

Episiotomy explained and when it is performed



What an episiotomy is

An episiotomy is a deliberate surgical incision in the perineum made during the second stage of vaginal birth, usually when the baby's head is crowning or birth is imminent. Its purpose is to enlarge the vaginal opening so the baby can be born more quickly or so instruments can be used with less obstruction. It is not a procedure done early in labor; it is performed only when the presenting part is low enough and delivery is close.

The perineum is richly supplied with nerves and blood vessels, and it supports the vaginal opening, anal sphincter complex, and pelvic floor. Because this tissue matters for continence, sexual comfort, and pelvic floor function, any incision should have a clear reason. A clinician may use local anesthesia if an epidural is not already providing adequate pain relief. After birth, the incision is inspected and repaired in layers with absorbable sutures.

Episiotomy is different from a spontaneous perineal tear. A tear occurs naturally as the tissues stretch and may be small or more extensive. An episiotomy is a controlled cut, but that does not mean it is risk-free. It can extend into a deeper tear, involve more postpartum pain than a minor tear, or require careful follow-up if healing is delayed.

Why routine episiotomy is no longer recommended

Historically, episiotomy was often performed with the belief that a clean incision would heal better than an irregular tear, protect the pelvic floor, reduce severe perineal trauma, and make birth easier for the baby. Evidence and clinical experience have changed that approach. Current practice in many settings is restrictive or selective: episiotomy should not be done automatically for every vaginal birth.

The reason is straightforward but important. Routine episiotomy does not reliably prevent severe perineal injury, urinary or fecal incontinence, or later pelvic floor problems. It also creates a wound that every patient must recover from, even when they might otherwise have had no tear or only a small superficial tear. In particular, midline episiotomy, a cut directed straight toward the anus, has been associated with a higher risk of obstetric anal sphincter injury compared with more selective approaches.

This does not mean episiotomy is never appropriate. It means the decision should be individualized. Selective episiotomy during labor may be reasonable when the likely benefit outweighs the risk, especially if the team needs to shorten the time to birth or create space for a safe assisted delivery. The key distinction is that episiotomy is a clinical tool, not a routine step in vaginal birth.

When episiotomy may be performed

An episiotomy may be considered when birth needs to happen quickly and the perineum is limiting delivery. One common example is concern about the baby's condition, such as a nonreassuring fetal heart rate pattern when the head is already low and vaginal birth is expected to be faster than cesarean birth. In that situation, the goal is not convenience; it is to reduce the time until the baby is delivered.

It may also be used during assisted vaginal birth with vacuum or forceps. Instruments require room to be placed and maneuvered safely, and the clinician may judge that the perineum is too tight or that the instrument-assisted birth is likely to cause uncontrolled tearing without an incision. Not every vacuum

or forceps birth requires episiotomy, but the possibility is higher than in spontaneous vaginal delivery.

Other situations can include shoulder dystocia maneuvers, very rigid perineal tissue preventing imminent birth, or specific circumstances where access is needed for the clinician's hand or instruments. Episiotomy does not by itself resolve shoulder dystocia, because the obstruction is usually at the bony pelvis rather than the vaginal opening, but it may create room for internal maneuvers.

Clinical judgment matters because the same scenario can look different from one birth to another. Fetal position, speed of descent, maternal pushing effort, tissue stretching, analgesia, previous perineal injury, and the clinician's assessment all influence the decision. If time allows, the healthcare professional should explain why the incision is being recommended and obtain informed consent.

How the procedure is usually done

When episiotomy is needed, it is typically performed at the peak of a contraction as the perineum is stretched and the baby's head or presenting part is distending the vaginal opening. If the birthing person has an epidural, it may already provide sufficient anesthesia. If not, local anesthetic should be used whenever possible before making the incision. The clinician uses sterile scissors to make a controlled cut, then supports delivery of the baby.

There are different incision directions. A midline episiotomy goes from the vaginal opening toward the anus. It may be easier to repair and can cause less bleeding, but it has a greater tendency to extend into the anal sphincter. A mediolateral episiotomy angles away from the anus and is often preferred in many guidelines because it may reduce the likelihood of extension into the anal sphincter, although it can be more painful and technically requires correct angle and placement.

After the baby and placenta are delivered, the clinician examines the vagina, perineum, and anus to classify the injury and check whether there has been extension. Repair usually involves absorbable stitches placed in the vaginal tissue, perineal muscles, and skin. Good lighting, adequate pain control, and

careful assessment are important, particularly if there is concern about a third- or fourth-degree tear involving the anal sphincter or rectal mucosa.

Recovery and what healing can feel like

Recovery varies. Some people describe mild soreness; others have significant pain, swelling, bruising, or a pulling sensation at the stitches. Discomfort is often worse with sitting, walking, urinating, or bowel movements in the first days. The sutures usually dissolve on their own, and the skin generally heals over several weeks, although tenderness, scar sensitivity, or pelvic floor symptoms can last longer.

Typical supportive measures may include cold packs in the first 24 hours, prescribed or approved pain relief, keeping the area clean, using a peri bottle while urinating, changing pads frequently, and preventing constipation with fluids, fiber, mobility as tolerated, and clinician-approved stool softeners when recommended. These measures are general comfort strategies, not a substitute for individualized medical advice.

It is important to seek care for worsening pain, increasing redness or swelling, pus-like discharge, fever, foul odor, heavy bleeding, wound opening, inability to pass urine, loss of bowel control, or severe pain with bowel movements. Emotional recovery also matters. Some people feel disappointed, frightened, or violated if an episiotomy happened urgently or without much explanation. A postpartum debrief with the maternity team can help clarify why it was performed and what it means for future birth planning.

Consent, preferences, and birth planning

Because episiotomy is sometimes performed in urgent circumstances, conversations before labor can be especially valuable. You might tell your clinician that you prefer to avoid episiotomy unless there is a clear medical indication, ask what techniques they use to reduce severe tearing, and ask which type of incision they generally use if episiotomy becomes necessary. These questions are reasonable and medically relevant.

Informed consent should include the reason for the procedure, expected benefit, pain control plan, and potential risks when there is enough time to discuss

them. In a true emergency, explanation may be brief, but respectful communication still matters. A supportive team can often say what is happening in simple terms, even while acting quickly.

People with a prior severe tear, previous traumatic birth, pelvic floor symptoms, vulvar pain conditions, or concerns about sexual recovery may benefit from discussing individualized planning with an obstetrician or midwife before delivery. This may include perineal support during crowning, warm compresses to the perineum, controlled delivery of the head, position options, and a plan for repair and follow-up if tearing or episiotomy occurs.