Archives of Gynecology and Obstetrics (2019) 300:1473–1474
https://doi.org/10.1007/s00404-019-05317-3

CORRESPONDENCE

Operative delivery in nuliiparous: deserves an episiotomy

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Received: 11 August 2019 / Accepted: 21 September 2019 / Published online: 1 October 2019

Dear Editors,

We read with great interest the study of Gachon et al. [1] in a recent issue of the Journal. The authors address the important issue of different policies of episiotomy during operative deliveries by measuring retrospectively the rates of obstetric anal sphincter injury (OASI) and mediolateral episiotomy (MLE) rates across a decade of practice. Not surprisingly, the authors reach the conclusion that a restrictive MLE for forceps delivery is associated with an increase in OASI.

However, there are several issues necessitating further clarification. First, the authors conclude that a restrictive approach for MLE is not associated with an increase in OASI when vacuum extraction (VE) is performed and that this comes in line with the current literature. The role of episiotomy in vaginal birth has been much debated and vastly studied when operative vaginal delivery is discussed, both retrospectively and to a lesser extent prospectively. Interestingly, in a meta-analysis by Lund et al. [2] examining more than 320,000 primiparous across 15 studies, there was a significant reduction in the rate of OASI for nulliparous women in VE deliveries with mediolateral or lateral episiotomy compared to deliveries without, with 19 needing MLE to prevent OASI. Coupled with this is the correct terminology of Lund et al. when discussing MLE, which in fact is a misnomer describing at times lateral episiotomy (which is probably the MLE discussed) and at times mediolateral episiotomy. It is probable that MLE decreases the risk for OASI compared to no MLE for nulliparous undergoing a VE, and this has been argued by various recent studies [3, 4]. Second, statistically speaking, it is unclear why outcomes with a level of significance greater than $p < 0.15$ in the univariate analysis were included in the multivariate analysis using logistic regression, as this is usually performed when $p < 0.05$. Moreover, the authors ignore other factors that might be associated with OASI during operative delivery as operator experience, experience in diagnosis of OASI, etc. [5]. Finally, we believe that higher awareness during the last decade for OASI during operative delivery has led to an increase in the detection rate of these injuries. This should also be discussed, as it might explain to some extant the rise in the diagnosis incidence of OASI. We do not argue differently from the authors regarding MLE and OASI in forceps delivery; however, we do believe that MLE during operative vaginal delivery in nulliparous should be performed to reduce the OASI rate. We do advocate for future prospective trials on this topic.

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Author contributions All authors contributed to the manuscript. GL: project development, manuscript writing/editing, literature search, AR: literature search, manuscript writing/editing.

Funding There was no study funding.

Compliance with ethical standards

Conflict of interest All authors declare that they have no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent This article does not contain any studies with human participants performed by any of the authors.

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