

5 INTRAPARTUM CARE

5.9 SECOND STAGE OF LABOUR

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5.9.3.1 Infiltration of the Perineum and cutting an Episiotomy
Section B
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5.9.3.1 INFILTRATION OF THE PERINEUM AND CUTTING AN EPISIOTOMY

BACKGROUND INFORMATION

Restrictive use of episiotomy is the preferred option rather than the routine use of episiotomy.¹ It is associated with less posterior perineal trauma, less suturing, fewer complications, but is associated with an increased risk of anterior perineal trauma. Evidence has indicated there are no differences in pain measurements or severe vaginal/perineal trauma.²

The midline episiotomy is associated with a higher rate of damage to the anal sphincter and rectum when compared to the mediolateral episiotomy.^{1,2,3} Mediolateral episiotomies are associated with increased postpartum pain, more blood loss, with increased difficulty of repair, and women experience more dyspareunia, especially if compared to spontaneous tears.¹ Evidence is insufficient to determine the superiority of either approach as both have similar outcomes including pain and resumption of intercourse.¹

Currently there is no scientific evidence is available to support the use of routine episiotomy to prevent intracranial haemorrhage in preterm deliveries.³

Episiotomy is associated with increased blood loss at the time of delivery. Other complications include haematoma formation, infection, and rarely abscess and rectovaginal fistula formation¹.

KEY POINTS

1. Restrictive use of the episiotomy is preferable rather than routine use of episiotomy.
2. A mediolateral episiotomy is associated with less risk for injury to the anal sphincter than a midline incision.
3. An episiotomy is not required routinely for pre term delivery. The decision to perform an episiotomy is based on individual needs.
4. Episiotomy is associated with a reduction in pelvic floor muscle function.³
5. Routine episiotomy does not prevent pelvic floor damage leading to incontinence.¹

INDICATIONS FOR EPISIOTOMY

ABSOLUTE

- To facilitate delivery in cases of non-reassuring fetal heart rate.⁴

RELATIVE

- Rigid perineum – rigid musculature may cause prolonged delay in second stage^{3,4}
- Preventing perineal trauma – when associated with a history of surgical repair of the pelvic floor, bladder or fistula⁴, and in cases when the perineal body is unusually short.¹
- Reducing maternal effort – e.g. cardiac disease, epilepsy or hypertension^{3,4}



- Facilitate safe delivery e.g. shoulder dystocia – allows space for manoeuvres to assist delivery³
- Operative vaginal delivery - based on clinical judgement¹

EQUIPMENT

1 x 20mL syringe
1 x 19 gauge needle
1 x 22 gauge needle (infiltration needle)
10 mL 1% Lignocaine
Mayo episiotomy scissors

	PROCEDURE	ADDITIONAL INFORMATION
1	Preparation	
	Explain the procedure and indication for the intervention to the woman	Allows the woman to make an informed judgement and be involved in her care ⁵
	Obtain verbal consent	This is a surgical procedure and requires maternal consent. ⁵
2	Infiltration	
2.1	Using the syringe and 19 gauge needle draw up 10mL of 1% Lignocaine	Ideally the infiltration should be done three to five minutes prior the episiotomy to ensure adequate analgesia. ⁴
	Check the medication and dosage with an assistant.	Ensures the correct medication and amount has been prepared. ⁵
2.2	Insert two fingers into the vagina between the presenting part and the skin.	Protects the presenting part from infiltration with local anaesthetic. ⁵
	For a medio-lateral episiotomy, direct the needle at an angle of approximately 45° for 4 to 5 cm at the same skin depth.	
	Aspirate the syringe.	Aspiration ensures the needle has not entered a blood vessel.
	While withdrawing the syringe, continuously inject approximately 3 mL of local anaesthetic into the area.	
	Leave the tip of the needle still inserted in the perineal area.	

PROCEDURE	ADDITIONAL INFORMATION
2.3 Repeat this step twice by redirecting the needle either side of the initial injection so that a fan shaped area is anaesthetised.	
2.4 Withdraw the needle and apply pressure over the injection site.	Applying pressure to the injection site minimises blood loss, and prevents haematoma formation.
3 Cutting an episiotomy	
3.1 Insert the index and middle finger in between the presenting part and the perineum, pointing downwards. Take the open scissors and position between the fingers, over the area intended for incision. Make a single, deliberate cut 3 to 4 cm into the perineum at the height of the contraction when the birth is imminent. The incision should start midline from the fourchette, and extend outwards in a medio-lateral direction, avoiding the anal sphincter. ⁴ Withdraw the scissors carefully.	Ensure there is good vision of the perineum and the incision is away from the anus and Bartholin's gland. A straight cut minimises perineal damage and facilitates optimal anatomical realignment. ³
3.2 Control the delivery of the presenting part and the shoulders.	Prevents sudden expulsion of the presenting part and extension of the episiotomy incision. ⁴
3.3 Apply pressure to the episiotomy between contractions with a sterile combine if there is a delay in the birth.	Controls bleeding from the wound. ³

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