Episiotomy—should we continue it as routine practice

Several studies show that routine episiotomy is an unnecessary operation that inflicts short- and long-term physical and mental trauma on women. Meta-analysis of prospective randomised controlled studies that compare routine episiotomy with restrictive episiotomy suggests that the latter is associated with less posterior perineal trauma (relative risk=0.88; 95% confidence interval, 0.84-0.92), less need for suturing, and fewer complications associated with healing.[1] Nevertheless there was a higher incidence of anterior perineal trauma, possibly due to the lack of space posteriorly and delay in initiating a required episiotomy. There appears to be no difference in the incidence of severe perineal and vaginal tears with the use of routine, selective, or restrictive episiotomy. In addition there was no difference in the incidence of perineal pain, dyspareunia, or urinary incontinence. The results were similar for midline or mediolateral episiotomy.

The report from Hong Kong indicates an episiotomy rate of 97.9% in nulliparae and 71.4% in multiparae.[2] There was less perineal tearing in those with episiotomy including third- and fourth-degree tears. These results contradict those of the meta-analysis.[1] The Hong Kong study is a retrospective descriptive study but the results should be debated by the obstetric community within Hong Kong. It is possible to conclude that the differences are due to different population base. It is stated that Chinese women in Hong Kong may have a shorter perineum and routine episiotomy therefore reduced the occurrence of third- and fourth-degree tears. In addition, one may argue that Chinese babies may be smaller than those born to a western population but are proportional to smaller women in Hong Kong. Allowing time to stretch the perineum and careful delivery may have avoided third- and fourth-degree tears in those who did not have routine episiotomies.

The obstetric fraternity in Hong Kong have to make a decision about their practice. They may decide there is no need for a randomised controlled trial and should continue the practice of routine episiotomy regardless of the Hong Kong paper. Alternatively, they may accept the results available in the literature and perform restrictive episiotomies. The results of the meta-analysis are well established, yet the practice in Hong Kong has not been reviewed. Positive action is needed and there are two options. First, medical students and student midwives should be taught to deliver babies without a routine episiotomy. Second, a simultaneous prospective randomised study could determine whether the incidence of third- and fourth-degree tears and other adverse problems associated with episiotomies are reduced by routine or restrictive episiotomy in the Hong Kong population. There is merit in training as many doctors and midwives as possible to deliver babies without routine episiotomy before the trial. Interventions are thought to be increased with a doctor-led or private practice–based delivery; this needs to be taken into account and controlled for when designing the study.

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