MATERNITY UNIT

GUIDELINE: Performing an Episiotomy

SCOPE: All midwives and obstetricians working in the maternity unit

AUTHOR: Midwife Educator and Quality Coordinator

PURPOSE: To provide good practice guidance on the reasons for, risks of and method of performing an episiotomy

DEFINITIONS:
An episiotomy is an incision through the perineum and perineal body. The cut is made in order to enlarge the vulval outlet and expedite the birth of the baby.

GUIDELINE:
Episiotomy has a history of liberal use in obstetric practice. Some of the previously suggested beneficial reasons for routine use are: reduced incidence of third degree tears; reduced incidence of spontaneous perineal trauma and associated pain and healing duration; preservation of the pelvic floor for sexual function; reduced urinary/faecal incontinence; reduced incidence of shoulder dystocia; fewer anterior vaginal/labial tears; shortened second stage of labour; easier to repair as opposed to a tear; reduced incidence of birth asphyxia in the baby; less cranial trauma to the fetal head; and less cerebral haemorrhage/pathology.

There is no current evidence which supports routine episiotomy.

An episiotomy is a surgical procedure that can have both short and long term implications for the woman. Ideally the reasons for an episiotomy in labour should be discussed with the woman in the antenatal period. This enhances her ability to make informed choices.

Episiotomy should be used to relieve fetal or maternal distress, or to achieve adequate progress when it is the perineum that is responsible for lack of progress.

The primary indication should be for fetal reasons, which may include:

- To hasten delivery when there is fetal distress and the head is on the perineum.
- When shoulder dystocia is apparent and initial manoeuvres are unsuccessful.

Possible maternal indications may include:

- When the woman experiences a ‘rigid’ perineum which causes extensive delay in the second stage of labour and the fetal head is unable to advance.
- When maternal distress is significantly hindering the birth of the baby
- Episiotomy may be justified where the woman has significantly raised blood pressure and /or cardiac disease. The purpose is to reduce maternal pushing efforts in the active second stage of labour.
- If the perineum is seen to ‘button-hole’ or other signs of likely extensive labial lacerations are present

Risks associated with performing an episiotomy:

- Possible extension into the anal sphincter/rectum
- Poor alignment of suturing, causing skin tags, asymmetry and/or excessive narrowing of the introitus
- Posterior vaginal wall prolapse i.e. rectocele
- Rectovaginal or anal fistula
- Increased risk of maternal blood loss
- Increased risk of haematoma formation
- Increased pain and/or oedema
- Increased risk of infection and/or dehiscence
  Increased risk of dyspareunia

Rationale for Episiotomy

The purported benefits of episiotomy include:

- Reduction in third and fourth degree tears
- Ease of repair and improved healing
- Preservation of the muscular & fascial support of the pelvic floor
- Reduction in neonatal trauma, such as with premature infant or macrosomic infant (shoulder dystocia)
- Reduction in dystocia by increasing the diameter of the soft tissue outlet

Episiotomy procedure:

There are two major types of episiotomy, mediolateral and median.

The mediolateral incision (preferred in the UK and NZ) starts at the midpoint of the fourchette and continues at a 45-degree angle to the midline, cutting at a point midway between the ischial tuberosity and the anus. This technique is common because it avoids the Bartholin's gland and is less likely to extend towards the anus. However the mediolateral episiotomy incises a greater volume of muscle with a rich vascular supply, thus it is associated with an increased blood loss. Some studies report an increase in dyspareunia.

The median incision (preferred in the US) is begun at the midpoint of the fourchette and extended caudally in the midline. This is typically easier to repair because it follows natural tissue planes. However, if it does extend, it may result in a third or fourth degree tear.

Procedure for performing an episiotomy:

Discuss the indication for the procedure, including possible complications and risks if possible, with the woman and obtain her informed consent.

Prepare the necessary equipment for the procedure on a sterile field. This will include scissors, Lignocaine 1%, 10 ml syringe, 22 gauge (black) needle, and sterile gloves.

The first and second fingers of the left hand are inserted into the vagina behind the perineal tissue in order to protect the fetal head.

Lignocaine 1% 10mls is used to numb the tissue. The needle is inserted under the skin for 4-5cms from the fourchette, into the area of the planned incision.

The woman may need to use entonox for this procedure, it should be available for her to use. If the woman has an effective epidural, local anaesthetic may not be required.

Draw back on the syringe (to check for blood vessel puncture), before administering Lignocaine, and then slowly start to remove needle whilst infiltrating.

Slide the Mayo scissor blade flat against the inside wall of the perineum.

For a mediolateral episiotomy, the mayo scissor blade is inserted in the midline, and then rotated 45 degrees before making the cut.

For a median episiotomy, the scissor is inserted in the midline and the cut is extended caudally into the vagina.

The cut may be made at the height of a contraction whilst the skin is stretched, with the aim of minimising the blood flow and reducing the associated bleeding.

The midwife must be ready to control the birth of the baby.

If there is any delay before birthing, pressure must be applied to the episiotomy wound to limit bleeding. Repair should be undertaken promptly after the birth for the same reason.

Document labour progress with an explanation of the indication for the episiotomy, the procedure performed, blood loss, analgesia used, and repair detail

If the episiotomy results in a 3rd or 4th degree tear then please refer to the *Perineal Trauma and Repair* guideline and the *3rd & 4th Degree Perineal Repair Care Pathway proforma.* ACC claim forms will require completion by the obstetrician.

ASSOCIATED DOCUMENTS

Maternity Unit Guideline – Perineal trauma and repair
Maternity Unit Guideline – 3rd & 4th Degree Perineal Repair Care Pathway.

REFERENCES:

ACOG Technical Bulletin #71, ACOG Recommends Restricted Use of Episiotomies

ACOG Practice Bulletin. Episiotomy. Clinical Management Guidelines for obstetrician-Gynecologists. Number 71, April 2006 accessed via http://www.ncbi.nlm.nih.gov/pubmed/16582142 09/06/2014

Enkin M, Keirse M, Neilson J, Crowther L, Duley L, Hodnett E & Hofmeyr J (2000) A guide to effective care in pregnancy and childbirth 3rd edition Oxford University Press.

Marshall J & Raynor MD (ed) (2014) Myles Textbook for Midwives 16th edition. Churchill Livingstone London

Goldberg, J. Sultana, C. (2004) Preventing perineal lacerations during labour. Contemporary Ob/Gyn September 2004 pp. 50 - 57

Henderson, C., Bick, D. (2006) Perineal care: An international issue. MA Healthcare. London

Robinson, J.N. (2013) Approach to episiotomy. Accessible via: http://www.uptodate.com/contents/approach-to-episiotomy?source=search_result&search=episiotomy&selectedTitle=1%7E49 Accessed 09/06/2014

MacDonald S (ed) (2011) Mayes' Midwifery – A Textbook for Midwives 14th edition Bailliere Tindall London.

Toglia, M.R. (2014) Repair of episiotomy and perineal lacerations associated with childbirth Accessible via:http://www.uptodate.com/contents/repair-of-episiotomy-and-perineal-lacerations-associated-with-childbirth?source=search_result&search=episiotomy&selectedTitle=2%7E49 Accessed 29/05/2014

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