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EPISIOTOMIES IN THE JOS UNIVERSITY TEACHING HOSPITAL

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ABSTRACT

Background: Episiotomy is the commonest minor obstetric operation. There is however significant risks associated with the routine use of episiotomy. It is associated with the immediate problem of more perineal pain in the puerperium, and the long-term problem of potential sexual dysfunction resulting from superficial dyspareunia or pain at the introitus.

Objective: To determine the rate of episiotomy, the indications, and to observe changes in the use of episiotomy since 1998 in the Jos University Teaching hospital.

Methodology: This was a retrospective study of all consecutive deliveries in the maternity unit of the Jos University Teaching hospital. The records of all deliveries in the maternity unit of the hospital were retrieved and checked for total deliveries within the study period. Records of patients that had episiotomy were collated and analyzed for age, parity, and the indication for the episiotomy. The records were analyzed using the Epi-Info 2002 software.

Results: A total of 15,228 deliveries were conducted and 3,769 episiotomies were performed with an overall rate of 24.8%. There was a general decrease of the rate from 28.4% in 1998 to 20.8% in 2003. Medio-lateral incisions were commonly used and the primipara accounted for 54.9% of the episiotomies. The commonest (52.6%) indication was for imminent perineal tear with the fetal head pressing on the perineum.

Conclusion: Episiotomies are commonly performed obstetric minor operations in the Jos University Teaching Hospital. Primiparity appears to be a risk factor for episiotomy. The commonest indication

was imminent perineal tear in the second stage of labour.

Key Words: episiotomy, vacuum, forceps, prematurity, perineum, obstetric, Jos.

INTRODUCTION

Many deliveries unfortunately end up with an episiotomy, considered by many as a necessary evil¹. Episiotomies are deliberate incisions in the perineum to enlarge the introitus². It is a minor obstetric operation that prevents against perineal tear, improves the safety of many obstetric vaginal procedures, and reduces the duration of the second stage of labour. Routine episiotomy prevents overstretching of maternal perineum with perhaps better perineal support later in life. The immediate problem is a more painful postpartum period, and the long-term problem of potential sexual dysfunction resulting from superficial dyspareunia or pain at the introitus. The indications are many but can be summarized into imminent perineal tear; previous 3rd degree perineal tear or colpoperineorrhaphy; forceps, vacuum or breech delivery; to expedite delivery in cord prolapse or fetal distress; in premature labour; and in delayed second stage of labour when the fetal head is pressing on the perineum. In prematurity, the main advantage is the prevention of un-necessary wear and tear on the fragile fetal skull or brain matter.

Episiotomy is also used to prevent the occurrence of third degree lacerations of the perineum, to make delivery more gentle for the fetal head and to shorten the second stage of labour². Medio-lateral episiotomy may prevent third-degree tears in nulliparous women⁴. A supposed advantage for the liberal use of episiotomies is the prevention of anal

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sphincter injury, or third degree perineal tear during vaginal delivery.

It is surprising that episiotomy, a commonly performed surgical procedure during vaginal delivery, has very inadequate follow-up after discharge from hospital. Three months after delivery, as many as 25% of patients with perineal complaints could be directly related to episiotomy². Short-term problems of episiotomy and its repair are bleeding, edema, perineal pain, and infection with or without wound breakdown. Bleeding can be easily controlled. On rare occasions, the Bartholin's duct is damaged with subsequent development of a Bartholin's cyst some time later. Long-term problems are dyspareunia, delayed resumption of intercourse and incontinence of flatus. Over the last three decades, childbirth activists, women themselves, midwives and obstetricians, have questioned the need for episiotomy⁵. Not all parturient require the incision but considerable experience is necessary to determine when it is safe not to perform it³. Episiotomy is not necessary in patients in whom normal spontaneous vaginal delivery is anticipated, that is, the fetus is cephalic and in occipito-anterior position, is at term and of average weight, and does not require an obstetric forceps delivery or vacuum extraction to aid in the delivery.

Materials and Methods

This was a retrospective study of all consecutive deliveries in the maternity unit of the Jos University Teaching hospital, from January 1998 to December 2003. Clinical record of all women that had episiotomy were retrieved, collated and analyzed. From the records, information on the patients' age, parity, indication for

the episiotomy were extracted and analyzed.

Limitations of the Study:

This was a retrospective study, and therefore only documented findings were analyzed. Complications of the procedure, and follow-up of the cases were not indicated or the treatments given.

The cadre of staff performing the episiotomy and the repair were not indicated in the records analyzed.

RESULTS

A retrospective study from January 1998 to December 2003 is presented. A total of 15,228 deliveries were conducted, and 3,769 episiotomies were performed, with the overall rate of 24.8%. The study demonstrated a gradual decrease in the episiotomy rate from 28.4% in 1998 to 20.8 in 2003, table 1. The commonest indication was for imminent perineal tear in 52.6%, followed by fetal distress in the second stage of labour 16.9%, and then delayed 2nd stage of labour in 7.7%, when the fetal head is pressing on the perineum. Episiotomy was offered in all instrumental vaginal deliveries, constituting 11.4% of the cases, table 2. The medio-lateral type of episiotomy was the commonest incision offered and used in 86%, while the J-shaped type was not recorded at all in the study, table 3. The age range of women that had episiotomy was from 15 to 50 years with a mean of 27.7 years, and parity ranged from 1-14, with a mean of 3.0. The primipara had the highest 54.9% percentage of episiotomies performed on them, while women of parity 5 and above achieved vaginal delivery with intact perineum in 90% of the cases, table 4.

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Table 1: Annual episiotomy rates

Year	Total deliveries	Episiotomies/rate (%)
1998	2712	770 (28.4)
1999	2271	634 (27.9)
2000	2354	541 (23.0)
2001	2390	638 (26.7)
2002	2257	512 (21.7)
2003	3244	674 (20.8)
Average	15,228	3,769 (24.75)

Table 2: Indications for episiotomy

Indication	Number (%)
Imminent perineal tear	1984 (52.6)
Fetal distress	637 (16.9)
Delayed 2 nd Stage of labour	170 (7.7)
Assisted Breech delivery	271 (7.2)
Vacuum Delivery	252 (6.7)
Forceps Delivery	178 (4.7)
Prematurity	157 (4.2)
Total	3769 (100.0)

Table 3: Types of episiotomy

Type	No. (%)
Medio-lateral incisions	3,240 (86.0%)
Medial incisions	313 (8.3%)
J-Shaped incisions	0 (0.0)
Not stated	216 (5.7%)
Total	3,769 (100.0)

Table 4: Episiotomy rates versus parity

Parity	Episiotomy rate (%)	Intact perineum (%)	1 ^o tear (%)	Others
1	54.9	36.6	8.5	0.0
2	34.7	59.2	6.1	0.0
3	2.7	80.0	8.6	8.7
4	18.5	77.8	3.7	0.0
5	5.0	90.0	5.0	0.0
≥6	3.8	90.0	3.6	2.6

(Others: 2^o and 3^o perineal tears: Total episiotomies 3.769)

DISCUSSION

The episiotomy rate in the study was 24.8%. This is lower than the reported rate of 28.0% in France², and 28.4% in

Belgium⁶. It is however very low compared with 38% from Denmark, and up to 62% in the United States⁷. Brazil has the highest rate of about 90-100% for women with vaginal births⁸. The

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episiotomy rate in the nulliparae in this study, of about 55%, was however much higher than the reported rate of 24.5% in the nulliparae in all Swedish wards in 1995⁵. The reason for this high rate might be for the fear of developing a third degree perineal tear when not offered. The Swedish study found a significant increase in the rate of 3rd and 4th degree tears in women who had episiotomy⁵. Episiotomies are much more frequently performed in other parts of the world compared with our rates in this study. Episiotomy was performed more frequently in primipara, about 55%, compared with about 45% in all multiparous women put together. This is probably because the multiparous woman's vagina and vulva might have been stretched before in previous pregnancies making subsequent stretch much easier and therefore less delay in the delivery of the fetus in the second stage of labour.

The role of episiotomy in obstetric practice has become increasingly controversial, as recent studies have questioned the benefits of the operation^{7,9}. A large body of multi-center studies in the literature strongly advocates the selective use of episiotomy. In Philadelphia, a stepwise reduction has been observed from 69.6% in 1983 to 19.4% in 2000¹⁰. Previous documented studies have changed the pattern of episiotomy usage in Sweden for the better⁵.

The high rate of episiotomy has been described as an example of ritual surgery¹¹, and 'a relic of the barbaric age'¹². The high frequency of perineal discomfort after the procedure means that a reduction in the episiotomy rate is desirable¹³. Most obstetricians however agree that episiotomy shortens the second stage of labour, and is necessary when fetal distress makes rapid vaginal delivery desirable¹⁴. The use of episiotomy should be restricted to specified fetal and maternal indications⁵. Fetal distress as an indication for episiotomy to shorten the second stage

of labour is about 5-10%¹³. The incision most commonly favoured in this center was the medio-lateral type³, and was performed in about 86% of the cases, while the J-shaped incisions were not recorded at all during the period of study. The medial incision, though easy to perform and repair, was not done very often for fear of its extension into the rectum and thus resulting in a 3rd or 4th degree perineal tear. The medial episiotomy has the advantages of easier repair and less painful recovery. It is done along the perineal raphe, separating the superficial transverse perineal muscles. The medio-lateral episiotomy may prevent third degree tears in the nulliparous patient¹, and may be considered for large infants, small perineal body or in some cases of forceps delivery.

Episiotomy rates have demonstrated a decrease in this study. It may be further effectively reduced through more studies in this environment by obstetricians, midwives and residents on the scientific evidence of the harmful effects of routine episiotomy. There is no doubt that episiotomy is required in certain circumstances where the benefits outweigh the risks. Routine practice of this clinical procedure without any scientific basis of its beneficial effects is simply not acceptable and should be discouraged.

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