

## ICEA Position Paper

# Episiotomy

## Position

**The International Childbirth Education Association (ICEA) agrees with the World Health Organization (WHO) and major medical organizations that routine performance of episiotomy is not supported by the evidence to decrease perineal damage and may lead to adverse outcomes. (WHO 2009, ACOG 2006, AAFP, 2017)**

## Background

In the past, episiotomy was one of the most common surgical operations in obstetrics (Lappen & Gossett, 2010). Routine use has fallen out of practice based on evidence of increased complications with its use. In 1996 the WHO recommendation for an episiotomy rate of 10% helped lead to the decline in prevalence. In the United States, the overall rate has dropped from 17.3% to 11.6% during the period from 2006-2013 (Berkowitz, L 2017)

In general, episiotomy is now performed on an individualized basis. It is considered when the clinical circumstances place the patient at high risk of a third or fourth degree laceration or when the fetal heart tracing is of concern and speeding up the process of vaginal delivery is believed to be better for the baby. Berkowitz et al report that based on birth certificate data, private practices have a 2-4 fold increase in episiotomy rates over trainees, academic faculty or midwives.

## Definition

An episiotomy is a surgical incision performed to enlarge the birth outlet and facilitate delivery of the fetus. 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 (Medio lateral)

Episiotomies are measured in degrees - the most common being a second 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, muscle and rectal sphincter; 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 1740's, episiotomies were not widely used until the mid-1900s. Obstetricians in the United States made the case that this small incision would speed labor, decrease trauma and allow the perineum to be restored (Meyvis, et al., 2012) By the 1960's routine episiotomy had made its way to the UK (Beech, 2004). According to Beech, the wide spread use of episiotomy in both the US and the UK was in response to the increase in active management of labor. As labor and birth

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moved from being viewed as a physiologic process to a pathologic one more interventions were seen necessary. The following reasons were used to promote the practice of episiotomy:

- › Reduction of trauma to the fetal head
- › Ease of repair and improved wound healing
- › Preservation of the muscular and fascial support of the pelvic floor
- › Prevention of anal sphincter laceration
- › Prevention of shoulder dystocia

Berkowitz, et. al. state that continued research shows no benefit for any of the above reasons for its use. Additionally, episiotomy puts the woman at risk for the following adverse outcomes:

- › Extension of the incision, leading to third and fourth degree tears, particularly for median episiotomy
- › Risk of unsatisfactory anatomic results (eg, skin tags, asymmetry, fistula, narrowing of introitus).
- › Increased blood loss
- › Higher rates of infection and dehiscence
- › Increased risk of severe perineal laceration in subsequent deliveries

They go on to say that performing an episiotomy should be left up to the judgment of the clinician at the time of delivery to determine if the benefit of an episiotomy outweighs the potential risks to the woman.

Cochrane supports the findings that the routine use of episiotomy has no benefit and the potential for adverse outcomes in their 2017 report:

The review of 11 trials (5977 women) comparing selective to routine episiotomy in women at low risk of instrumental delivery in 10 different countries. The authors conclude:

*“In women where no instrumental delivery is intended, selective episiotomy policies result in fewer women with severe perineal/vaginal trauma. Other findings, both in the short or long term, provide no clear evidence that selective episiotomy policies results in harm to mother or baby.*

*The review thus demonstrates that believing that routine episiotomy reduces perineal/vaginal trauma is not justified by current evidence. Further research in women where instrumental delivery is intended may help clarify if routine episiotomy is useful in this particular group. These trials should use better, standardized outcome assessment methods.”*

While episiotomy is decreasing in many practices, there are some private practices that have higher rates and according the WHO, “routine episiotomy, or liberal use of episiotomy, is unfortunately very common, both in under-resourced settings and in some developed countries. The latter may be contributing to the persistence of this practice also in under-resourced settings despite overwhelming evidence against its routine use.”

As an international organization, ICEA takes into consideration practices from all over the world. The International MotherBaby Childbirth Organization (IMBCO) has published the 10-steps for the MotherBaby Initiative. Step 6 specifically addresses potentially harmful practices that have no scientific support for routine use. Episiotomy is one of the possible procedures identified. IMBCO states that discussing the benefits and risks, along with informed consent are necessary before such interventions should occur (IMBCO 2017)

When looking at rates in areas, where HIV/AIDS is epidemic, it must be considered that in some of the most stricken countries, more than 1/3 of women giving birth are infected with HIV. Both the protection of the health workers and the risk of vertical transmission from episiotomy must be considered. During suturing of episiotomies the risk of a finger-prick injury is high, especially if a small needle is used. Current data indicate that the role of mother-to-child HIV transmission at birth may have been underestimated. Thus, any invasive intervention may increase the risk of vertical transmission. There are strong reasons to counteract the overuse of episiotomy in developing and developing countries alike. (WHO)

The results of the review apply equally to developed and developing countries. One area where not enough is known, however is the routine use of

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episiotomy in women who have undergone any of the types of female genital mutilation (FGM). In its most advanced forms, FGM severely restricts the vaginal outlet, and both practice by traditional birth attendants and health care staff in such cases includes routine episiotomy. Not enough is known about the optimal application of episiotomy in women with FGM, both as regards indication and technique (WHO)

The conclusion from the literature is that without sufficient data to develop evidence-based criteria for performing episiotomies, clinical judgment remains the best guide to determine when its use is warranted (ACOG)

## Implications for Practice

ICEA Childbirth Educators have a mandate to present evidence based information. While episiotomy rates have dropped in many settings, there are still practices with higher rates; particularly in private practice and for women in lower socio-economic regions.

Educators should be aware of rates where they practice. By knowing these rates, they can guide the class participants in communication with care providers and ways to reduce episiotomy or tearing.

Upright/gravity positions, changing positions, physiologic pushing and breathing along with warm compressions and lubrication can all have a positive impact on the perineum during pushing and birth.

Perineal massage during pregnancy is often times recommended to reduce trauma to the perineum. Although in general, not harmful, the evidence is limited on the benefits. While some studies have shown a positive effect, they have been done on a small sample size (N) thus limiting the validity. A compilation of all studies shows (Dekker 2012):

For first time moms perineal massage leads to relative risk of 10% decreased episiotomy thus leading to a decreased risk of trauma requiring stitches.

For second time moms there was no reduction in tearing but a possible reduction in perineal pain at 3 months postpartum.

There was no consensus on the frequency and duration for massage. Some studies showed that more frequent massage had less benefit than less frequent massage.

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