Frimley Health
NHS Foundation Trust

Episiotomy

Key Points

- The possible need for an episiotomy should ideally be discussed during the first stage of labour
- Every attention should be given to ensuring the comfort, dignity and support of the woman and her partner
- Effective analgesia should be provided prior to carrying out an episiotomy unless in an emergency due to acute fetal compromise
- Repair should take place immediately after the birth to minimise the risk and complications of bleeding, infection, bruising, pain and apprehension and fear in the mother

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Abbreviations

HES	Hospital Episode Statistics
NICE	National Institute for Clinical Excellence
OASI	Obstetric Anal Sphincter Injury
RCOG	Royal College of Obstetricians and Gynaecologists

Contents

1. Definition

Episiotomy is the surgical enlargement of the birth canal by incision of the perineum at the time of birth. There is wide variation in episiotomy rates both between and within countries. Episiotomy may only be carried out by doctors and midwives or by students under direct supervision.

2. Benefits

The evidence that episiotomy prevents Obstetric Anal Sphincter Injury (OASIS) and / or anal incontinence is conflicting. Hospital Episode Statistics (HES) data have shown that episiotomy is associated with the lowest risk of OASIS. Some studies have shown a protective effect while others have not. Therefore, The National Institute for Clinical Excellence (NICE) has concluded that routine episiotomy during spontaneous vaginal birth is not protective.

In the absence of robust evidence to support either routine or restrictive use of episiotomy at assisted vaginal birth, the decision should be tailored to the circumstances at the time and the preferences of the woman. The evidence to support use of mediolateral episiotomy at assisted vaginal birth in terms of preventing OASI is stronger for nulliparous women and for birth via forceps.

The angle of the episiotomy away from the midline has been shown to be important in reducing the incidence of OASIS with NICE and The Royal College of Obstetricians and Gynaecologists (RCOG) recommending episiotomy should be performed on the woman's right side mediolaterally at a 60-degree angle from the midline at crowning to ensure a sutured angle of at least 45 degrees.

3. Indications

- To expedite delivery where there is presumed fetal compromise
- Instrumental delivery
- Rigid perineum
- Shoulder dystocia
- Breech delivery using the clinician's individual judgement
- Button holing
- Preterm delivery
- Prevention of uncontrolled or serious tearing if the clinician deems necessary
- Malpresentation
- Female Genital mutilation not resolved antenatally
- Each birth requires the need for episiotomy to be judged by the individual clinician.

4. Technique

- The possible need for an episiotomy should ideally be discussed during the first stage of labour. This should be documented.
- Every attention should be given to ensuring the comfort, dignity and support of the woman and her partner.
- Ensure that all necessary equipment for birth is available and there is good lighting.
- If time allows, the perineum should be cleaned with sterile water prior to the episiotomy.
- Effective analgesia should be provided prior to carrying out an episiotomy unless in an emergency due to acute fetal compromise[2].This may include local infiltration, a pudendal block or regional anaesthetic.
- The baby's head should be guarded with two fingers inserted into the vagina during infiltration of the perineum. A green needle is inserted to its full length along the medio-lateral plane and 5-7mls lidocaine 1% injected continuously as the needle is withdrawn. This may be done in one or three stages (one third each injection, the needle being reinserted once to either side – 'fanning'). This is best done at the height of a contraction.
- The incision should be made with Episcissor-60 if available[3] or sharp, straight bladed, blunt ended scissors at the height of the contraction to a length of 4- 5cm.
- Before making the incision, check that the blades are mediolateral with an angle of 60 degrees from the midline at crowning to ensure a sutured angle of **at least** 45 degrees[6].
- If the episiotomy has been timed correctly, the head should be delivered with the same or with the following contraction. The advance of the head should be slow and controlled, manual perineal protection at crowning can be protective in reducing Obstetric Anal Sphincter Injury (OASI).

5. Repair

Repair should take place immediately after the birth to minimise the risk and complications of bleeding, infection, bruising, pain and apprehension and fear in the mother. In case of heavy bleeding from the episiotomy site, apply pressure and ask for help to expedite repair.

Please refer to the Perineal Trauma guideline

6. Auditable Standards

The indication for episiotomy. Verbal consent has been obtained and documented. Post repair analgesia is appropriate.

7. Monitoring compliance

This guideline will be subject to a three yearly audit. The audit midwife is responsible for coordinating the audit. Results presented to the department clinical audit meeting. Action plans will be monitored at the quarterly department clinical governance meeting.

8. Communication

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness), staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them.

9. Equality Impact Assessment

This policy has been subject to an Equality Impact assessment.

10. References

1. Edozien LC, Gurol-Urganci I, Cromwell DA, Adams EJ, Richmond DH, Mahmood TA, et al. Impact of third- and fourth-degree perineal tears at first birth on subsequent pregnancy outcomes: a cohort study. *BJOG* 2014; 121:1695–704.

2. Intrapartum care for healthy women and babies. Clinical guideline [CG190] N.I.C.E. December 2014 Last updated: February 2020

3. The Management of Third- and Fourth- Degree Perineal tears. Royal College of Obstetricians and Gynaecologists 2015 June 2015. Report.:29

4. Assisted Vaginal Birth. London: Royal College of Obstetricians and Gynaecologists, 2011 April. 2020 Report.: 26

5. Andrews A, Thakar R, Sultan AH and Jones PW. Are mediolateral episiotomies actually mediolateral? *BJOG* 2005 112:1156-8

6. Eogan M, Daly L, O'Herlihy C. Does the angle of episiotomy affect the incidence of anal sphincter injury? *Am J Obstet Gynecol* 2005: 556; S157

7. Murphy DJ, Strachan BK, Bahl R, on behalf of the Royal College of Obstetricians Gynaecologists.Assisted Vaginal Birth. BJOG 2020;127:e70–e112.

Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Feb 2017	Lead Midwife for Perineal Management, FPH	Draft	
2.0	April 2017	Lead Midwife for Perineal Management, FPH	Final	Ratified at Obstetrics and Gynaecology Clinical Governance Committee, 23 March 2017
3.0	Oct 2020	S Milford, Midwife, FPH; A Oatley, Midwife, FPH	Final	Ratified at Obstetrics and Gynaecology Clinical Governance Committee, 30 September 2020
4.0	March 2024	Sarah Haigh, Midwife, WPH	Final	Approved at Cross site Obstetrics Clinical Governance Meeting 27.03.24

Related Documents

Document Type	Document Name
Guideline	Perineal Trauma