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*Review Article*

# Episiotomy – A Review from Modern & Ayurvedic Texts

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**ABSTRACT:**

In strict sense, episiotomy is an incision of the pudenda. Episiotomy often is used synonymously with perineotomy. It is a deliberate surgical incision given to avoid a ragged perineal laceration during delivery of fetus, as well as to protect the fetal head from excessive compression & injury[1]. In Ayurveda Acharya's have mentioned vitapachedana/ muladhar chedana / utkartana indicated in different conditions of Mudhagarbha. Also we can take it as sadhyovrana / Vaidhyakrita vrana. Many Yantras & Shustras, sivanakarma and vana ropak aushadhies also mentioned by Acharyas[2].

**KEY WORDS:** Episiotomy, Vitapachedana, Perineum, incision, Vrana

## INTRODUCTION:

The Word episiotomy derived from the Greek word episton. Pubic region, plus tomy to cut. In obstetrics episiotomy is the most common surgical incision performed on perineum and posterior vaginal wall during second stage of labour to aiding the actual delivery process or preventing tears and lacerations. This procedure is common practice for almost all women having their first delivery. Another commonly cited but unproven benefit of routine episiotomy was that it prevented pelvic relaxation – that is cystocele, rectocele and urinary incontinence[3]. A deliberate in cision avoids stretching and laceration of perineal muscles and maintains the integrity of perineal strength. However routine episiotomy is associated with an increased incidence of anal spincter and rectal tears.

While explaining mudhagarbha, utkartana Bhedan, chedan are indicated for Apatya-patham anuprapta anirasyamana and also in conditions like garbhasangha and bhagasankocha[2]. According to, shushruta for vrana four types of sivan karma were explained[4] He also explains about care of vrana after sivana by using ropana & shodhana dravyas and also upadrava and its management.

**Indications:**

- Primigravidas with tight perineum.
- Rigid perineum
- Big Baby
- Prior to forceps or vaccume delivery
- Breech vaginal delivery
- Face to pubes delivery in direct occipito-posterion presentation.
- Premature fetus
- Previous vaginal repair operations

In Ayurvedic contexts also indications can be derived as Mudhaapana, Kilamudhagarbha, Beejaka mudhagarbha, Upavishtaka, Savruta yoni[5].

**Types and timing:**

The timing of performing episiotomy needs judgment, if performed unnecessarily early bleeding from episiotomy may be considerable during the interval between incision and delivery. If it is performed too late, lacerations will not be prevented. It is common practice to perform episiotomy when the head is visible during contraction to a diameter of 3 to 4 cm. When used in conjunction with forceps delivery, perform an episiotomy after application of blades [6].

**Types :**

1. Mediolateral - The incision made downwards and outwards from the midpoint of the fourchette either to the right or left 2.5 cm. away from the anus.
2. Median – The incision comes from the center of the fourchette and extends posteriorly along the midline about 2.5 cm.
3. Lateral – The incision starts form about 1 cm away from the center of the fourchette and extends laterally. It has got many drawbacks including chance of injury to the Bartholin's duct. 4 –'J' shaped. The incision begins in the center of the fourchette and is directed downwards and outwards along 5 or 7 o'clock position to avoid the anal spincter.

**Procedure:** [8]

Episiotomy is done at the appropriate time neither too early nor too late with the help of an episiotomy scissors. This is done under local infiltration with 1% xylocaine (5-10 ml). Inserting 2 fingers (Using of the left hand) into the woman's vagina. The incision starts at the fourchette and extends mediolaterally (centrally in median), on the right side (rarely on the left), adequately cutting through the skin, posterior vaginal mucosa and the muscles of the perineum – approximately 2.5 cm. Midline verses Mediolateral episiotomy: [9]

**Table No. 1: Showing types of Episiotomy**

| Types of Episiotomy | | |
|---|---|---|
| Characteristic | Midline | Mediolateral |
| Surgical Repair | Easy | More Difficult |
| Faulty Healing | Rare | More Common |
| Postoperative Pain | Minimal | Common |
| Anatomical Results | Excellent | Occasionally Faulty |
| Blood Loss | Less | More |
| Dyspareunia | Rare | Occasional |
| Extensions | Common | Uncommon |

Except for the important issue of 3rd and 4th degree extensions. Midline episiotomy is superior. Proper selection of cases can minimize. This one disadvantage, following factors to be associated with an increased risk of third and fourth degree lacerations: nulliparity, second-stage arrest of labour, present occiput posterior position, mid or low forceps, use of local anesthetics.

**Timing of the episiotomy Repair:** [10]

The most common practice is not to repair episiotomy until the placenta has been delivered. This policy permits undivided attrition to signs of placental separation and delivery. A Further advantage is that episiotomy repair is not interrupted or disrupted by the obvious necessity of delivering the placenta, especially if manual removal must be performed.

**Technique of suturing:**

There are many ways to close an episiotomy incision, but haemostasis and anatomical restoration without excessive suturing are essential for success with any method. Episiotomy should be sutured by three layers - Vaginal mucosa & submucosa, muscles of incised perineum. Chromic catgut 3-0 is comely used. Derivatives of polyglycolic acid are used by same to reduce pain & dyspareunia.

According to vrana four types of siran karma were explained. Vellitumkam, Tunnasevane, Rijugrandhi, vayasatuda [11] can be taken as matress, continues, simple and figure of eight sutures respectively.

**Complications:** [12]

1. Extension of an episiotomy to form a 3rd degree perineal tear is more commonly seen.
2. Recto-vaginal fistula, when a button hole made during cutting in the anal wall.
3. Heamatoma formation- rarely causes heamostatic shock & severe anaemia
4. Infection and gaping of the wound.
5. Pain full scar and later dyspareunia.
6. Implantation cyst formation.
7. Scar enclometriosis.

By taking episiotomy as a Vrana, dustavrana lakshanas can be taken as complications like, shola, vishistata, Madhitaah, Hata, Marmahata, prahara[13], explained by Acharyes.

**CONCLUSION**:

Episiotomy is a procedure to reduce the complications during 2nd stage of labour. A planned cut, suturing, healing, avoiding stitch complication is always better than teared one. Although in new era restricted episiotomy is preferred by many doctors. In Ayurveda also vitapachedana is explained in only & where it indicates eg. In some types of mudhagarbha. For repair (sivan), local antiseptics like vrunashodhan & ropan dravyas & complications are also mentioned. Concluding in both medicines,

Episiotomy is best protector for baby & mother when it done where indicated at proper timing, well sutured & well managed.

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