شبكة المعلومات الجامعية

بسم الله الرحمن الرحيم

شبكة المعلومـــات الجامعية

التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

جامعة عين شمس

التوثيق الالكتروني والميكروفيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
علي هذه الأفلام قد اعدت دون آية تغيرات

يجب أن

تحفظ هذه الأفلام بعيداً عن الغبار

في درجة حرارة من 15 – 20 منوية ورطوبة نسبية من 20-40 %

To be kept away from dust in dry cool place of
15 – 25c and relative humidity 20-40 %

بالرسالة صفحات

لم ترد بالأصـــل

بعض الوثائق الأصلية تالفة

LIBERAL VERSUS RESTRICTED EPISIOTOMY

Thesis

Submitted in Partial Fulfillment of Master Degree
In Obstetrics and Gynaecology

By

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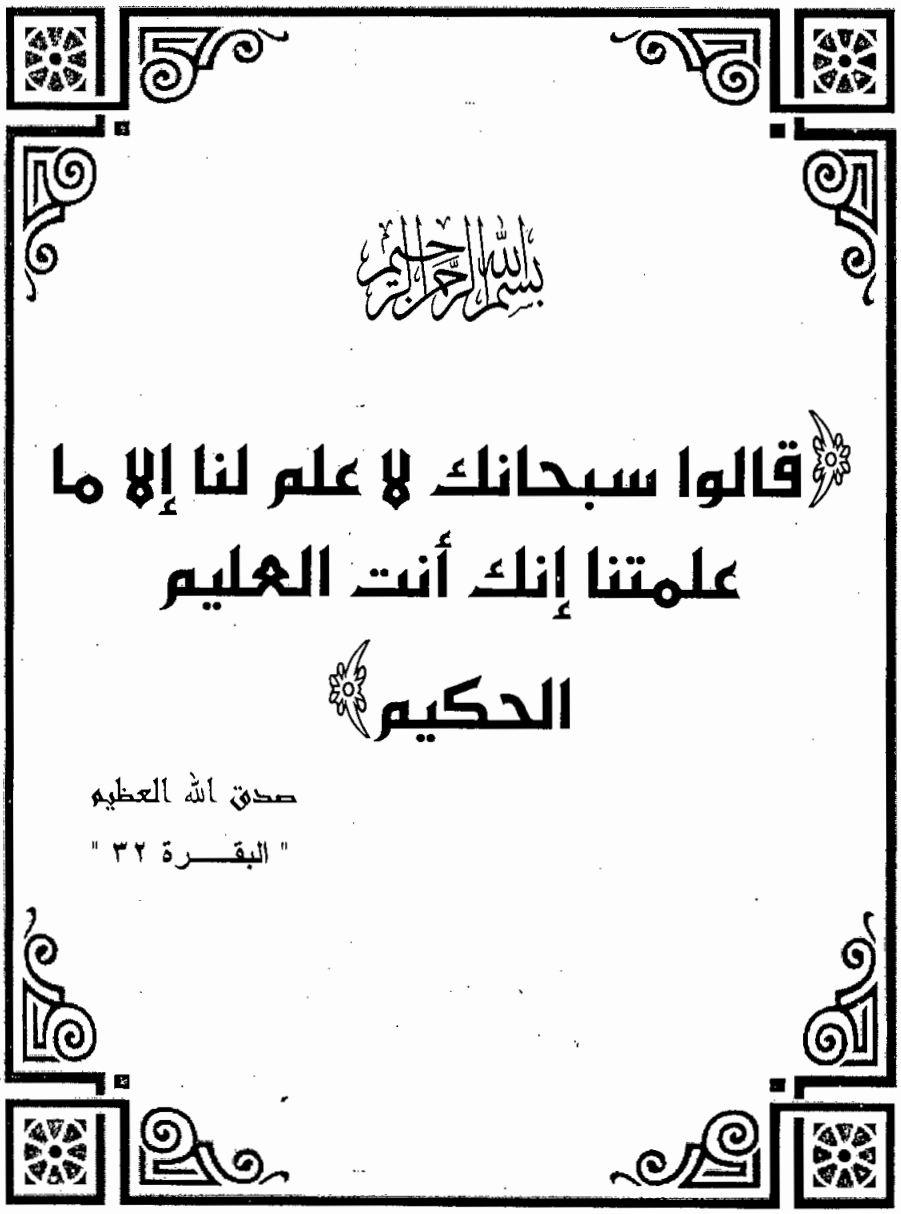

بسم الله الرحمن الرحيم

قالوا سبحانك لا علم لنا إلا ما علمتنا إنك أنت العليم الحكيم

صدق الله العظيم

" البقـــرة ٣٢ "

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INTRODUCTION

INTRODUCTION

Episiotomy, the commonest intervention during childbirth, was first introduced for complicated deliveries. However, in many centers it became a routine policy in clinical practice without scientific evidence of its benefits ***(Röckner and Fianu - Janasson, 1999)***. During the last three decades the need for episiotomy has been questioned by childbirth activists, women themselves, midwives and obstetricians ***(Thacker and Banta, 1983 - Sleep et al., 1984 - Harrison et al., 1984 – Throp and Bowes, 1984 - House et al., 1986 - Angentine Episiotomy Trial Collaborative Group, 1993 - Klein et al., 1994 - Woolley, 1995 - Graham, 1997)***.

Traditional teachings and obstetric practice recommend liberal use of episiotomy because of many alleged benefits. Firstly; that it is prophylactic in preventing deep perineal tears, fetal brain damage in premature fetuses, birth injuries, relaxation of pelvic floor with subsequent urinary/ fecal incontinence and/or vaginal prolapse, and better sexual function. Secondly; that episiotomies, compared to perineal tears, are easier and better to repair, heal better, with less short-term and long-term pain ***(Banta and Thacker 1982 - Pritchard et al., 1985)***.

Thacker and Banta (1983), published a comprehensive review of the English literature, on benefits and risks, of episiotomy between 1860 to 1980, including more than 350 articles, reports and book chapters. They found no convincing evidence that episiotomy prevented tears into the rectum, damage to the pelvic floor, and trauma to the fetal head, and that episiotomies were easier to repair and heal better than tears.

Moreover, like any other surgery, episiotomy has risks including; extension of the incision, blood loss, pain, poor healing, infection and dyspareunia, all of which are documented in the literature. The risks of episiotomy are more severe than many appreciate and although rarely associated with a life-threatening problem, they can be a source of serious morbidity to young mothers.

Thacker and Banta's (1983), review has had a profound effect. The pace of research on episiotomy has increased dramatically since their publication, and the quality of much of the data exceeded anything available in 1980; shifting towards evidence-based medicine *(Woolley, 1995)*.

Woolley (1995), published another review of the English literature between 1980 and October 1994 on benefits and risks of episiotomy including, journal articles and chapters in prominent obstetric textbooks. The authors concluded that episiotomies prevent anterior perineal lacerations, which carry minimal morbidity. However, episotomies failed to accomplish any of the other maternal and fetal benefits traditionally described. Moreover, episiotomies were found to increase maternal blood loss, the average depth of posterior perineal injury and its long-term morbidity (at least for midline episiotomy), risk of improper wound healing, and the amount of pain in the first several postpartum days and later on. The authors pointed out that 12 years later, it is still the case as concluded by Thacker and Banta in 1983 regarding alleged benefits of routine episiotomy.

It is unfortunate, that despite two decades of evidence to the contrary, obstetricians in USA and Canada and in some other countries

still adhere to the practice of liberal use of episiotomies. As an example, the Canadian Multicenter Randamized Controlled Trial ***(Klein et al., 1992)*** could not get doctors to abandon the practice of liberal use of episiotomy, and the rates were reduced by only one third in the so-called restricted arm of the study, and more than half of the primiparous (57%) and nearly on third (31%) of multiparas in the restricted group still had episiotomies. In Europe however, there is appreciable decrease in episiotomy rates in many countries and episiotomy rates under 30% have been accomplished on some national scale and rates under 10% at the scale of individual institutions ***(Sleep et al., 1984 - Buekens, 1985 – Röckner and Ölund, 1991)***. Lately, ***Röckner and Fianu-Jonasson (1999)***, reported episiotomy in only 302 out of 4575 consecutive nulliparous women (6.6%) with no adverse fetal or maternal effect in Huddinge University Hospital in Sweden.

In Egypt, liberal episiotomy appears to be the practice of most obstetricians who still follow the old teachings that episiotomy is needed for nulliparous women or previously incised multiparous women to avoid a perineal lacerations, and for many other conditions, in which episiotomy was found to be of a questionable value. This non-evidence based practice (which is practiced in our department also) led us to undertake this clinical study to compare the benefits and risks of liberal "routine" versus restricted episiotomy in the same obstetric setting, namely the Department of Obstetrics and Gynecology, in Benha University Hospitals.

AIM OF THE WORK