J. of Obst. & Gyn. of India Vol. 52, No. 6 : November/December 2002 Pg 70-71

Complications Of Episiotomy

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Introduction

Episiotomy is routinely employed over last hundred years in the belief that it greatly benefits both the unborn baby and the mother. This belief is now shattered by scientific studies published by Sleep et al (1984), Sleep and Grant (1987), Goldberg et al (2002), Signorella et al (2000) and many others. Like any surgical procedure episiotomy also has its share of complications. Perineal wound infection and wound disruption are occasionally experienced by every obstetrician. Serious complications, however are uncommon. The current rethinking against routine episiotomy and emphasis on avoiding unnecessary episiotomies in line with WHO stand (Thompson, 1997) prompt us to report two cases of serious complications seen in the seventies.

Case No.1

Mrs. K, a 25 year old female presented at our private consultation with the complaint of pain in the perineum since her last delivery 4 months back at a private Maternity & Surgical Nursing Home of a competent Obstetrician & Gynaecologist. She was married for 1 ½ years and this was her first pregnancy. The delivery was normal and needed a right mediolateral episiotomy which was promptly sutured. She complained of perineal pain during the postpartum period and was treated with pain killers. During the 3 months following delivery she was seen 3 times by her obstetrician for persistent perineal pain for which symptomatic treatment like local fomentation and analgesics were prescribed. She did not have much relief.

General examination was unremarkable. Perineal wound was well healed. Vaginal examination showed normal retroverted mobile uterus with palpable ovaries and otherwise free fornices. Rectal examination revealed no abnormality. However, there was tenderness on deep pressure on the episiotomy scar. Sonography facilities were not available those days. Plain x-rays of the pelvis revealed a curved needle in the perineal area. Surgical removal of the needle was planned. Routine pre-operative investigations showed no abnormality [(Fig. 1 & 2)]

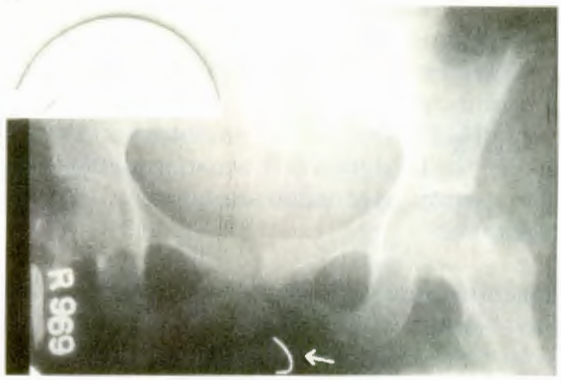

Fig. 1: A-P x-ray - Arrow pointing the needle. Inset shows the removed needle

Fig. 2: Lat x-ray - Arrow pointing the needle. Inset shows the removed needle

Patient was operated at Shushrusha Citizen's Cooperative Hospital under low spinal anaesthesia. The episiotomy wound was cut open. The needle was neither seen nor felt in the wound. After a patient search, digital as well as instrumental, in different areas around the wound the needle was finally located in the levator muscle lateral to and 1 cm away from the wound. The needle was extracted with some difficulty without injuring the rectum. The wound was closed in layers and healed well. The patient was followed up for 2 months and was completely relieved of her symptom.

Case No. 2

Mrs. S a 28 year old woman attended our private consultation in October 1976 with the complaint of occasional passing of flatus through the vagina. She also complained of passing stools per vaginum (in addition to per rectum) whenever she had diarrhoea. She had a normal vaginal delivery 6 months back at a Maternity & Surgical Nursing Home run by a competent Obstetrician & Gynaecologist. She was married two years back and this was her first delivery. A midline episiotomy was employed during delivery. Her symptoms started 2 weeks after delivery. Her obstetrician advised antibiotics for her problem and later assured her of spontaneous cure in due course. Her general examination revealed nothing abnormal. Vaginal, speculum, rectal and proctoscopic examinations demonstrated small sinus openings - one on the perineal scar, two in lower vagina and one in the lower rectum. There was no abnormality in the pelvis. An x-ray was planned after injecting urograffin in the perineal and / or vaginal openings of the sinuses. But the dye could not be injected through any of the openings because of resistence to the injection. Subsequently, the patient was examined in the operation theatre at which time methylene blue injected through the perineal opening was seen coming out from the vaginal openings and through the rectum. It was planned to excise the sinuses. Routine preoperative investigations revealed no abnormality. She was operated in our private nursing home under spinal anaesthesia. Ten percent methelene blue was injected through the perineal opening to define the sinus tracts. Each of the sinus tract was cut opened after passing a sinus probe through it. Sinus tracts exhibited blue staining and they were completely excised along with a margin of normal tissues. The wound was converted into complete perineal tear during the process. After thorough hemostasis the wound was closed in layers. She was given antibiotics and the wound healed well. The patient was discharged in good condition and she was followed up for 3 months. She was symptom free.

The excised sinuses were sent for histopathology study to exclude tuberculosis. The report was chronic inflammation without any suggestion of tuberculosis.

Discussion

Episiotomy is usually undertaken and handled as a very minor surgery. Complications do occur and after symptomatic treatment the wound ultimately heals. Breakdown of the wound does occur occasionally, needs resuturing and results in satisfactory healing. Serious complications are very rare and often remain unreported. Our first case presents a problem not so very rare in surgical practice. The needle obviously broke during the suturing of the episiotomy. Possibly the broken part of the needle must have been looked for in the wound, but on not finding it, it must have been presumed to have been dropped outside the wound and lost in the linen. A dangerous presumption indeed ! Those were the days when needled sutures were not in use needles were not of the quality that needles in current use possess and needles were reused repeatedly and became blunt and weak.

Needled sutures are still not used in many parts of our country. All this, perhaps aided by faulty technique without paying attention to meticulous details during suturing results in breaking of the needle. The needle, with some exceptions like employing microsurgical sutures, should be held by needle holder two third distance away from its tip and must be directed at right angles to the edges of the would that is being sutured. What cannot, however, be condoned is that without any evidence it was presumed, that the broken part of the needle must have dropped out of the wound.

In our second case it is most likely that during the suturing of the episiotomy the needle must have picked up the rectal wall at some spot resulting in the fistulae. It is advisable that at the end of the episiotomy a finger be inserted in the rectum and anterior rectal wall carefully palpated for any suture piercing through it. If so the would should be immediately opened up and resutured.

References

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