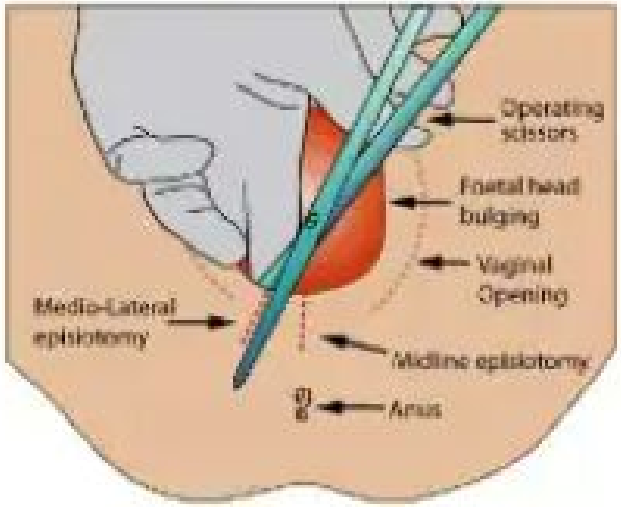
Episiotomy


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

Definition

- A surgically planned incision on the perineum and the posterior vaginal wall during the second stage of labour is called episiotomy.

Objectives

- To enlarge the vaginal introitus so as to facilitate easy and safe delivery of the fetus- spontaneous or manipulative.
- To minimise overstretching and rupture of the perineal muscles and fascia; to reduce the stress and strain on the fetal head.

Indications

- In elastic rigid perineum
- Anticipating perineal tear: Big baby, face to pubis delivery, Breech delivery, Shoulder dystocia
- Operative delivery: Forceps delivery, Ventouse delivery
- Previous perineal surgery: Pelvic floor repair, Perineal reconstructive surgery

Indications

Common indications are:

1. Threatened perineal injury in primigravidae
2. Rigid perineum
3. Forceps, breech, occipito-posterior or face delivey

Timing of the episiotomy

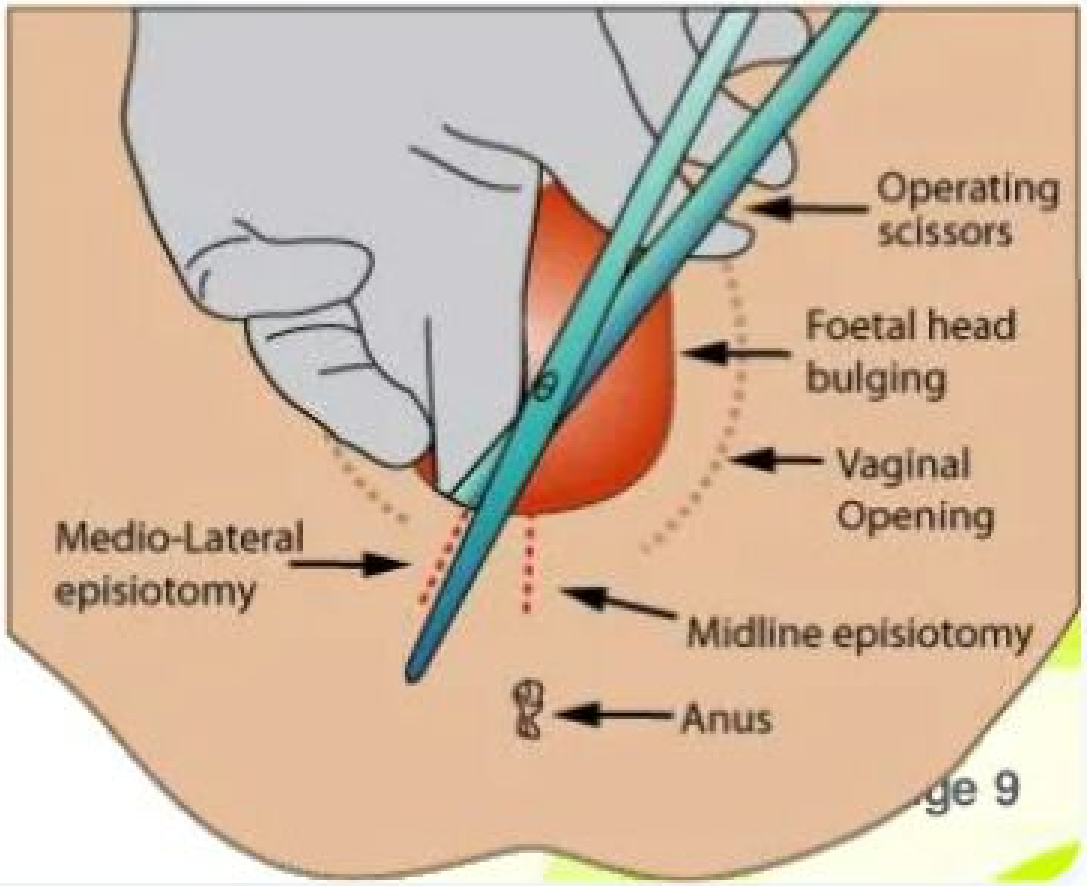
Bulging thinned perineum during contraction just prior to crowning is the ideal time.

Advantages

- Maternal:
  - A clear and controlled incision is easy to repair and heals better than a lacerated wound that might occur otherwise.
  - Reduction in the duration of second stage
  - Reduction of trauma to the pelvic floor muscles
- Fetal:
  - It minimises intracranial injuries specially in premature babies or after coming head of breech

Types

- Medio-lateral
- Median
- Lateral
- T-shaped



Relatives merit of median and mediolateral episiotomy

Median

- The muscles are not cut.
- Blood loss is least.
- Repair is easy
- Post operative comfort is maximum
- Healing is superior
- Wound disruption is rare
- Dyspareunia is rare

Medio-lateral

- Relatively safety from rectal involvement from extension.
- If necessary, the incision can be extennded

Relatives demerits of median and mediolateral episiotomy

Median	Medio-lateral
• Extension, if occurs, may involve the rectum.	• Apposition of the tissues is not so good
	• Blood loss is little more
• Not suitable for manipulative delivery or in malpresentation	• Post operative discomfort is more.
	• Relative increased incidence of wound disruption
	• Dyspareunia is comparatively more

Steps of episiotomy

- Provide emotional support and encouragement.
- Use local infiltration with lignocaine.
- Make sure there are no known allergies to lignocaine or related drugs.
- Infiltrate beneath the vaginal mucosa, beneath the skin of the perineum and deeply into the perineal muscle.
- **Note: Aspirate (pull back on the plunger) to be sure that no vessel has been penetrated**

Steps of episiotomy

- Wait 2 minutes and then pinch the incision site with forceps.

- Wait to perform episiotomy until:
  - the perineum is thinned out; and
  - 3–4 cm of the baby's head is visible during a contraction.

Steps of episiotomy

- Wearing high-level disinfected gloves, place two fingers between the baby's head and the perineum.
- Use scissors to cut the perineum about 3–4 cm in the mediolateral direction

Steps of episiotomy

- Use scissors to cut 2–3 cm up the middle of the posterior vagina.
- Control the baby's head and shoulders as they deliver.
- Carefully examine for extensions and other tears and repair

Repair of episiotomy

- Apply antiseptic solution to the area around the episiotomy.
- If the episiotomy is extended through the anal sphincter or rectalmucosa, manage as third or fourth degree tears, respectively
- Close the vaginal mucosa using continuous 1-0 suture

Repair of episiotomy

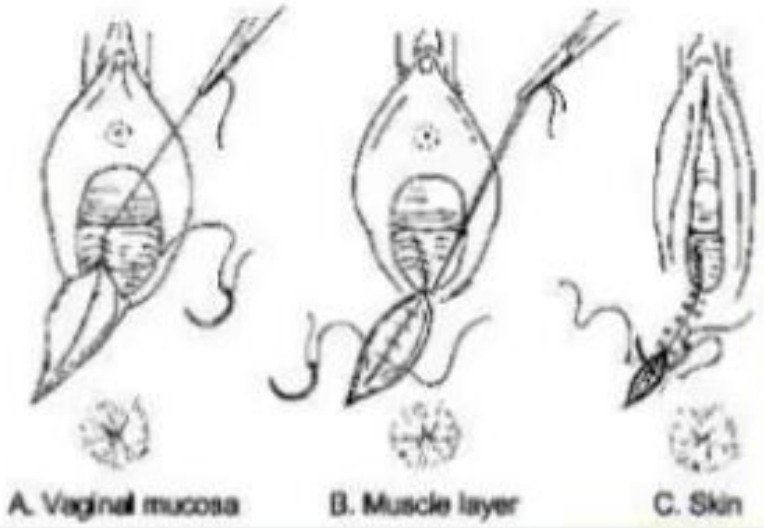
- Start the repair about 1 cm above the apex (top) of the episiotomy. Continue the suture to the level of the vaginal opening.

- At the opening of the vagina, bring together the cut edges of the vaginal opening

- - Bring the needle under the vaginal opening and out through the incision and tie.

Repair of episiotomy

- Close the perineal muscle using interrupted 1-0 sutures
- Close the skin using interrupted (or subcuticular) 1-0 sutures



Post operative care

- Dressing
- Comfort
- Ambulation
- Removal of stitches

Complications

- **Immediate**
- Extension of the incision to involve the rectum
- Vulval haematoma
- Infection
- Wound dehiscence
- Injury to anal sphincter causing incontinence of flatus or faeces
- Rectovaginal fistula (Rarely)
- Necrotising fascitis

Complications

- **Remote**
- Dyspareunia
- Chance of perineal lacerations
- Scar endometriosis (rare)

THANK YOU