

EPISIOTOMY IN BRAZIL: A NARRATIVE REVIEW IN AN EVIDENCE BASED PERSPECTIVE

Júlio César Soares Aragão¹
Maria Cecília Siqueira Ferreira²
Marília Barros Padilha³
Maria Martha Rennó Ribeiro Chaves Freitas⁴

ABSTRACT

Episiotomy, an incision used in obstetrical practice, has been shrouded by much controversy in recent decades. In order to discuss the practice of episiotomy and its complications, a narrative review was carried out on publications on this topic between 2007 and 2017. Currently classified as category D by the World Health Organization, episiotomy adoption as a routine practice is unjustified and harmful, and selective use is still debatable. It is an obstetric violence category and increases short and long term complications. Brazilian obstetricians ignore scientific evidence and it is imperative to reformulate practices and update professionals regarding outdated practices.

KEY WORDS: Episiotomy, Violence against women, Evidence based medicine.

RESUMO

A episiotomia, uma incisão usada na prática obstétrica, tem sido envolvida por muita controvérsia nas últimas décadas. Para discutir a prática da episiotomia e suas complicações, foi realizada uma revisão narrativa das publicações sobre o tema entre 2007 e 2017. Atualmente classificada como categoria D pela Organização Mundial da Saúde, a adoção da episiotomia como prática rotineira é injustificada e prejudicial, e o uso seletivo ainda é discutível. É uma categoria de violência obstétrica e aumenta as complicações de curto e longo prazo. Os obstetras brasileiros ignoram as evidências científicas e é imprescindível reformular as práticas e atualizar os profissionais sobre as práticas desatualizadas.

PALAVRAS CHAVE: Episiotomia, Violência Contra Mulheres, Medicina Baseada em Evidências

¹ Possui graduação em Medicina pelo Centro Universitário de Volta Redonda (1992), Mestrado em Saúde da Mulher e da Criança pela Fundação Oswaldo Cruz (1999), Doutorado em Saúde Coletiva pela UERJ (2007) e Pós Doutorado em Educação no Instituto de Educação da Universidade do Minho. É Professor do Centro Universitário de Volta Redonda atuando no Curso de Medicina desde 1996 e no Mestrado em Ciências da Saúde e do Meio Ambiente desde 2008.

² UNIFOA, Centro Universitário de Volta Redonda, Departamento de Ciências da Saúde

³ UNIFOA, Centro Universitário de Volta Redonda, Departamento de Ciências da Saúde

⁴ UNIFOA, Centro Universitário de Volta Redonda, Departamento de Ciências da Saúde

INTRODUCTION

The World Health Organization (WHO) defines episiotomy as a scalpel or scissors performed perineal incision to enlarge the birth canal during third stage of labor. The term derives from the Greek word *epision*, which means the pubic region, added of *tomus*, cut or incision to designate vulvoperineal surgical section performed during vaginal birth (GARRETT; OSELAME; NEVES, 2017; MONTENEGRO; REZENDE, 2018; OLIVEIRA et al., 2016; POMPEU et al., 2015). This practice was introduced in the 18th century by Irish obstetrician Sir Fielding Ould to aid in difficult births. In 1847, Dubois proposed an oblique incision in the perineum, currently known as medial-lateral episiotomy (AMORIM, 2012; CARVALHO; SOUZA; FILHO, 2010; CARVALHO et al., 15DC).

From the beginning of the 20th century, the use of episiotomy has spread mainly by Pomeroy and De Lee. The latter, openly an intervention advocate, incorporated systematic episiotomy into his book in order to reduce the likelihood of severe forceps perineal lacerations and to minimize the risk of fetal trauma of and hypoxia (DE LEE, 1938). The technique ended up being incorporated into the obstetric practice initially in the United States and later throughout the American continent, including Brazil. This period coincides with a vision change about birth, which ceases to be a natural and physiological event and becomes a hospital based process, demanding medical intervention that would avert maternal and fetal complications. These principles were reproduced worldwide in obstetrics textbooks, when intervention proposals could still be made even in absence of reliable scientific evidence of effectiveness (AMORIM, 2012; AMORIM; KATZ, 2008; BRASIL, 2016; CARVALHO; SOUZA; FILHO, 2010).

Variations on the incision are basically two: the midline episiotomy, which follows the perineal raphe from the navicular fossa towards (but not including) the anus; and mediolateral

episiotomy, consisting of a 45° angle incision navicular fossa, usually to the left, but also possible to the right side (GARRETT; OSELAME; NEVES, 2017; LÔBO, 2010; MONTENEGRO; REZENDE, 2018; PEÑA; GOMES, 2016).

With the dawn of feminist movements in the 70's, women's health and childbirth assistance models began to be questioned. In Brazil, obstetric violence, understood as violence against women occurring in gravid puerperal cycle (dehumanization, physical damage, or excessive medicalization pathologizing of physiological processes), has become cause for reflection by part of our society, and routine episiotomy plays a major role as an important factor (ANDRADE; AGGIO, 2014; JUAREZ et al., 2012). Beyond physical suffering and health issues, this scenario imposes a special ethnic and socio-demographic bias, establishing oppression and domination as a rationale in an already fragile relationship between patients and care providers (JARDIM; MODENA, 2018).

This article aims to discuss the practice of episiotomy from a rational, evidence based perspective, in order to encourage professional debate on the technique and trigger further discussions on women's autonomy in light of national and international scientific published data on the subject.

METHOD

This research is a narrative review about episiotomy use in obstetrics and the disparity between extensive scientific evidence that shows its inefficacy as a routine procedure in medical practice contrasting with a practice scenario in which the persistence of its massive and systematic use is the norm. This type of study, rather than a systematic review or even an integrative review, has the intention to produce review that is neither detailed nor protocolary pre-determined (CORDEIRO et al., 2007; ERCOLE; MELO; ALCOFORADO, 2014). As pointed by ROTHER (2007):

Narrative literature review articles are publications that describe and discuss the state of science of a specific topic or theme from a theoretical and contextual point of view. These types of review articles do not list the types of databases and methodological approaches used to conduct the review nor the evaluation criteria for inclusion of retrieved articles during databases search. Narrative review consists of critical analysis of the literature published in books and electronic or paper based journal articles (p.vii).

This personal and “fluid” characteristic also made this kind of review to be usually called unsystematic reviews, characterizing it as a demeritorious form to name the research (GREEN; JOHNSON; ADAMS, 2006).

For the review, we used the terms episiotomy and evidence-based medicine that were inserted in 03 different databases resulting in 32 articles of Virtual Library Health, 29 from PubMed, and 9 from Scielo. The articles were published from 2007 to 2017, in English, Spanish and Portuguese. Documents published by FEBRASGO (Brazilian Federation of Gynecology and Obstetrics), medical textbooks and blogs with relevant scientific contents were also consulted and brought to the discussion. The selected texts were submitted to critical reading and resulted in 24 articles that were compiled in a discursive format to construct a narrative of the real conditions that involves episiotomy practice as childbirth assistance in Brazil.

RESULTS AND DISCUSSION

In the early 20th century, episiotomy was adopted in maternal-child prevention, in a period

when childbirth was subjected to continue and systematic medicalization and hospitalization. Its routine use was justifiable in light of many alleged benefits: relieving stress of third stage of labor, preserving the pelvic muscles, relieving tension of the pelvic floor on the fetal head, preventing uterine prolapse and fourth degree laceration and restoring the previous characteristics of the vagina. However, all these arguments were accepted based only on expert’s opinion, and even in the absence of scientific data supporting its use, this practice was widespread and maintained for several decades in the medical world (PRIETO, 2015).

The reevaluation of episiotomy use started in 1983 with the publication of the article by Thacker and Banta (1983). These authors reviewed over 350 articles about the benefits of episiotomy from 1860 to 1980 and concluded there was no evidence for its recommendation. From that moment, several systematic reviews have demonstrated absence of maternal and perinatal benefits from systematic use of episiotomy, indicating the need for adjustment of its use, in cases such as fetal distress or in the imminence of third degree lacerations (COSTA et al., 2015; LÔBO, 2010; MATTAR; AQUINO; MESQUITA, 2007). This evidences points to the need for changes of conduct to ensure more humanized assistance and better quality care for women in labor (MATTAR; AQUINO; MESQUITA, 2007).

Studies showing correlations between routine episiotomy and comorbidities showed an increase in the rate of sexual dysfunction, urinary and fecal incontinence, vaginal prolapse, and rectovaginal fistula, in addition to evidence that women with no episiotomy in childbirth had a greater likelihood to keep perineal integrity after delivery, possibly due to vaginal tissue elasticity, compared to those submitted to surgical section and consequent scarring (CARVALHO et al., 15DC; PEÑA; GOMES, 2016; PRIETO, 2015). Systematic reviews conducted after these studies have concluded that the practice of selective episiotomy ensures greater perineal and vaginal

protection, being the routine practice proven unjustified (JIANG et al., 2017; MACÊDO et al., 2017). Other researchers also suggest investigating the real necessity to use the technique in any case, in spite to absence of scientific evidence showing better results in patients submitted to episiotomy (JIANG et al., 2017; MACÊDO et al., 2017).

Regarding practices used in medicine, WHO uses a well-known four categories classification of procedures ranging from the category A (practices to be stimulated) to the category D (practices used improperly). Episiotomy was classified in category D (LÔBO, 2010; SANTOS; SANTOS, 2016). Similarly, for Montenegro & Rezende (MONTENEGRO; REZENDE, 2018), both lateral and median episiotomy are responsible for a greater prevalence of dyspareunia even when compared with cases of spontaneous lacerations.

In Brazil, official documents and guidelines recommend the use of episiotomy selectively, based on carefully analyzed criteria. These documents point an ideal rate between 10 to 30% of vaginal births. However, throughout Latin America, this technique has been widely used routinely in primiparous and pregnant women with a history of previous episiotomy (GARRETT; OSELAME; NEVES, 2017; MATTAR; AQUINO; MESQUITA, 2007). This procedure is performed on approximately 54% of the women. However, as it is considered a routine procedure, it is believed that underreporting in medical records may occur, and there may be a higher number due to sub notification (AMORIM, 2012; COSTA et al., 2015).

In a major portion of the cases, information about episiotomy for pregnant women is denied. In such cases, absence of knowledge and misunderstanding about pain, wound healing and surgical infection are an obvious cause for complications (VILLELA et al., 2016); therefore, prenatal care providers should offer clear and evidence-based information to guide and prevent the spread of the interventionist culture. Regarding information about episiotomy on

antenatal care, a research conducted in the Family Health Strategy of a municipality in the State of São Paulo found out that all users had not obtained any information about episiotomy from any health professional and those who had information said they received it through friends, family or the media (COSTA; CÉSAR; SILVA, 2016).

As women are unaware of episiotomy indications and do not actively participate in decision-making regarding its use, its practice became a clear form of disrespect for human rights, mutilation and obstetric violence. In a survey conducted in the city of Campo Largo, it was found that of 85 vaginal births, 59 (69.40%) performed episiotomy, a rate way superior to the advocated by the Ministry of Health. Furthermore, when considering women subjected to episiotomy, 45 (76.27%) had not consented the procedure (GARRETT; OSELAME; NEVES, 2017). In an international study, 34% of women subjected to episiotomy reported that they did not participate in the decision-making process and much less received guidance on how it would be performed (VILLELA et al., 2016).

In Montes Claros study, it was observed that independently of the individual characteristics of the studied population (age, marital status, education, occupation, and family income), most women did not even know the term "episiotomy". After a brief description of the procedure, the patient were asked if they knew its purpose and, according to them, episiotomy would be a form of pain relief, a possibility to reduce the time of fetal expulsion, avoid problems in the female genital organ and even a procedure necessary and essential for the occurrence of the first childbirth, as they see it as a part of medical recommendations (CARVALHO et al., 15DC).

Another concern raised by the high rates of episiotomy are the short or long term complications in such as: wound bruising and infection, fistulas, blood loss, sexual dysfunction, dyspareunia, scar endometriosis, urinary or fecal incontinence and even cervical prolapse; as well as prolonged use of urinary catheter, increased

hospitalization and poorest wound healing compared to women with spontaneous lacerations (COSTA et al., 2015). A survey on Hospital Amparo Maternal in São Paulo with 303 women who gave birth vaginally found episiotomy in 75.4% of them and the prevalence of perineal pain in 18.5% of cases (SILVA et al., 2013). The episiotomy healing process was investigated in six months after giving birth and showed that 49.4 percent of women reported some type of perineal scar alteration as some degree of fibrosis, increased sensitivity and changes in skin coloration. Another study found prevalence of 16.2% of dyspareunia in women interviewed one year after childbirth, and 66.2% of them had been subjected to episiotomy (OLIVEIRA et al., 2016; SILVA et al., 2013).

Research shows that there are some maternal, fetal and care factors, that are correlated with high episiotomy rates. Primiparity, the extremes of maternal age, perineal stiffness, previous episiotomy and diseases present in the moment of childbirth (especially the hypertensive syndromes) correspond to the justifications for the incision. Regarding fetal factors, episiotomy was mainly associated with macrosomia, but was also adopted in various weight categories. Also, the procedure was performed in all deliveries in which the Kristeller maneuver associated with oxytocin was used (SANTOS; SANTOS, 2016).

Another important factor to consider is the fact that women undergoing episiotomy frequently report negative feelings and anxiety related to the moment of birth, emphasizing the need for clarification and guidance about the practice, preferably during the antenatal period, but also during the admission process and hospital stay (KÄMPF, 2013; LÔBO, 2010; PRIETO, 2015). Physical and emotional sensations experienced on the episiotomy site can impair self-care, hinder their adaptation to the new family context, undermine their self-esteem and sex life, as some women report feeling ashamed of their partner due to aesthetic modifications on the incision site. Pain is generally less noticed and specially underrated, both by healthcare

professional and family, as the main attention is directed to the newborn (OLIVEIRA et al., 2016). In contrast, morbidity in patients without episiotomy is definitely lower than those who had procedure (ROY et al., 2015).

The debate about humanization of childbirth has been of interest of national and international researchers and efforts have been made to reduce cesarean section rates and episiotomy in Brazil (PRIETO, 2015). Many people, including experts, researchers, activists and health professionals are involved in initiatives to reverse birth medicalization, mainly by encouraging the abandonment of interventions that are not based on scientific evidence (KÄMPF, 2013). Incorporating these changes into obstetric practice requires health professionals being constantly updated, reviewed and monitored, since unnecessary and unjustified procedures indication may compromise the physiological progress of childbirth and bring harmful outcomes, physical and emotional, for both the woman and newborn (KÄMPF, 2013; PEÑA; GOMES, 2016).

Although there is abundant evidence that routine episiotomy does not constitute a good standar of care, most obstetricians, even those accountable for medical education, are reluctant to abandon it, because it was so incorporated into their undergraduate and professional practice that it has assumed the status of a ritualistic tradition (MATTAR; AQUINO; MESQUITA, 2007). Episiotomy, as well as the practice of other operative procedures used in large scale in childbirth assistance, instils in the assisted population the idea that this an extremely complex and dangerous process, whose strict control is a medical imperative (PROSEN; KRAJNC, 2013). The health professional whose understanding of the mechanisms of parturition starts from a pathologizing and medicalized optical perspective tends to assume all control of decisions, reinforcing the power and hierarchy exercised in decision-making process during childbirth (CIELLO et al., 2012; COSTA; CÉSAR; SILVA, 2016; FOUCAULT, 1987; POMPEU et al., 2015).

This attitude of mastery is in clear opposition of the principles of humanized health assistance, turning the woman into an object of technical intervention. These practices reinforce the patriarchal culture of our society in which the female body is subject to the control of a specialist – holder of the knowledge/power – to whom all protagonism is conceded, reinforcing the process of docilization of bodies and appropriation of oppressive discourse by the oppressed. (FOUCAULT, 1987; FREIRE, 1996; MÜLLER; PIMENTEL, 2013).

While dealing with health issues, biopsychosocial aspects should always be considered. In pregnancy, childbirth and postpartum care, health professionals should understand the individuality of every woman, provide dialogue-based information, stimulate autonomy, family participation and offer practices with updated technical and scientific knowledge. Furthermore, it's imperative to understand consent not as documents and signatures, but as a joint form of decision-making in the conduct of childbirth (BRASIL, 2010; PRIETO, 2015). One of the basic concepts of the humanization of childbirth is the embracement to all women and respect for their subjectivity and individuality. Respecting the will and knowledge of women is essential, since every procedure requires information and consent (VILLELA et al., 2016). From this point of view, undiscussed, unconsented and mostly unwanted episiotomy can be considered a violation of human rights (D'SOUZA et al., 2015).

The obstetric model in Brazil is not yet focused on women's autonomy and rights, and the model logic is hospital centered, having few or even no rules to prevent indiscriminate use of outdated procedures, so that childbirth is now seen as essentially dangerous and cause of suffering that should be abbreviated by the doctor, without regard to the inherent capacity and power of women and the birth process (AMORIM; KATZ, 2008; GARRETT; OSELAME; NEVES, 2017; KÄMPF, 2013; LÔBO, 2010; MUNIZ; BARBOSA, 2012; PEÑA; GOMES, 2016).

Although a significant number of Brazilian obstetricians still ignore scientific evidence and WHO recommendations for childbirth assistance, women's movements for the humanization of birth in Brazil have raised important discussions about harmful practices during parturition, highlighting the need for continuing education and paradigmatic changes (BALDISSEROTTO; THEME FILHA; DA GAMA, 2016; KÄMPF, 2013).

CONCLUSION

The studies cited in this article show that the obstetric Brazilian model ignores scientific evidence and WHO recommendations on childbirth assistance. It is imperative to reformulate behavior and update health professionals, especially physicians, in regard to outdated practices and habits that are considered to have no benefit and are even harmful as the episiotomy. The perpetuation of this practice in our country configures serious distortion of medical practice and can (and should) be interpreted as demeaning conduct to the physical, mental and social well-being of women and their children.

At this point it is paramount to emphasize that this article does not intend to point fingers, impute blame or demonize any health professionals. We believe that the majority of these persons are not aware of the damage they might have been causing, and we are sure that we can all work together towards improvement of care, women's empowerment and human rights assurance to everyone.

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