



## Reply to “Operative delivery in nulliparous: deserves an episiotomy” by Levin et al.

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We read with interest the letter to the editor by Levin et al. entitled “Operative in nulliparous: deserves an episiotomy” in reply to our paper “Does the implementation of a restrictive episiotomy policy for operative deliveries increase the risk of obstetric anal sphincter injury?”. We reported in this study that the implementation of a restrictive policy of mediolateral episiotomy was associated with an increase in OASI occurrence in forceps deliveries, whereas the rate of obstetric anal sphincter injury (OASI) for vacuum deliveries remains stable across a 11-year period [1].

Despite a protective effect of mediolateral episiotomy for OASI occurrence during vacuum-assisted operative deliveries reported in the literature [2], our results shown that a restrictive policy of episiotomy is possible and did not increase OASI occurrence. It seems that the protective effect of episiotomy is not linear and that an increased rate of episiotomy would not prevent more OASIs in case of vacuum-assisted operative deliveries. This appears consistent with the clinical observation that forceps increase the fetal cephalic perimeter and particularly its transverse diameter, which lead to an increased stress on the perineum. Our point of view is that the indication of episiotomy to prevent OASI during an operative delivery should be modulated according to the type of instrument used.

We included in our multivariate model variables having a level of significance greater than  $p < 0.15$  in the preliminary univariate analysis, but the level of significance considered for the final multivariate analysis was  $p < 0.05$ . This method is usually reported for such an analysis to consider all potential confounding factors in the multivariate analysis [3].

In our team, the mediolateral episiotomy recommended is a section from the posterior fourchette in direction of the ischiatic tuberosity with a 60° angle from midline as recommended by the French guidelines [4]. We agree that the retrospective design does not allow to affirm that all episiotomies were effectively mediolateral ones.

We totally agree with Levin et al. about the strong necessity of large prospective studies in this thematic. The place of episiotomy during childbirth is the subject of a large societal debate with especially the question of the women’s autonomy principle respect. A randomized trial does not appear feasible for methodological, ethical and practical reasons and a large observational study may be a safe option to consider. The real question we need to answer in the future, is “which pregnant woman need an episiotomy to deliver?” We need to develop a predictive model that would allow obstetricians and pregnant women to get individualized information about the place of episiotomy to give her the possibility to make an autonomous decision about how to give birth according to the recommendation of the English Supreme Court [5].

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## 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.

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