Robert L. Barbieri, MD
Editor-in-Chief

It's time to restrict the use of episiotomy

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I confess. In the past, when performing a vaginal delivery, I frequently cut an episiotomy. During my residency training, I was taught that an episiotomy shortened the second stage and reduced the risk of tears to the anterior perineum and periurethral area. In addition, repair of the episiotomy offered an opportunity to perform a "posterior repair" and reconstruct the perineal body.

In that era, our overall cesarean section rate was 26%, our forceps operative vaginal delivery rate was 25%, and our episiotomy rate during vaginal deliveries was more than 40%. With time, the operative vaginal delivery rate and the episiotomy rate have fallen substantially.

Currently, our practice has an episiotomy rate for vaginal deliveries of less than 5% and an operative vaginal delivery rate of less than 6%, mostly vacuum-assisted deliveries. Both consumer-driven secular trends to reduce surgical interventions during vaginal delivery and clinical evidence influenced these changes.

***FAST** TRACK*

Evidence has never supported the benefits traditionally ascribed to episiotomy

Benefits were never proven

Interestingly, decades of clinical research has discovered that episiotomy had few documented benefits.

- **Comprehensive surveys** of the clinical evidence (reported in 1983[1] and 1995[2]) suggested that the main benefit of episiotomy was a reduced rate of anterior perineal tears. However, episiotomy was associated with many potential adverse effects, including an increased rate of deep posterior perineal tears, increased intrapartum bleeding, and increased postpartum perineal pain.
- **Recent meta-analyses**[3,4] reported that maternal benefits traditionally ascribed to episiotomy are not supported by the literature.

Routine episiotomy is harmful because some women who would not have had a perineal tear had a surgical incision.

The 2006 ACOG Practice Bulletin recommends that obstetricians restrict their use of episiotomy.[5] The Bulletin notes that if an

What does the evidence support?

Good and consistent scientific evidence (Level A)

- **Restricted use** of episiotomy is preferable to routine use
- **Median episiotomy** is associated with higher rates of injury to the anal sphincter and rectum than is mediolateral episiotomy

Limited or inconsistent scientific evidence (Level B)

- **Mediolateral episiotomy** may be preferable to median episiotomy in selected cases
- **Routine episiotomy** does not prevent pelvic floor damage leading to incontinence

Source: 2006 ACOG Practice Bulletin[5]

episiotomy is necessary, a mediolateral episiotomy is associated with reduced risks of anal sphincter and rectal mucosa injury, compared with a median episiotomy. Obstetricians who are comfortable performing a mediolateral episiotomy may want to consider this approach.

We can do better

Will the episiotomy rate ultimately drop to less than 1% of vaginal deliveries? That is unlikely, because clinical conditions, such as a nonreassuring fetal heart rate tracing in the late second stage, sometimes necessitate an episiotomy. Sometimes we need to perform episiotomy based on clinical judgment.[6] However, it is likely that we could do much more to restrict the use of episiotomy.

What are the quantitative correlates of a "restricted policy" for episiotomy? From my perspective, given an average cesarean section rate in the range of 30%, it is possible to reduce the rate of episiotomy to less than 5% during vaginal delivery.

- **For nonoperative vaginal delivery**, the episiotomy rate could be less than 3%.
- **For operative vaginal deliveries** (about 5% to 8% of all vaginal deliveries), the episiotomy rate could be less than 25%.

I confess. It was difficult for me to change my practice from liberal episiotomy to restricted episiotomy. The residents in my program stimulated my change, and now that I have adopted a new practice pattern, it is relatively easy to maintain.

My advice to the readers of OBG MANAGEMENT: It is time to stop the practice of liberal episiotomy and restrict the use of this timeworn procedure.

obg@dowdenhealth.com

FAST TRACK

It is possible to reduce the episiotomy rate to less than 5%

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