiotomy to avoid tears' has no scientific basis. It must also be emphasised that episiotomy does harm rather than good. It obviously imposes avoidable blood loss which varies from patient to patient and depends on the situation. An impatient obstetrician cutting the perineum too early causes more blood loss. Thacker and Banta (1983) state that in 10% women subjected to episiotomy the blood loss was 300 ml or more. Apart from blood loss, episiotomy leads to possible morbidities in the form of pain and discomfort, healing complications, wound infection, wound disruption needing resuturing, increased risk of

anal incontinence etc. Rare complications of episiotomy are rectovaginal fistula and broken suture needle left in the wound (Parikh, 2002). It is also obvious that unnecessary episiotomies mean waste of scarce resources like suture material, antibiotics, pain killers, manpower etc. all of which are always greatly inadequate in countries like ours. Avoiding episiotomies wherever possible should be mandatory in health services at all levels in our country. WHO has taken a definite stand against routine episiotomies (Thompson, 1997). The incidence of episiotomies is too high, thanks to the current practice of routine episiotomy. The incidence in our country is difficult to compute but is much higher in hospital deliveries and in those conducted by doctors than in those conducted by midwives and birth attendants. In Latin American hospitals over 90% of primiparas have episiotomy (Althabe et al, 2002). Similar is the fate of women in Nigeria (Ola et al, 2002) and Argentina (Argentine episiotomy trial collaborative group, 1993). The current recommendation is that episiotomy should be employed only for definite indications like fetal problem, instrumental delivery, malpresentation, large baby and imminent perineal tear. A policy shift from routine episiotomy to selective or restrictive use of episiotomy brought down the episiotomy rate from 69.6% in 1983 to 19.4% in 2000 at Thomas Jefferson University Hospital in USA (Goldberg, 2002). Argentine episiotomy trial collaborative group (1993) states that episiotomy rates beyond 30% are not justified. The real problem in reducing episiotomy rates is the usual resistance and traditional reluctance of obstetricians to change their current practice. We should look at the mounting scientific evidence against routine episiotomy and change over to the practice of episiotomy only when indicated. It is our duty and obligation to our patients.

Lastly, in our country, episiotomy is traditionally performed without the patient's consent or even her prior knowledge. Since it is a surgical procedure does it not

need mandatory informed written consent of the patient? Patient's right to information, possibility of complication resulting from episiotomy and Consumer Protections Act make it advisable to obtain patient's informed consent in writing prior to episiotomy.

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