Episiotomy: Proper repair prevents fistula

TO THE EDITOR:

I read with interest Dr. John T. Repke's article, "When is episiotomy warranted? What the evidence shows" (October 2003). I have been involved in obstetrics and gynecology in private practice in the same area since 1965, and frequently supervise residents at a local teaching hospital. In recent years I have become concerned by the reluctance of many residents to do episiotomies. Often the result is a tear perineally, vaginally, or—worst of all—periurethrally. I have tried to impress on residents that an episiotomy accomplishes some positive outcomes: namely, less stress of pushing by the mother, as well as fewer painful, hard-to-repair tears that can sometimes lead to fistulae.

In my training we were required to perform episiotomy on almost all primiparous patients and many multiparas. I am not sure whether that resulted in less pelvic relaxation, but I do believe it was better for the mother.

All my episiotomies are midline, and I have never had a rectovaginal fistula. If a fourth-degree extension is properly repaired, a fistula should never develop.

ALLAN CLEMENGER, MD
PHOENIX, ARIZ

Restore perineal anatomy in episiotomy repair

TO THE EDITOR:

Trained to do episiotomies in the 1970s, I was resistant to the idea of avoiding them for fear of difficult-to-repair lacerations and pelvic floor dysfunction. Since becoming involved in resident education, however, I have become convinced that they should be avoided if possible.

Still, I am disturbed by 2 things: One is that I have seen residents graduate without ever repairing a fourth-degree laceration. The other is the way in which episiotomy repair is performed and taught. For many clinicians, it seems the goal is to repair the incision as fast as possible and, if feasible, with just 1 continuous suture. Little thought is given to restoring the anatomy of the perineal body.

Dr. Repke's article presents a good review, but it seems there is a paucity of evidence comparing repair techniques. Just as we repair rectus fascia on abdominal incisions if we want to prevent incisional hernias, I believe we must properly restore the pelvic floor anatomy and not just put "stuff" together as quickly as we can.

DAVID L. WILLIAMS, MD
ROANOKE, VA

'Play it safe' to minimize introitus damage

TO THE EDITOR:

I have always marveled over the elasticity of the cervix and vagina. The former stretches to full dilation to accommodate a descending fetal head, usually about 10 cm in diameter—yet just 6 weeks postpartum we find only a "fishmouth" appearance. The latter is capable of amazing expansion that lets a full-term baby wiggle through with relative ease, and 2 weeks later I have seldom detected any "battle scar."

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The introitus, on the other hand, is something else. I have never seen the introitus stretch to 10 cm in diameter without incurring some tear for the passage of an 8-lb baby. Some such tears are small and easy to repair, while others may be large and irregular with serious consequences.

Allow me to use an analogy: What would happen if you forced your adult-sized head through the opening of an infant's turtleneck? Clearly the rim would be damaged, but we have no way to predict where that damage would occur or how severe it would be.

Have we forgotten Dr. James Marion Sims? Or the Hamlins, who set up a vesicovaginal repair hospital in Ethiopia? One wonders if the rectovaginal tear is one excuse for polygamy.

Statistics offer only the big picture. You have to individualize. Vaginal birth after cesarean may be safe, but if uterine rupture occurs, then what? Play it safe!

YASUO ISHIDA, MD
ST. LOUIS, MO

DR. REPKE RESPONDS: I appreciate the interest in my article shown by Drs. Clemenger, Williams, and Ishida.

Dr. Clemenger reasserts many of the clinical biases addressed in my article—clinical biases unsubstantiated by data. That said, I would agree with Dr. Clemenger's assessment that avoiding episiotomy may result in slightly greater risk of anterior damage—a fact pointed out in my article. The question is whether such avoidance is worth the "routine" use of episiotomy. The data would say it is not.

Dr. Williams is correct in stating that proper surgical technique is essential for achieving a satisfactory anatomic and functional result after episiotomy repair. While an appropriately designed clinical trial may be impossible to conduct, his points are nonetheless well taken.

Dr. Ishida likewise expresses concern over damage to the introitus resulting from episiotomy avoidance. His citation of the African experience with rectovaginal fistulae is misleading, however, as these fistulae have very little to do with episiotomy use or nonuse, but instead are nearly always related to mismanaged and protracted labors (lasting days, not minutes or hours). I would, however, agree with his cautionary note about individualization of care. The point of my article was actually to emphasize precisely that concept. Episiotomy should be performed when clinical judgment dictates its use is indicated. Episiotomies should not, however, be routine.

The burden of administrative costs

TO THE EDITOR:

I read with interest Dr. Robert L. Barbieri's October 2003 editorial, "Exploding health-care costs threaten other vital needs." But I wonder why he didn't list as one of the causes the increased administrative costs of the health-care insurance industry. I've been told insurance companies have added at least 20% to the health-care dollar to "manage" managed care, thereby increasing insurance premiums and reducing payments to physicians.

Lowering the costs of medications and ambulatory surgeries might be an excellent remedy—but reducing the increase in insurance premiums seems easier and faster.

WALTER FREIDEL, MD
DENVILLE, NJ

DR. BARBIERI RESPONDS: I appreciate Dr. Freidel's insight—my editorial was incomplete for omitting this important point. I focused on the components of direct patient-care costs that are rising most rapidly. If the costs of pharmaceuticals, ambulatory surgical procedures, and imaging procedures increase at an annual rate of 20%, these services could soon dwarf all other health-care costs. In this scenario, the complete elimination of administrative costs would not avoid a "day of reckoning," in which the overall health-care budget would need to be examined prospectively. ■