5.9.3.1 INFILTRATION OF THE PERINEUM AND CUTTING AN EPISIOTOMY

Keywords: Perineum infiltration, 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.¹⁻³ 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 formation.¹

KEY POINTS

1. Restrictive use of the episiotomy is preferable rather than routine use of episiotomy.¹
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 preterm delivery. The decision to perform an episiotomy is based on individual needs.
4. Episiotomy is associated with a potential 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 is cases of non-reassuring fetal heart rate.³,⁴

RELATIVE

- Rigid perineum – rigid musculature may cause prolonged delay in second stage³,⁴
- Preventing severe perineal trauma³ – when associated with signs of severe perineal trauma (e.g. ‘button-holing’),⁴ a history of surgical repair of the bladder or fistula, and in cases when the perineal body is unusually short.²
- Reducing maternal effort – e.g. severe cardiac disease, epilepsy or hypertension³
- Facilitate safe delivery e.g. shoulder dystocia – allows space for manoeuvres to assist delivery³
- Operative vaginal delivery - based on clinical judgement.¹

EQUIPMENT

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

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| 1 | **Preparation**  
Explain the procedure and indication for the intervention to the woman.  
Obtain verbal consent. | Allows the woman to make an informed judgement and be involved in her care.  
This is a surgical procedure and requires maternal consent. |
| 2 | **Infiltration**  
2.1 Using the syringe and 19 gauge needle draw up 10mL of 1% Lignocaine.  
Check the medication and dosage with an assistant.  
2.2 Insert two fingers into the vagina between the presenting part and the skin.  
For a medio-lateral episiotomy, direct the needle at an angle of approximately 45° for 4 to 5 cm at the same skin depth. | Ideally the infiltration should be done a few minutes prior to the episiotomy to ensure adequate analgesia.  
Ensures the correct medication and amount has been prepared.  
Protects the presenting part from infiltration with local anaesthetic. |
| 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.  
Withdraw the scissors carefully.  
3.2 Control the delivery of the presenting part and the shoulders.  
3.3 Apply pressure to the episiotomy between contractions with a sterile combine if there is a delay in the birth. | 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.  
Prevents sudden expulsion of the presenting part and extension of the episiotomy incision.  
Controls bleeding from the wound. |

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Clinical Guidelines: Section B  
King Edward Memorial Hospital  
Perth Western Australia  
2014  
All guidelines should be read in conjunction with the Disclaimer at the beginning of this manual
REFERENCES (STANDARDS)


National Standards – 1- Care provided by the clinical workforce is guided by current best practice
Legislation - Nil
Related Policies - WA Health Consent to Treatment Policy 2011
Other related documents –
• KEMH Clinical Guideline B: 5.15.1 Suturing an Episiotomy/Genital Laceration
• Patient brochure: Caring for Your Perineum

RESPONSIBILITY

Policy Sponsor: Nursing & Midwifery Director OGCCU
Initial Endorsement: April 2003
Last Reviewed: September 2014
Last Amended: Review date September 2017

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Access the current version from the WNHS website.