Is episiotomy still common and its impact on delivery

What episiotomy means in modern birth care

An episiotomy is not simply a "small cut." It is a deliberate surgical enlargement of the vaginal opening, usually performed when the baby’s head is crowning or during an assisted vaginal birth. Local anesthetic may be used if an epidural is not already providing adequate pain relief, and the incision is repaired with absorbable sutures after birth.

The procedure became common in the twentieth century because clinicians hoped it would make birth more predictable: a straight incision seemed easier to repair than a spontaneous tear, and it was thought to protect the pelvic floor. However, later research did not confirm these hoped-for benefits for routine use. In particular, routine episiotomy does not consistently reduce urinary or fecal incontinence, pelvic organ prolapse, or severe perineal trauma after birth. In some cases, it may increase the chance of deeper injury.

Modern practice emphasizes "restrictive" or selective episiotomy. This means the birth team does not perform it automatically but considers it only when a specific clinical indication arises. Many people now give birth vaginally without an episiotomy, even if they have minor spontaneous tears that heal with minimal repair or no stitches at all.

Is episiotomy still common?

Episiotomy is less common than it used to be, especially in settings that have adopted evidence-based restrictive use. Rates vary widely by country, hospital, clinician training, parity, fetal position, and whether forceps or vacuum is used. A first vaginal birth generally carries a higher likelihood of perineal intervention than a later vaginal birth, but routine cutting is no longer considered best practice.

The decline reflects a major shift in interpretation of the evidence. Natural tearing is often preferred because many spontaneous tears are superficial or limited to the vaginal mucosa and perineal skin. By contrast, an episiotomy always creates at least a second-degree injury, because it cuts through perineal muscle. That does not mean episiotomy is never helpful; it means the expected benefit must outweigh the added wound.

It is reasonable to ask your hospital or clinician about their typical approach. Some units audit episiotomy rates and severe tear rates together, because a very low episiotomy rate is not the only goal. The more important question is whether episiotomy is being used thoughtfully: avoided when unnecessary, but available when it may shorten a dangerous interval or facilitate a safer instrumental birth.

When an episiotomy may still be needed

Selective episiotomy is most often considered when extra space is needed for urgent or technically difficult delivery. Examples include a nonreassuring fetal heart rate when the head is already low, a need to expedite birth, or operative vaginal delivery with forceps or vacuum when the perineum is limiting safe descent. It may also be considered during shoulder dystocia during birth, when the baby’s shoulders are stuck after the head is born and maneuvers must be performed quickly.

Importantly, episiotomy does not fix every emergency. For example, in shoulder dystocia it does not enlarge the bony pelvis; rather, it may create room for the clinician’s hands to perform internal maneuvers. Similarly, in fetal distress, it is relevant only if the baby is already close to being born

vaginally. If the head is high or vaginal birth is not imminent, an emergency C-section during labor may be the safer route.

Clinicians also consider assisted vaginal delivery eligibility before using forceps or vacuum. This includes fetal station and position, cervical dilation, membrane status, estimated fetal size, maternal pelvis, anesthesia, and the ability to proceed to cesarean if needed. Episiotomy may be part of that plan, but it should not be a substitute for careful assessment.

Types of episiotomy and why the angle matters

The two main types are midline, also called median, and mediolateral episiotomy. A midline incision runs straight from the vaginal opening toward the anus. It is often easier to repair and may involve less bleeding and less immediate pain, but it has a higher risk of extending into the anal sphincter or rectum, creating a third- or fourth-degree tear.

A mediolateral incision angles away from the anus. It may be more painful, bleed more, and require a more technically precise repair, but it is designed to reduce the likelihood that the incision will extend directly into the anal sphincter. The exact protective effect depends on the angle at the time of cutting and after the tissues stretch during crowning; an incision that looks adequately angled before birth can become more midline as the perineum distends.

Other variants exist but are less common. The choice of incision depends on training, local practice, anatomy, urgency, and whether instruments are being used. From a patient perspective, the key point is that "episiotomy" is not one uniform procedure. The direction and depth influence bleeding, pain after vaginal birth, repair complexity, and the risk of anal sphincter involvement.

How episiotomy can affect the delivery itself

During birth, an episiotomy may shorten the final moments of delivery if the perineum is tight and the baby needs to be born quickly. It can also improve access for forceps, vacuum, or internal obstetric maneuvers. In a true emergency, seconds and minutes matter, and a well-judged episiotomy can be one component of a safe response.

However, the procedure also changes the delivery by adding a surgical wound that must be repaired. It may increase blood loss compared with an intact perineum or a small spontaneous tear, though the amount is usually manageable in a monitored birth setting. It may also affect immediate postpartum comfort, positioning for feeding, mobility, urination, bowel movements, and willingness to sit upright.

The impact should be understood alongside the alternative. If the choice is between a selective episiotomy that enables a safe forceps birth and a delay with worsening fetal status, the incision may be beneficial. If the choice is between routine cutting and allowing gradual stretching with supportive perineal care, avoiding episiotomy may reduce unnecessary injury. This is why context matters more than the procedure label alone.

Recovery, pain, and longer-term pelvic floor considerations

Recovery after episiotomy usually involves perineal soreness, swelling, and tenderness around the sutures. Pain often peaks in the first few days and improves over one to two weeks, although deeper aching or discomfort with sitting can last longer. Cold packs, appropriate analgesics recommended by the care team, peri bottles, stool-softening strategies, and avoiding constipation are commonly discussed postpartum measures.

Wound healing can be affected by infection, hematoma, suture breakdown, diabetes, smoking, anemia, or significant swelling from a long second stage. Warning signs include worsening pain rather than gradual improvement, fever, foul-smelling discharge, increasing redness, pus, wound separation, or new difficulty controlling gas or stool. These symptoms deserve prompt medical review.

Longer-term outcomes vary. Some people heal well and have no persistent problems. Others experience scar tenderness, pain with intercourse, pelvic floor weakness, or anxiety about future birth. If the injury involved the anal sphincter, follow-up is especially important. Pelvic floor physical therapy can be valuable for rehabilitation, but it should be individualized after assessment rather than started as a one-size-fits-all program.

How to discuss episiotomy before labor

A supportive birth discussion can be both preference-based and safety-aware. You might say, "I prefer to avoid routine episiotomy, but I understand it may be needed for urgent delivery or specific obstetric indications." This gives the team clear consent values while acknowledging that labor can change quickly.

Useful questions include: What is your usual episiotomy rate? In which situations do you recommend it? Which type do you usually perform? How do you reduce severe tears? What perineal support techniques do you use during crowning? How would you communicate the need for episiotomy if time is limited?

It can also help to discuss related decisions, such as operative vaginal birth, fetal monitoring, and thresholds for cesarean section. Birth is dynamic, and the safest decision may depend on fetal heart tracing, descent, maternal exhaustion, bleeding, infection, and the availability of skilled staff. The goal is not to refuse all intervention or accept all intervention; it is to use the right intervention for the right reason, with respectful communication whenever possible.