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Evidence Update

Does routine episiotomy for vaginal births prevent major degree perineal tears? Summary of the evidence and its application to Sri Lanka

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Abstract

An updated Cochrane Review concluded that in addition to increasing the risk of major perineal/vaginal trauma by 30%, routine episiotomy does not play a role in lowering the risk of many other outcomes including blood loss at delivery, perineal pain, delivering a non-asphyxiated baby or urinary incontinence at six months compared to selective episiotomy.

This review evaluated 12 randomized controlled trials carried out on 6177 women from Europe, North America, South America, South Asia and South-East Asia.

Following critical evaluation of the systematic reviews conducted so far in this field along with local evidence and the aptness of this evidence to local setting, we strongly recommend changing the current practice of routine episiotomy to selective episiotomy in vaginal delivery, in accordance with the National Guidelines of Sri Lanka.

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Introduction

Episiotomy, defined as a surgical incision of the vagina and perineum carried out by a skilled birth attendant to enlarge the vaginal opening [1], is one of the most commonly performed surgical procedures throughout the world [2]. Millions of women undergo episiotomy every year with or without their informed consent.

The origin of episiotomy is difficult to determine, but one of the first to document it was a midwife, Sir Fielding Ould in 1742 [3]. The procedure is carried out mainly with the intention of minimizing third- and fourth-degree perineal tears during the delivery. Expected other outcomes include rapid surgical healing, less blood loss at delivery, less pain, delivery of a non-asphyxiated newborn, prevention of urinary incontinence and genital and urinary prolapse and dyspareunia in the long run [1]. Extensive use of this practice in the United States of America was a result of Dr. DeLee's address at the American Gynaecological Society in Chicago in 1920, based on his personal experience