Episiotomy

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Episiotomy is a surgical incision to enlarge the vaginal introitus.

- The decision to perform an episiotomy is made by the birth attendant.
- The worldwide rates of episiotomy vary dramatically (14% in England, 8% in the Netherlands, 50% in the USA).

WHO recommends that episiotomy should be considered in the following circumstances:

1-complicated vaginal delivery included :

- breech
- shoulder dystocia
- forceps
- ventouse.

2- If there is extensive lower genital tract scarring:
- female genital mutilation
- poorly healed 3rd or 4th degree tears.

3- When there is fetal distress

Types of episiotomy :

1- Mediolateral episiotomy extends from the fourchette laterally (thus • reducing the risk of anal sphincter injury).

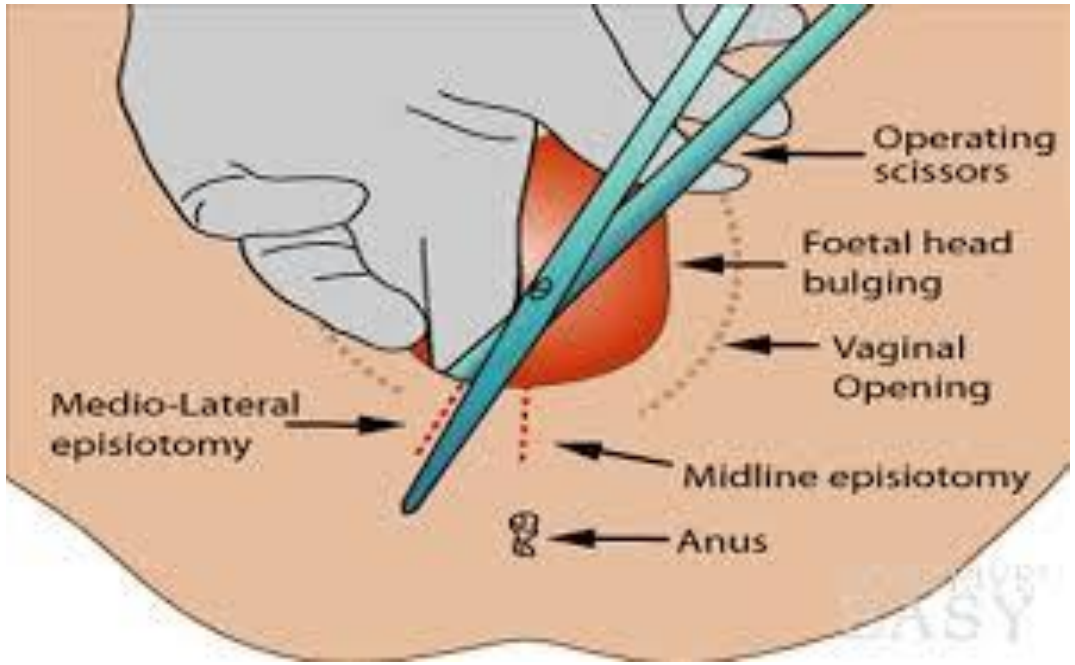
2- Midline episiotomy extends from the fourchette towards the anus • (common in the USA, but not recommended in the UK).

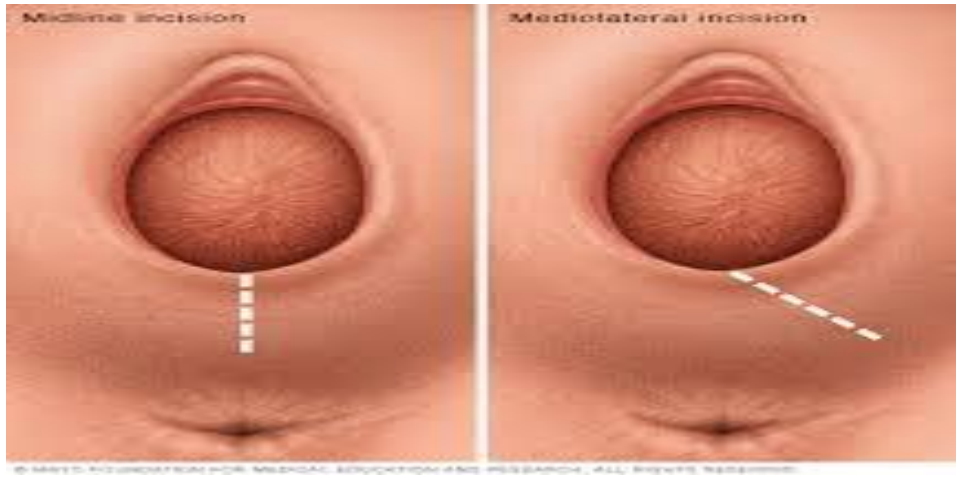
Advantages of the midline episiotomy are :

1-less blood loss
2-It easier to repair
3- The wound heal quicker
4-There is less pain in postpartum period
5-The incidence of dyspareunia is reduced

Disadvantage of midline episiotomy :

It carries a more than six fold risk of extending to involve the anal sphincter(3rd and 4^{th} degree perineal tear .


Operating scissors
Foetal head bulging
Vaginal Opening
Medio-Lateral episiotomy
Midline episiotomy
Anus


Midline incision
Mediolateral incision

How to perform an episiotomy :

- If the woman does not have a working regional block (epidural) then the perineum should be infiltrated with lidocaine (lignocaine).

- Two fingers should be placed between the baby's head and the perineum (to protect the baby).

- Sharp scissors are used to make a single cut in the perineum about 3–4cm long (ideally this should be at the height of the contraction when the perineum is at its thinnest .

- Every effort should be made to anaesthetize the perineum early to provide sufficient time for effect.
- It will cause bleeding so must not be done too early and should be repaired as soon as possible.
- Always check for any extension or other tears (including a PR examination to ensure no trauma to the anal sphincter).

General complications of episiotomy :

1- Bleeding.
2- Haematoma.
3- Pain.
4- Infection.
5- Scarring, with potential disruption to the anatomy.
6- Dyspareunia.
7- Very rarely, fistula formation

Perineal tears :

Classification of perineal tears :

- 1st-degree: injury to the skin only.
- 2nd-degree : injury to the perineum involving perineal muscles (includes episiotomy).
- 3rd-degree: injury to the perineum involving the anal sphincter complex:

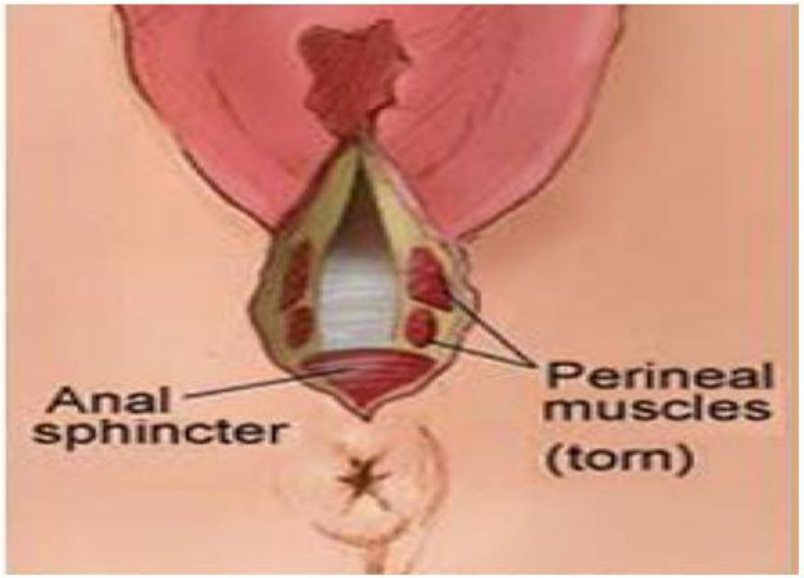
3a: <50% of the external anal sphincter (EAS) thickness torn .

3b: >50% of the EAS thickness torn.

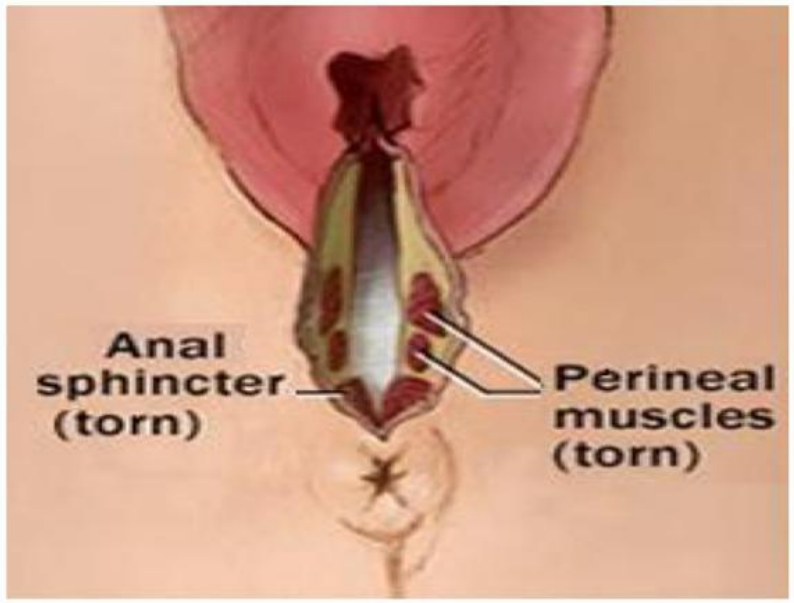
3c: internal anal sphincter (IAS) torn.

- 4th-degree: injury to perineum involving the anal sphincter complex (EAS and IAS) and the anal/rectal epithelium.

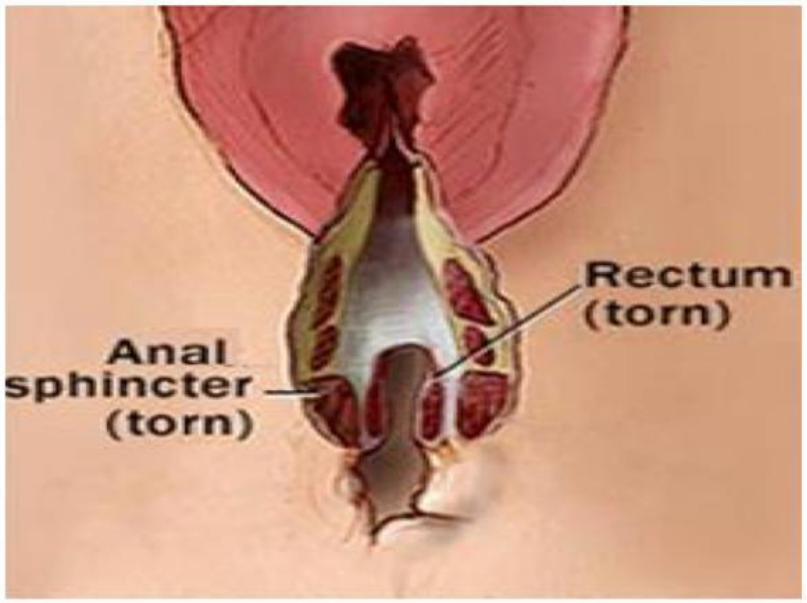
First Degree Perineal Tear



Second Degree Perineal Tear



Third Degree perineal tear



Fourth Degree Perineal Tear

Principles of basic perineal repair :

- Suture as soon as possible to reduce bleeding and infection risk.
- A rectal examination is recommended before starting, to ensure there is no trauma to the anal sphincter complex.

- The attendant should have adequate training for the type of tear.
- difficult trauma should be repaired in theatre under regional or general anaesthesia by an experienced operator.

The woman should preferably be in lithotomy position.

- There should be a good light source and adequate analgesia.
- Use of rapid-absorption polyglactin suture material is associated with a significant reduction in pain.

- Apex of the cut should be identified and the suturing started from just above this point.
- A loose, continuous non-locking suturing technique used to appose each layer is associated with less short-term pain than the traditional interrupted method.
- Perineal skin should be sutured with a subcuticular suture as this is associated with less pain.
- Anatomical apposition should be as accurate as possible and consideration given to cosmetic results.
- Rectal examination after completion ensures that no suture has • accidentally passed into the rectum or anal canal.

Third- and fourth-degree tears:

Approximately 1–3% of vaginal deliveries will result in injury to the anal sphinter.

- ✓ Prediction and prevention are both difficult.

Factors associated with increased risk of anal sphincter trauma :

1- Forceps delivery.
2- Nulliparity .
3- Shoulder dystocia.
4- 2nd stage >1h.
5- Persistent OP position.
6- Midline episiotomy.
7- Birth weight >4kg.
8- Epidural anaesthesia.
9- Induction of labour.

Management of 3rd- and 4th-degree tears :

All women sustaining genital tract injury should be carefully examined before suturing is started (including a rectal examination).

- Repair must be carried out by a trained senior clinician in theatre with adequate analgesia.
- The technique used can be end to end or overlapping for the EAS using either polydioxanone suture (PDS) or vicryl suture material.

The IAS should be repaired with vicryl using interrupted sutures.

- Women must receive broad-spectrum antibiotics and stool softeners.
- They should receive physiotherapy input.
- Ideally, they should be reviewed 6wks later by an obstetrician or gynaecologist.

✓ Women must be warned of the risk of incontinence of faeces, fluid, and flatus: those experiencing symptoms at 6wks should be referred to a specialist gynaecologist or colorectal surgeon for investigation with endoanal ultra sonography.

Around 60–80% will have a good result and be asymptomatic at 12mths.

For future deliveries they should be advised that the result may not be so good from a 2nd repair .

 if symptomatic they should be given the option of delivery by CS.