liberal versus restricted episiotomy

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To compare the outcomes of the current practice of liberal (routine) use of episiotomy, to prevent perinal tears and pelvic floor relaxation, with a policy of restricted episiotomy done for specific fetal or/and maternal indications.Study design :Prospective observational study.Setting :Qepartment of Obstetrics and Gynaecology, Benha Faculty of Medicine Egypt from September 1999 to June 2000.Subjects :297 primiparae, of , the same socioeconomic class who had spontaneous vaginal deliveries of singleton, mature (37-41 weeks) fetuses, in occipito-anterior position. They included 2 groups.1-Restricted episiotomy group : 153 primiparae in whom delivery was conducted by the same resident who tried to avoid an episiotomy except for specific fetal/maternal indications.2-Routine episiotomy group : 144 primiparae in whom delivery was conducted by other department residents who performed routine episiotomy to avoid perineal tears, pelvic floor relaxation and their consequences.Materials :The technique of delivery was planned to be the same in bothgroups.-In both groups mediolateral episiotomies were done, and the repair technique was the same.-All women were examined at discharge from the hospital, at 7-10-days and at 3-months postpartum.Outcomes measured :Comparison between the restricted and routine episiotomy groups was statistically done regarding :1- Perinea! outcome :•Episiotomy rate in the restricted group.•Episiotomy extension.•Occurrence of perineal tears, and their degree.,•Occurrence of anterior vulva! tears.2- Other lower -genital tract injuries : as vaginal & cervical tears.3- Postpartum complicationsa Short term (on discharge and at 7-10 days P.P) regarding : perinea! pain (measured by need for analgesia), -and wound complications.b-Long-term (After 3 months) regarding : urinary/tlatus or fecal incontinence, perinea’ heaviness or discomfort, vaginal introitus capacity, levator ani tone, vaginal prolapse, condition of external anal sphincter and sexual function (resumption, sexual satisfaction and dyspareunia).4- In the restricted episiotomy groups :Comparison was done between women who had an episiotomy and those with a sustained perineal tear, regarding short-term and long-term effects.Both groups matched regarding mean age, height, weight, gestation weeks, the condition of the perineum head position, cord around the neck and fetal weightThe rate of episiotomy in the restricted group was 45 out of 153 deliveries (29.4%) compared to 100% in the routine group (P = 0.000).There was no cases of urinary incontinence or vaginal prolapse in both groups.There was no statistically significant difference (P > 0.05) between both groups regarding : Apgar score, associated vaginal tears, cervical tears, second degree perineal tears and anterior tears, levator ani tone, weakness of the external anal sphincter, and in

varians types of dyspareunia (except for persistent, superficial, moderate dyspareunia).Routine episiotomy, compared to restricted episiotomy was associated with more :1-Need for postpartum, analgesia (98.6% VS 49.0%, P = 0.000).2-Third and fourth degree perineal tears (12.4% VS 0.0%, P = 0.02).3-More left lateral wall vaginal tears (12.5% VS 4.6%, P = 0.03).4-Total wound complications (11.2% VS 4.2%, P = 0.049), and wound dehiscence (4.5% ys 0.0%, P = 0.03).5-Persistent pelvic heaviness or discomfort at 3-months follow up (21.1% VS 3.7%, P = 0.02).6-Flatus incontinence at early postpartum follow up (5.6% VS 0.0%, P = 0.02), but this disappeared at 3-months follow up.7-Narrow vaginal introitus (10.5% VS 0.0%, P = 0.000).8-Later resumption of sexual function (40.7 + 9.9 clays VS 39.9 + 5.7 days, P = 0.000).9-Number of cases with total dyspareunia, (54% VS 39%, P = 0.02) and number of cases with persistent, superficial, moderate dyspareunia (12.9% VS 5.1%, P 0.046).10-Number of cases with less sexual satisfaction (14.5% VS 2.9%, P 0.002).. Restricted episiotomy, compared to routine episiotomy, t ’as associated with :1-Longer crowning-delivery time (3.1 + 0.9 min. VS 2.7 + 0.9 min., P = 0.000), but with no effect on Apgar score..2-More first degree perinea’ tears (12.4% VS 0.7%, P = 0.000).3-More bilateral vaginal tears (7.8% VS 2.1%, P = 0.04).In the restricted episiotomy group, women who had an indicated episiotomy and those who sustained perinea’ tears were compared and showed that there was no significant difference between both group (P > 0.05) regarding :-The need for analgesia.-Wound complications.- Perineal heaviness or discomfort at 3-months follow up.-Time of resumption of sexual function postpartum.- Number of cases with dyspareunia.-Number of cases with less sexual satisfaction.Episiotomy rate in primparae could be reduced from 100% to 29.4% without any fetal or maternal untoward effects.Our study confirms published evidence-based data that routine (liberal) use of episiotomy :1- Fails to accomplish any of the many fetal and maternal benefits traditionally ascribed including :a-Prevention of perineal damage and its sequalae.b-Prevention of pelvic floor relaxation and its sequelae.c-Protection of the newborn.2- Increases the risk of anal sphincter and anal canal damage (ri and 4th degree perineal tears).3- Increases the amount of postpartum pain, early and late.4- Increases wound complications and improper healing.5- Increases adverse effects on sexual function; dyspareunia and less sexual satisfaction.RECOMMENDATIONSThe practice of routine (liberal) episiotomy should be abandoned and substituted by ’restricted episiotomy policy of patience during delivery and doing episiotomy, only for specified fetal or/and maternal indications, even at the expense of a spontaneous tear, which is of a first degree in the majority of cases, at most of a second degree.