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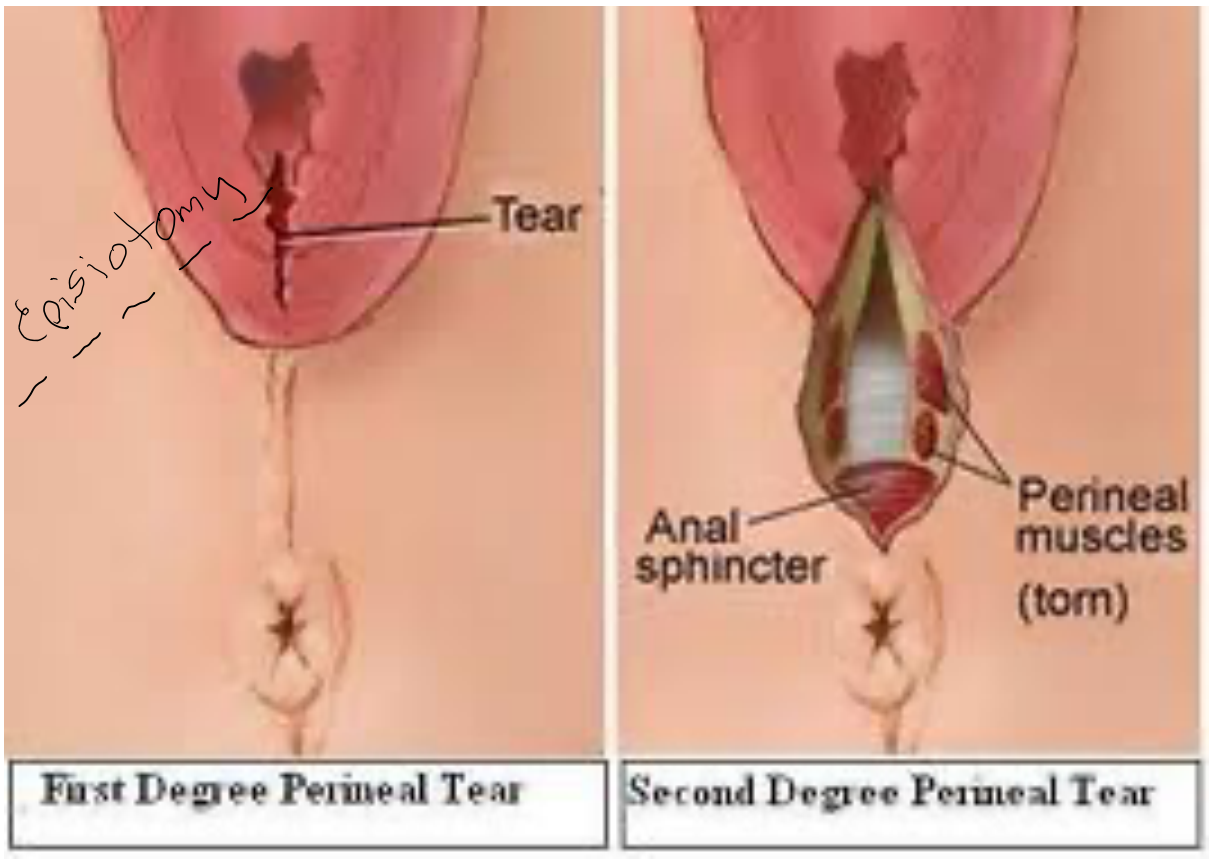
Information about Episiotomies

What is a perineal tear?

The perineum is the area between the vagina and anus. During childbirth this area can tear. This is called a perineal tear. These tears are very common (in up to 90% of women having their first baby) and mostly cannot be prevented but fortunately most of these tears heal very well and will not cause any problems in the future (we call these first or second degree tears). Most women with tears will need stitches. The stitches will dissolve during healing. The area will be swollen and sore but settles over several weeks. Some tears are really small. Occasionally some tears are bigger and can involve the muscles around the anus (the bottom) or even the anus itself (we call these third or fourth degree tears).



Third or Fourth Degree Tears

About 1 in 20 first time mothers who give birth vaginally, sustain 3-4th degree tears and unfortunately they are not all avoidable or predictable despite steps taken to decrease the chance of these occurring. About 9% of women with 3-4th degree tears experience more severe symptoms of seeping poo or being unable to defer pooing at the toilet for more than 15 minutes, affecting their quality of life at 6 weeks after the birth (1 in 200 women), and half of these by

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6 months (1 in 400 women). For this final group of women, the problem can be lifelong.

What is an episiotomy? (dotted line in the picture above)
An episiotomy is when a cut is performed to enlarge the birth outlet and help with the baby coming out. It is performed by a doctor or midwife. Most women with tears or an episiotomy will need stitches. The stitches will dissolve during healing. The area will be swollen and sore but settle over several weeks. Episiotomies are mostly performed with surgical scissors after first providing pain relief (either an epidural or local anaesthetic), and are cut when the baby's head is already beginning to stretch the birth outlet (perineum). Most women are not aware that an episiotomy is being cut in the moment it is occurring.

When is an episiotomy performed?
Doctors and midwives do not routinely perform an episiotomy. About one in five women do have one though when the doctor or midwife feels it is necessary. Sometimes they are performed during natural birth. However they are often recommended during instrumental birth (see later paragraph titled ‘Forceps, vacuums and episiotomies’.

Episiotomies are mostly performed for one of two reasons:
1. To hasten vaginal delivery when the doctor or midwife thinks that the baby is not receiving enough oxygen which is sometimes called fetal distress.
2. When there is concern that the patient is at risk of a more severe tear (a third or fourth degree tear). This is most commonly if the doctor needs to use an instrument (vacuum or forceps) to assist the birth of a baby (see later paragraph titled ‘Forceps, vacuums and episiotomies’).

What is the difference between a tear and an episiotomy?
The main difference is that tears occur as a natural part of childbirth and an episiotomy is a deliberate cut by a doctor or midwife. In most countries, including Australia, episiotomies are also likely to be directed to one side of the perineum whereas natural tears normally tear toward the anus.

What are some of the problems that can occur after tears or episiotomies?
Most episiotomies and natural tears heal well and although they are sore for a few days, do not cause many problems. Occasionally the wound may become infected and require antibiotics. Severe perineal tears can lead to loss of muscle function around the anus. This can cause the leakage of wind, and sometimes of stools. This is called flatal or faecal incontinence.

Do episiotomies reduce the risk of having a third or fourth degree tear?
There is evidence that episiotomies directed toward the side of the perineum to avoid the anus do reduce the risk of sustaining a third or fourth degree tear in certain situations- mainly when the doctor needs to do a forceps or vacuum

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delivery. Cutting an episiotomy though does not guarantee you will avoid a third or fourth degree tear, but it might lessen the severity of the tear.

Do episiotomies help delivery of the baby?
Episiotomies help with the birth of the baby only if the head is being blocked by perineal tissues (episiotomy will not improve 'pushing' efforts).

Who determines if an episiotomy should be cut?
Normally a doctor or midwife will advise you that they recommend cutting an episiotomy. Rarely, in an emergency, they may be unable to communicate this before an episiotomy is made. In this case they will inform you after your baby is born. You always have the right to refuse an episiotomy. If you do not want an episiotomy under any circumstances, let your doctor and midwife know prior to the birth.

Do episiotomies cause more pain after the birth?
Most women will experience some pain after childbirth. Even women without any tear have some pain. We think that episiotomies do cause a bit more pain than second degree tears after childbirth. Studies suggest that there may be a small amount of extra pain for up to several weeks following childbirth. Similar studies also show that episiotomies cause less pain after childbirth than a third or fourth degree tear. They also cause less pain after childbirth than a caesarean section.

Do Episiotomies cause problems with sexual function?
Studies have shown that episiotomies do not cause more problems with sexual function than natural tears.

Forceps, Vaccuums and Episiotomies
A woman having a forceps birth has about a 40% chance of a 3-4th degree tear, but if an episiotomy is performed the risk reduces to 8%. An episiotomy would have to be performed on 3 women having forceps to protect one of them from sustaining a 3-4th degree tear.

Vaccuum birth has a lower chance of contributing to a 3rd degree tear with 12% of first vaginal births sustaining 3-4th degree tears, but only 4% if an episiotomy took place. An episiotomy would have to be performed on 12 women undergoing vacuum birth to protect one of them from sustaining a 3rd or 4th degree tear.

Vaccuum births tend to be performed when a birth of a baby will be easier, which is why 3rd degree tears are less frequent with vacuum birth. Forceps tend be used if the vaginal birth is deemed to be more difficult, and a vacuum deemed to be unlikely to achieve a vaginal birth.

Blood can collect under the scalp of a baby (called a cephalhaematoma) in about 11% of vacuums and about 6% of forceps. This is usually temporary but

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babies can require observation in the nursery. Only 30% of these vacuums occurred with episiotomies. Episiotomies are likely to result in less pulling on a baby's head so the rate of cephalhaematoma is likely to be lower.

It is rare for more serious bleeding in the brain to occur. It occurs in about 1 in 860 vaccuums and 1 in 664 forceps, and 1 in 907 caesareans.

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