

Episiotomy: a too often unnecessary and harmful practice

Introduction

Episiotomy was introduced in obstetrics during the 18th century and today it has become one of the most performed interventions in clinical practice. In the first times, it was used in exceptional cases. Then, its use has been so widespread that it became quite a routine procedure in obstetrics, based on the fact that it was considered necessary to make delivery safer and to prevent possible long-term pelvic pathologies. In recent times, yet, its routine use and particularly its usefulness have been increasingly questioned, both by patients and by practitioners, bringing this topic to the attention of the media.¹⁻³ Moreover, since their possible short- and long-term consequences, the occurrence of spontaneous lacerations and/or the execution of episiotomy during labor are important women's health problems.⁴

Episiotomy is routinely performed in over half of the hospital-based deliveries in the United States (USA) and is broadly widespread also in the United Kingdom (UK), despite the dearth of scientific data demonstrating its usefulness in uncomplicated cases. The main reasons for the execution of episiotomy are:

- i. It reduces perineal trauma; and
- ii. It prevents long-term pelvic floor disorders.

Yet, literature review shows little evidence to this. Episiotomy may predispose the gravid woman to third- and fourth-degree lacerations. It could therefore be argued if this intervention is beneficial.⁵ In fact, routine execution of episiotomy is now increasingly subjected to doubt, as much as its role as a protective factor against pelvic floor disorders. Another issue that is more considered than before is quality of life.⁶

Episiotomy is often poorly executed and repaired with little thought as to the importance of a supple pain-free scar.⁷ In fact, sexual difficulties resulting from episiotomy frequently result from inaccuracy of siting and repair in favor of speed and dispatch. However, some postpartum difficulties in return to sexual function can result from emotional factors.⁸ Childbirth appears to have a lasting impact on sexual function, due to psychological more than physical factors, well beyond the postpartum period.⁹ In recent times, childbirth management has given increasingly importance to its possible consequences on female sexuality.¹⁰ The first sexual intercourse after childbirth may be challenging for women, especially if the birth resulted in injuries in the genital area. Tears in the vagina, perineum, sphincter ani, or rectum are associated with a delay in women's resumption of sexual intercourse 6 months after childbirth.¹¹

Perineal pain is common after childbirth.¹² Acute postpartum perineal pain is common among all women. However, perineal pain is more frequent and severe for women with increased perineal trauma.¹³ Dyspareunia and perineal pain affect 42% of women within the first two weeks after their first vaginal delivery.¹⁴ Postpartum dyspareunia is quite common and can be a significant source of difficulty in the months after delivery. It is an under detected problem and deserves more study.¹⁵ Some factors can safely shorten postpartum sexual abstinence time reducing perineal pain:

- i. Episiotomy repair with a fine polyglycolic acid (PGA) suture on small needles;
- ii. The use of absorbable suture materials instead of non-absorbable ones;
- iii. The infiltration of the perineum with normal saline before making the suture;
- iv. The sinking of the suture just below the skin surface; and, last but not least,
- v. The skill of the operator.¹⁶

Acute postpartum perineal pain is common among all women. The most painful perineal trauma is obstetric anal sphincter injury. Spontaneous second degree tears cause less perineal pain than episiotomies. In the evaluation of pain, the 11-point visual analog scale (VAS) is considered more accurate than the 4-point verbal rating scale (VRS). The current management of postpartum perineal pain appears inadequate. Perineal pain following vaginal birth is associated with interventions during labor as well as with maternal characteristics. Despite the negative impact on a woman's daily activities, perineal pain following birth is neglected by care givers and usually not reported by women who may consider it to be a normal outcome of giving birth. Care providers need to ensure all interventions during labor and birth are informed by evidence of benefit and that barriers to implementation of evidence are addressed.¹⁷⁻²¹

Rare complications of vaginal birth are episiotomy dehiscence and infection. However, wound dehiscence, if untreated, may lead to major complications of physical, psychological, and social order. In fact, the natural healing by secondary intention often results in a longer period of high morbidity for women, as confirmed by randomized controlled trials (RCT) that showed how the suturing of perineal wounds is the best management approach, resulting in a better outcome for women.²²

Also our experience confirms no prevention of pelvic floor disorders by routinely execution of episiotomy, rather there can be a significantly greater morbidity in these women than among those remaining with intact perineum or sustaining spontaneous tears. Perineal pain in the immediate postnatal period is highly associated with

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older maternal age and use of episiotomy, although the overall reporting of perineal pain is low. Primigravid patients have a reasonable chance of retaining an intact perineum if episiotomy is carried out only when considered to be essential. Moreover, if primigravid patients do sustain a second degree tear, they will fare no worse in terms of postpartum pain than if they had undergone episiotomy and their perineal wound will heal just as well. Severe soft tissue injury, however, can occur even with an intact perineum, and as there can be valid medical indications for episiotomy, the final decision whether to perform episiotomy can be made only at the time of imminent delivery and must therefore rest with the obstetrician who should take it only in the presence of specified fetal-maternal indications.

In conclusion, the most painful policy is epidural analgesia and episiotomy, the less painful is intact perineum.

The chance for intact perineum is increased in a restrictive policy and if the fetus is of low weight.^{23,24}

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Conflict of interest

The author declares no conflict of interest.

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