

ICEA Position Paper

Episiotomy

Position

The International Childbirth Education Association (ICEA) agrees with the World Health Organization (Räisänen, et al., 2012; Thacker, 2000; WHO & UNICEF, 2009) that episiotomy should not be a routine procedure because there is no evidence that routine episiotomy decreases perineal damage and associated concerns.

Background

One of the most common surgical operations in obstetrics is the episiotomy (Lappen & Gossett, 2010). Clinically speaking, an episiotomy is an incision of the *puenda* (external tissue). A perineotomy is incision of the *perineum* (internal tissue). In the US, episiotomy and perineotomy are used interchangeably. The incision may be made in the midline (median or midline - straight down toward the rectum) or it may begin in the *midline* but be directed downward and then laterally away from the rectum (*mediolateral*).

Episiotomies are measured in degrees -- the most common being a 2nd degree (midway between the vagina and the anus) and the least common being a 4th degree (extending through the rectum, called the episiorctoprotomy). A 1st degree involves the skin layer only; 2nd degree involves skin and muscle; 3rd degree involves skin, muscles and rectal sphincter; and 4th degree involves the skin, muscles, rectal sphincter, and anal wall.

Factors Influencing the Use of Episiotomy

First described by a Scottish midwife in the 1740s, episiotomies were not widely used until the mid1900s. US obstetricians made the case that childbirth was a pathological process and this small incision would speed labor, decrease trauma and allow the perineum to be restored (Meyvis, et al., 2012). Joseph DeLee, the best known early proponent of episiotomy, admitted he lacked evidence to support his recommendation and no further evidence emerged for many years.

Concurrent with view of childbirth as a pathological procedure often needing surgical intervention, episiotomy enabled the chasm between the medical model of birth and the physiologic model of birth to widen.

Episiotomy does allow for a more rapid and predictable second stage, and so it fit into the assembly-line hospital model of childbirth (Dahlen, et al., 2012). It also was reported to reduce trauma to the fetal head, a fact later put into question (Goer & Romano, 2012).

Historically, episiotomy has been indicated in circumstances such as abnormal labor progression, nonreassuring fetal heart rate pattern, vacuum- or forcepsassisted vaginal delivery, and shoulder dystocia. It also was believed to hasten the second stage of labor and reduce the risk of spontaneous perineal tearing, subsequent pelvic floor dysfunction, urinary and fecal incontinence, and sexual dysfunction (American College of Obstetricians and Gynecologists, 2006).

The ACOG Statement goes on to say that recent studies show that common indications for episiotomy were based on limited data. Additionally, there was a general underestimation of potential adverse consequences associated with the procedure, including extension to a third- or fourth-degree tear, anal sphincter dysfunction, and painful sex.

Data suggest that women who have an episiotomy do not have significantly improved labor, delivery, and

recovery compared with those who do not have one. Without sufficient data to develop evidence-based criteria for performing episiotomies, clinical judgment remains the best guide to determine when its use is warranted, according to ACOG.

Important to the discussion of episiotomy is perineal massage. Perineal massage is the practice of massaging a

pregnant woman's perineum around the vagina before birth and during the birthing process. The intention is to attempt to prevent tearing of the perineum during birth, the need for an episiotomy or an instrument (forceps or vacuum extraction) delivery. Perineal massage decreases the rate of episiotomies and lacerations as well as the size of episiotomies (Hale & Ling, 2007). A lubricant such as KY Jelly, Vitamin E oil or Almond Oil may be used.

Research has shown that perineal massage is associated with a decrease in perineal trauma, prevention of tears and size and rate of episiotomy and lacerations (Karacam, et al., 2012).

Implications for Practice

Childbirth educators have a mandate to present evidencebased information, including that of episiotomy. While episiotomy rates continue to be high and variable within country, state/province, city and even within provider group, numerous medical journals have provided evidence that routine use of episiotomy should be abandoned and episiotomy rates of >30% do not seem justified. While US rates dropped from 1980 (64/100 vaginal deliveries) to 2006 (16.0/100 vaginal deliveries), rates still are extremely variable (Pietras & Taiwo, 2012).

Educators can impact the hegemony of the medical model (Dahlen, HG, et al., 2012) by actively promoting gravity position/upright positions for the second stage of labor (Chalmers, et al., 2012; Lamaze International, 2009), encourage informed decision making regarding the use of interventions that restrict movement or add to the risk of
obstetric anal sphincter injury

(Liljestrand, 2003; Thacker, 2000), teaching physiologic pushing and breathing while discouraging prolonged breath-holding or "purple pushing" (ICEA, 2009) and advocating for emotional support and effective communication by all whom attend the labor and birth.

Additionally, educators may wish to establish a foundation for teaching about episiotomies by creating a database of journal articles with the evidence-based information. Evidence showing the benefits to mothers of restrictive episiotomy policies (less severe perineal trauma, less posterior perineal trauma, and fewer healing complications (Aasheim, et al., 2011) and quoting professional bodies who have issued statements addressing routine episiotomy (ACOG: American College of Obstetricians and Gynecologists, RCOG: the Royal College of Obstetricians and Gynaecologists UK; and NICE: National Institute for Health and Clinical Excellence UK) may be useful to support this teaching. At the same time, information showing that episiotomy at the first vaginal birth significantly and independently increases the risk of repeated episiotomy and spontaneous tears in subsequent delivery (Klein, et al., 1995).

Studies imply that rates of intervention in labor and birth (including episiotomy) are not always evidence-based but may be influenced by a variety of other factors (Carroli & Mignini, 2012). The "other factors" include the physicians' desire to expedite labor as well as their favorable view of episiotomy.(Harley, et al., 2013; Karacam, et al., 2012). Some physicians felt the evidence did not support the guidelines, some felt the recommendations were like a 'cookbook' or reduced physician autonomy, or did not apply to their patient population (Karacam, et al., 2012).

Childbirth educators are in a unique position to promote physiologic birthing with fewer interventions, including episiotomy. Through the use of a variety of teaching media, educators can take the lead on disseminating information to both parents and professionals about the latest research involving episiotomy.

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