Evidence Update

Maternal Health Series *January 2004*

What are the benefits and risks of restrictive versus routine episiotomy during vaginal birth?

Restrictive episiotomy policies, where health staff avoid the procedure, appear to have a number of benefits compared to policies where episiotomies are performed routinely.

Inclusion criteria

Types of studies:

Randomised controlled trials.

Types of participants:

Pregnant women having a vaginal birth.

Types of intervention:

Primary comparison: restrictive use of episiotomy versus routine use of episiotomy.
Secondary comparisons: restrictive use of mediolateral episiotomy versus routine use of mediolateral episiotomy; restrictive use of midline episiotomy versus routine use of midline episiotomy; use of midline episiotomy versus mediolateral episiotomy.

Types of outcome measures:

Maternal outcomes: number of episiotomies, assisted delivery rate, severe vaginal/perineal trauma, severe perineal trauma, need for suturing, posterior perineal trauma, anterior perineal trauma, blood loss, perineal pain, use of analgesia, dyspareunia, haematoma, healing complications and dehiscence, perineal infection, and urinary incontinence.
Neonatal outcomes: Apgar score less than 7 at one minute and need for admission to Special Care Baby Unit.

Results

Six studies were included; five were adequately concealed.

- Compared with routine use, restrictive episiotomy policies resulted in less posterior perineal trauma (RR 0.88; 95% CI 0.84 to 0.92), less suturing (RR 0.74; 95% CI 0.71 to 0.77) and fewer healing complications (RR 0.69; 95% CI 0.56 to 0.85).
- Restrictive episiotomy policy was associated with more anterior perineal trauma (RR 1.79; 95% CI 1.55 to 2.07) but there was heterogeneity between studies.
- There was no difference in severe vaginal or perineal trauma (relative risk 1.11, 95% confidence interval 0.83 to 1.50); dyspareunia (RR 1.02; 95% CI 0.90 to 1.16); urinary incontinence (RR 0.98; 95% CI 0.79 to 1.20) or several pain measures.
- There were similar effects in trials of both mediolateral and midline episiotomy.

DFID Department for International Development

Adapted from Carroli G, Belizan J. Episiotomy for vaginal birth (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Chichester, UK: John Wiley & Sons Ltd.

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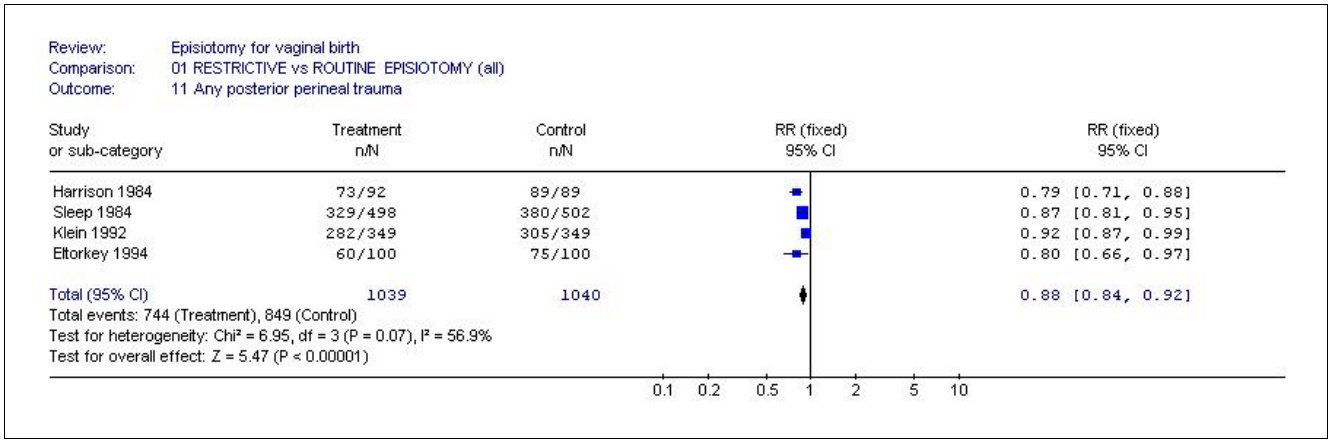

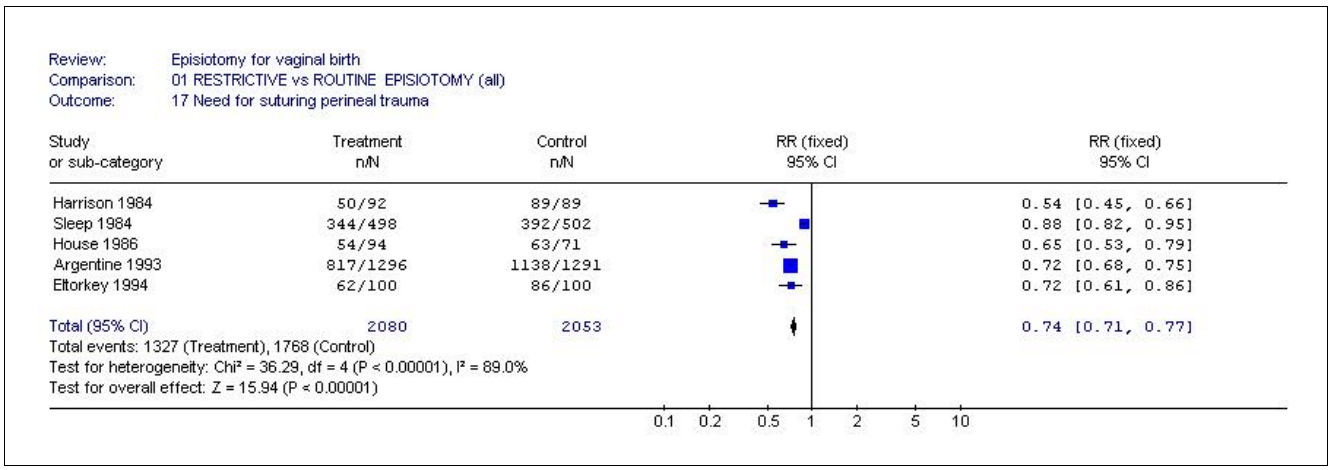

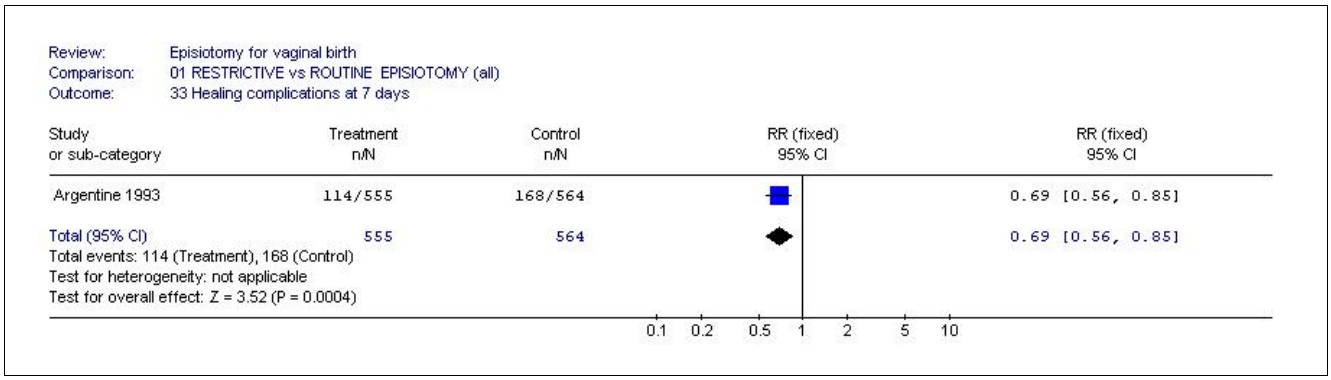

Reviewer's conclusions

Implications for practice:

There is clear evidence to recommend policies that restrict the use of episiotomy. These results are evident in the overall comparison and remain after stratification according to the type of episiotomy. Until further evidence is available, the choice of technique should be that with which the midwife or doctor is most familiar.

Implications for research:

Further trials are needed to determine the indications for the restrictive use of episiotomy at an assisted delivery (forceps or vacuum), preterm delivery, breech delivery, predicted macrosomia and presumed imminent tears. There is a need to evaluate which episiotomy technique (mediolateral or midline) provides the best outcome.