

Post -Episiotomy Morbidity amongst Parturients at the University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria.

Type of Article: Original

Tammy .K. Nyengidiki, Solomon Nyeche

Department of Obstetrics and Gynaecology, College of Health Science, University of Port Harcourt, Port Harcourt, Nigeria.

ABSTRACT

Background

Episiotomy, a commonly performed obstetric operation is associated with complications following its administration and care. These complications largely go unnoticed because of the deviation of attention after a successful delivery and subsequent loss of follow up of parturients after delivery. The objective of this study is to identify the morbidities associated with episiotomies and factors associated with such morbidities.

Methods:

This was a cross sectional descriptive study among females who were attended to at the Obstetric Department of the University of Port Harcourt Teaching Hospital between 1st of January and 31st of May 2010. The study population consisted of patients who had episiotomies in their previous confinements attending either the antenatal clinic or the post natal clinic in the University of Port Harcourt Teaching Hospital.

Results

Majority of the subjects were in the 31-35 year age group. Post operative pain was the commonest complication and dyspareunia accounted of 70% of sexual complications. Majority of episiotomies were performed on subjects in their first confinement and repair performed by interns.

Conclusion

There is need to have a review of the pain management of patients with episiotomies and surgical techniques of interns repairing episiotomies. A restrictive use of routine episiotomy amongst primigravidae is advised to reduce the rate of episiotomy amongst this group.

Keywords: Post Episiotomy; Morbidity; Port Harcourt.

Correspondence: Dr T.K. Nyengidiki

Email: tammynyengs@yahoo.com

The University of Port Harcourt Teaching Hospital is a centre with documented high episiotomy rate¹¹ and this study is intended to highlight the postoperative episiotomy morbidities experienced by patients attending postnatal and antenatal clinics and the factors associated with such morbidities with a view to highlighting the gravity of the problem which has gone unnoticed by most practitioners.

SUBJECTS AND METHOD

This was a cross sectional descriptive study among females who were attended to at the Obstetric Department of the University of Port Harcourt Teaching Hospital between 1st of January and 31st of May 2010. The study population consisted of patients who had episiotomies in their previous confinements attending either the antenatal clinic or the post natal clinic in the University of Port Harcourt Teaching Hospital.

A sample size of 450 respondents was estimated using the Kish formula, episiotomy prevalence rate of 39%¹¹, desired precision rate of 5% confidence and an allowance of 25% for unreturned questionnaire.

A systematic random sampling technique was employed and the data collection instrument utilized was a structured anonymous questionnaire. The questionnaire was pre-tested prior to distribution and necessary corrections made. The authors and experienced public health nurses personally administered the questionnaires after obtaining an informed consent from the patients to be interviewed. A sampling ratio of one in twenty starting with the first patient that attended the clinic was employed. Data collected were analyzed using Microsoft Excel version 2007 software.

RESULTS

A total of 450 questionnaires were sent out and 400 were returned giving a retrieval rate of 89%.

Socio- Demographics:

The socio-demographic characteristics of parturients are shown in Table 1

Age:

The mean age of respondent was 28.9±7.04 years. The age range of patients was 16-39years. The age distribution is as shown in table 1. Among the female surveyed majority 40% were aged 31-35years with the least (5.5%) in the 36-40 year age group.

Parity:

Majority of the subjects who were in the Para 2-3 group constituted 54.50% of respondents, while 27.5% were primipara and 8% were grandmultiparous.

INTRODUCTION

An episiotomy is a surgical incision made on the perineum to increase the diameter of the vaginal outlet during child birth¹. The essence of episiotomy is to reduce the risk of injuries to maternal soft tissue during the birth process, reduce the resistance of soft tissue to delivery and reduce risk of child injury². Despite current evidence supporting the restrictive use of episiotomies which had been adopted by most developed countries with resultant reduced rates,^{6,7} routine episiotomy is still an integral part of the traditional midwifery practice in Nigeria.^{10,11} The practice of routine episiotomy had resulted to high episiotomy rates with increased accompanying complications³⁻⁵.

Educational Status:

All respondents had some form of education with 42% attaining tertiary education, 37. 50% had secondary education and 20. 50% had only primary education.

Episiotomy and Parity:

Episiotomy was administered to 70% of women in their first confinement while 11% had in their second confinements. During first and second confinement 15% had episiotomy as against 2.75% that had in their first, second and third confinements respectively. Only 1.25% had episiotomy in their fourth confinements. No respondent had episiotomy with parity greater than 4. (Table 2)

Personnel Performing Episiotomy

Midwives took 65% of deliveries, Senior Registrars and Registrars constituted 29% of personnel that took deliveries while Consultants took 2% of the deliveries (figure 1)

Personnel Repairing Episiotomy

Interns repaired 82.50% of episiotomies in the respondents, 15.50% were done by the registrars/ senior registrars while 2% were repaired by the consultants. (Table 3)

Complications

Following the administration of episiotomy, 45% of respondents had complications. Pain was the most reported complication observed in 45.0% of subjects. Bleeding was reported in 22.0% while 9% had prolonged wound healing. Post episiotomy infection was reported in 6% with 5% of having breakdown of episiotomies. Fecal and flatus incontinence occurred in 6% and 3% of subjects respectively (figure 2). 30% of respondents had the episiotomy affecting their sexual life with dyspareunia constituting 70% of sexual complications. Psychological inhibitions to sexual activity was observed in 16.7% of subjects because of the shape of their vulva while 13.3% had capacious vagina.(Table 4)

Follow Up Assessment

Amongst respondents 63% had their episiotomy site examined during the postnatal visit while 37% never had their episiotomy sites examined during the postnatal visit.

Table 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

VARIABLE	FREQUENCY	PERCENTAGE
Age		
15-20	24	6
21-25	48	12
26-30	146	36.5
31-35	160	40
36-40	22	5.5
Educational status		
-No formal education	-	-
-Primary	82	20.50
-Secondary	150	37.50
-Tertiary	168	42
Parity		
0-1	110	27.5
2-3	218	54.5
4-5	40	10
>5	32	8

Table 2: Parity at time of Episiotomy

Parity	Frequency	Percentage
1	280	70
2	44	11.0
1,2	60	15.0
1,2,3	11	2.75
4	5	1.25
5>	0	0

Fig 1: Cadre of labour ward staff that took the delivery

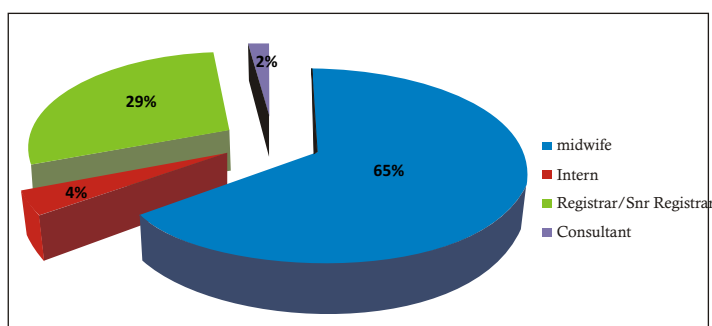


Table 3: Cadre of Doctors Repairing Episiotomy

CADRE	FREQUENCY	PERCENTAGE
Interns	330	82.50
Registrar/Senior Registrar	62	15.50
Consultants	8	2

Fig 2: Forms of episiotomy complications

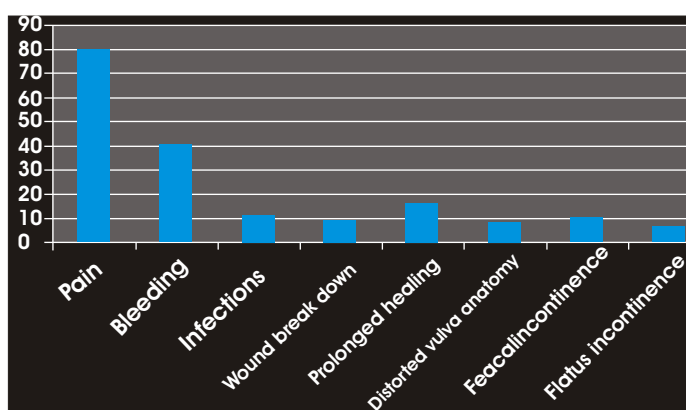


Table 4: Sexual Dysfunction Amongst Respondents

Type	Frequency	Percentage
Pain at intercourse	84	70
Laxity of vaginal canal	16	13.3
Psychological inhibitions due to		
Anatomical distortions of introitus	20	16.6

DISCUSSIONS

The finding that most respondents in this study fell within the age group of 31-35 years is similar to observations in other studies.^{12,13} Preponderance of this age group can be explained by the high proportion of respondents that had attained tertiary education before embarking on their reproductive career. The issue of higher education had been highlighted as an independent risk factor by Howden et al.

Nulliparity was identified as a major predictor of episiotomy in this study as 70% of parturient had episiotomy in their first confinement, which was also, highlighted by various studies.^{8,9,12,13-15}

The increase in the rate of episiotomy amongst nulliparous patients is based on the presumptive fear of increased risk of perineal laceration once the perineum had not been tried hence considered as rigid. However, this practice has erroneously increased the episiotomy rate in nulliparous patient but studies have found reduction in rates if episiotomies are not given presumptively for fear of perineal lacerations.¹⁶⁻²¹

The probability of having an episiotomy had been linked to the attendant at delivery and the institution the delivery is being conducted²². More than half of the deliveries in this study were conducted by midwives and episiotomies were given in the process.

These high values may be explained by the fact that episiotomies given by the midwife are not repaired by the giver hence the liberty in giving further episiotomies as against that given by the doctor¹¹. In addition, the training orientation of the midwives tend to favour administration of episiotomies to nulliparous patients as observed in this study as against observations by Ola et al that doctors give more episiotomies than nurses.⁹

Despite the fact that most interns do not conduct deliveries, most repairs were carried out by them which may on its own contribute to the increased rate of complications. Further studies are suggested to compare the morbidities in association to the personnel repairing the episiotomy. An astounding observation is the fact that 68% of parturient were not given any form of anaesthesia before the procedure leading to significant levels of pain as demonstrated by 44.1% having severe pain. This alone provides a good ground for resentment of the procedure and further discourages mothers

from delivering in the hospital as highlighted by Otoide et al.

The need for restrictive use of episiotomy as advised by the world health organization and other agencies^{4,5,7,20,23}, can be affirmed by the percentage of respondents who had complications of various degrees from the procedure of which the most common complication was the occurrence of pain. The complication of pain and post episiotomy introital dyspareunia observed in this study would have resulted from a misplaced, too generous or too tight crown stitch, which can be avoided by the placement of loose approximations of tissues to allow for oedema formation². The high proportion of subjects with dyspareunia and perineal pain reported in this study has been previously documented by other studies²⁴.

In addition, postpartum sexual dissatisfaction as evident by increased introital opening, displeasure at the resultant anatomy after repair and dyspareunia as highlighted in this study further reinforces the need for restrictive use of episiotomies.²⁵ This is an obvious aftermath of the repair process after administration which was largely left for the intern as observed in this study.

A route of ameliorating some of the complications of the procedure is the examination of the parturients during the postnatal visit. However it was observed that 37% of parturients did not have their episiotomy sites examined during such visits which closed a window of opportunity to either counsel such patients or correct any defects identified.

CONCLUSION

Episiotomy has long and short term complications on affected women both psychosexual and physically. Based on available evidence, restricted use of episiotomies should be encouraged by careful selection of parturients including nulliparous patients and encouraging antenatal perineal massage which had been known to be beneficial in reducing the incidence of episiotomies²⁶. There is also need to improve the quality of care of patients. Enhanced supervision and retraining of interns is advocated since they form a bulk of practitioners repairing the episiotomies administered.

REFERENCES:

1. Johnson R. Obstetric procedures. In Edmond KD (ed). Dewhurst's Textbook of Obstetrics and Gynaecology for Postgraduates. 6th edn. Oxford, Blackwell Scientific Publications. 1999; 308-329.
2. Warren PC. Episiotomy and Repair. In Darlene P, Martins W, Joan M (eds). Surgical Obstetrics. WB Saunders Publications. 1992; 365-72.
3. Thacker B, Banta HD. Benefits and risk of episiotomy: An interpretative review of the English literature 1860-1980. *Obstet Gynaecol Surv.* 1983.38:322-328.
4. Royal college of Obstetricians and Gynaecologist (RCOG) Guidelines NO. 23: Methods and materials used in perineal repair. 2000:1-2.
5. Mascarenhas T, Elliot BW, Mackenzie B. Comparison of perinatal outcome, Antenatal and Intrapartum Care between England, Wales and France; *British Journal of Obstet and Gynaecol*; 1992:555-558.
6. Argentine Episiotomy Trial collaborative Group. Routine versus Selective Episiotomy. A randomized control Trial, *Lancet* 1993; 343:1517- 1518.

7. Graham IB. Episiotomy- Challenging Obstetrics Intervention, Oxford Blackwell Science Publications.1997:3-7.
8. Carole G, Belizaan J, stamp G. Episiotomy policies in vaginal birth. In: Pregnancy and child birth module of the Cochrane Database of systemic reviews. The Cochrane Library. Oxford: Update Software. 1997.
9. Ola ER, Bello O, Abudu OO, Anorluu RI. Episiotomy in Nigeria- should their use be restricted? Nigeria Postgraduate Medical Journal 2002(1): 13-16.
10. Otoide VO, Ogbonmwan SM, Okonuofua EF. Episiotomy in Nigeria. International Journal of Gynaecology and Obstetricians 2000. 68(1): 13-17.
11. Enyindah CE, Fieba PO, Anya SE, Okpani AOU. Episiotomy and Perineal Trauma Prevalence and Obstetric risk Factors in Port Harcourt Nigeria. Nigerian Journal of Medicine. 2007.16(3):242-245.
12. Houden NL, Weber AM, Meyen LA. Episiotomy Use Amongst Residents in Faculty Compared to Private Practitioners. Obstetric Gynaecology. 2004. 103(1):114-118.
13. Weber AM, Meyn L. Episiotomy use in the United State of America. 1979- 1997. Obstet, Gynaecol. 2002:100(6): 1177-1182.
14. Williams FL, Du V. Florey C, Mires GJ, Ogston SA. Episiotomy and Perineal Tears in the low risk U.K Primigravidae. Journal of Public Health Med. 1998. 20(4): 422- 427.
15. Marinho AO. Episiotomies and Tears in 9255 Nigerian Obstetric patients. West Africa Journal of Medicine 1986. 5 (2): 117-120.
16. Lorenz N, Nougara A, Garner P. Episiotomy in Burkina Faso. Tropical Doctor, 1998.28(2): 83-85.
17. Henriksens TB, Bek KM, Hedegaard M, and Secher NJ. Changes in use of Episiotomy- Methods and Consequences. Ugeskr Laeger. 1995.157(40): 5525-5529.
18. Henriksens TB, Beks KM, Hedegaard. M, Scher NJ: Episiotomy and perineal lesions in spontaneous vaginal delivery. Ugeskr Laeger 1994. 156(21):3176-3179.
19. Reynold JL: Reducing the frequency of Episiotomies through a continuous quality improvement programme. CMAJ 1995.153(3): 275-282.
20. Dimitrov A, Nikolov A, Nalbanski B, Stamenov G, Dimitrov I, Lazarova L et al. The Result of the limited use of Episiotomy in managing the second stage of labour. Akush Ginekol (Sofilia). 1997. 36(1): 3-4.
21. Dannecker C, Hillemanns P, Strauss A, Hasbargen U, Hepp H, Anthuber C. Episiotomy and perineal tear presumed to be imminent: Randomized controlled trial: Acta Obstet Gynaecology Scand 2004. 83(4): 364-368.
22. Zonderan KT, Buitendijk SE, Anthony S, Van Rijssel EJ, Verkerk PH. Frequency and Determinants of Episiotomy in second line Obstetrics in Netherlands Ned Tijdscher Geneckd 1995. 139(9): 449- 452.
23. Anthony S., Buitendijk S.E., Zonderan K.T, Van Rijssel E.J Verkerk P.H. Episiotomies and the occurrence of severe perineal laceration. British Journal of Obstet and Gynaecology. 1994. 101(12): 1064-7.
24. Sartore A, De Seta F, Maso G, Pergazzi R, Grimaldi E, Guaschino S. The effect of mediolateral episiotomy on pelvic floor function after vaginal delivery. Obstet Gynaecol 2004. 103(4): 669-673.
25. Peon AC, Fel Bersma RJK, Dekker GA, Deville W, Cuesta MA, Menwissen SGM. Third degree obstetric perineal tear; risk factors and the preventive role of Mediolateral Episiotomy. British Journal of Obstet Gynaecol. 1997. 104:563- 566.
26. Shipman MK, Boniface DR, Tefft ME, Mc Cloghry F. Antenatal perineal massage and subsequent perineal outcome. A randomized controlled trial British Journal of Obstet Gynaecol. 1997.104(70) 787-91.
27. Imarengiaye C0, Andet AB. Post partum perineal pain amongst Nigerian women. West African Journal of Medicine. 2008. 27(3) 148-51.

Conflict of interest: None