Episiotomy and Repair of Higher Degree Perineal Lacerations

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Disclosure

- I have no significant financial conflict of interest
Agenda

- Introductions
- Didactic review of episiotomy
- Simulation and practical
- Debrief
Objectives

- Understand the indications for episiotomy
- Review episiotomy technique and repair
- Perform simulation skills training of episiotomy and repair
- Debrief
Anatomy of Perineum

- Mons pubis
- Anterior commissure of labia majora
- Prepuce of clitoris
- Pudendal cleft (groove or space between the labia majora)
- Glans of clitoris
- Frenulum of clitoris
- External urethral orifice
- Labium minus
- Labium majus
- Openings of paraurethral (Skene’s) ducts
- Vestibule of vagina (cleft or space surrounded by labia minora)
- Vaginal orifice
- Opening of greater vestibular (Bartholin’s) gland
- Hymenal caruncle
- Vestibular fossa
- Frenulum of labia minora
- Posterior commissure of labia majora
- Perineal raphe (over perineal body)
- Anus
Anatomy of Perineum
Episiotomy: Historical Perspective

- Technique used for delivery of fetus for many centuries
- First reported in the United States in 1852
- J.B. DeLee popularized the episiotomy in early 1900s
- Became routine practice in the 20th Century
- Initially began as more a mediolateral approach but transitioned to midline approach by 1950s-1960s
- Routine practice of episiotomy begins to be questioned in the 1980s leading to decreased frequency of use and today’s practice of episiotomy with indication
Episiotomy: Current Practice and Indications

- Insufficient evidence for establishing criteria/recommendations regarding performance of episiotomy

- Clinical judgment is the best guide
  - Has been used to shorten second stage of labor
  - Has been used in providing perineal protection
Episiotomy

- Mediolateral
- Midline
## Extension of Episiotomy

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>First-degree tear:</strong></td>
<td>A superficial laceration of the mucosa of the vagina, which may extend into the skin at the introitus. It does not involve deeper tissues and may not require repair.</td>
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<tr>
<td><strong>Second-degree tear:</strong></td>
<td>A first-degree laceration that involves the vaginal mucosa and perineal body. It may extend to the transverse perineal muscles and requires a suture repair.</td>
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<tr>
<td><strong>Third-degree tear:</strong></td>
<td>A second-degree laceration that extends into the muscle of the perineum and may involve both the transverse perineal muscles as well as the anal sphincter. It does not involve the rectal mucosa.</td>
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<tr>
<td><strong>Fourth-degree tear:</strong></td>
<td>A laceration involving the rectal mucosa.</td>
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</tbody>
</table>

**Note:** Some definitions are limited to the three levels of tear and will combine the first- and second-degree tears as only one level.
Episiotomy: Procedure

- Ensure adequate anesthesia
- Protect the fetal head or presenting part by inserting the index and the middle finger into the vagina
- Incise the perineum using scissors
Episiotomy: Mediolateral Repair

Fig. 9. Repair of mediolateral episiotomy.
Episiotomy: Complications

- Bleeding
- Extension of episiotomy
- Infection/breakdown of wound
- Pain
- Dyspareunia
“The best available data do not support liberal or routine use of episiotomy. Nonetheless, there is a place for episiotomy for maternal or fetal indications, such as avoiding severe maternal lacerations or facilitating or expediting difficult deliveries.”
Higher Degree Perineal Lacerations

Risk factors:
- Prior extensive laceration
- Fetal macrosomia
- Post-term gestation
- Operative vaginal delivery
- Precipitous delivery
Higher Degree Perineal Lacerations

- Repair is similar to episiotomy repair
- Ensure adequate exposure and review extent of laceration
References

1. Episiotomy. I. Ling, Frank W. II. American College of Obstetricians and Gynecologists. III. Title. [DNLM: 1. Episiotomy. WQ 415 H163e 2007]
Questions?